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F 241 SS=E	483.15(a) DIGNITY 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, interview and record review, it was determined the facility did not provide care to enhance each resident's dignity for 4 of 5 alert and oriented residents who participated in a confidential group interview and 1 of 15 sample residents who stated they waited longer than 5 minutes for assistance when they used their call lights and for 1 supplemental resident who called out for help without timely response. Resident identifiers: 2 and 20. Findings included: 1. Resident 20 was admitted to the facility 12/28/06 with diagnoses that included diabetes mellitus, congestive heart failure and depression. Resident 20's comprehensive Minimum Data Set (MDS) assessment, dated 1/10/07, was reviewed on 3/14/07. Resident 20 had been assessed by the Interdisciplinary Team as needing 2-person assistance to transfer to and from different surfaces, as having a functional deficit of her lower extremities on one side, and as being able to communicate clearly. On 3/13/07, resident 20 was observed continuously from 2:27 PM until 2:46 PM. Resident 20 was observed to be in the doorway to her room, sitting in her wheelchair, and calling,	F 241		5/1/07

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

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"Help, help." Resident 20's room was within twenty feet of a nurses' station where four nurses and a medical records staff were busily trying to process two residents for discharge. The nursing assistants were meeting in a room behind the nurses' station.

At 2:31 PM, resident 20 was continuing to call "Help. Help. Oh, please help me," and "Help. Hey, help." A fifth nurse approached the nurses' station, looked for something there, then left, passing resident 20 on the way. Within a minute, a social services worker entered the area to talk with the residents who were leaving. At 2:36 PM, the social services work left.

At 2:35 PM, nursing staff 7 was at the nurses' station and nursing assistant 6 arrived at the nurses' station, Nursing assistant 6 and nursing staff 7 both left the area. Resident 20 remained in her doorway calling for help.

At 2:39 PM, resident 20 had moved out into the hallway and nursing assistant 8, who had been at the nurses' station briefly, asked resident 20 what she needed. Nursing assistant 8 moved resident 20 into the resident's room and said she would get someone to help the resident.

At 2:40 PM, the surveyor entered resident 20's room. Resident 20 was observed to be sitting in her wheelchair, facing the doorway to her room. Resident 20 stated she wanted to lie down for awhile.

At 2:46 PM, two nursing staff entered resident 20's room to assist her into bed. Resident 20 had been observed for nineteen minutes while the resident called out for help before she got the

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help she needed.

2. Resident 2 was admitted to the facility 9/9/06 with diagnoses that included urinary tract infection, anxiety disorder, depression and arthritis.

Resident 2's medical record was reviewed on 3/14/07. Resident 2's Minimum Data Set (MDS) assessments, dated 9/22/06 and 12/11/06, were reviewed. Resident 20 had been assessed by the Interdisciplinary Team (IDT) as having no memory deficit and having modified independence in cognitive skills for daily decision making. The IDT documented that resident 2 was continent of bowel and bladder but required extensive assistance of one person to transfer and to use the toilet. The IDT documented that resident 2 had repeated anxious concerns with body functions.

On 3/13/07 at at 1:50 PM, resident 2 was observed to be in her bed with the side rails up. Resident 2 was awake and stated that she was resting comfortably. At 2:08 PM, resident 2 was observed to be in her room in her wheelchair. Resident 2 was unable to locate her call light and became anxious. Resident 2 relaxed after she found the call light button. Resident 2's call light and button were found hanging behind a tall dresser approximately three feet from the head of the resident's bed.

On 3/13/07 at 3:00 PM, resident 2 was interviewed in her room. Resident 20 stated that she had concerns regarding her call lights being answered too slowly. Resident 2 stated that she needed to use the bathroom frequently throughout the night. Resident 2 stated that her

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F 241	Continued From page 3 call lights were often answered after more than five minutes, especially during the night shift. Resident 2 stated she had waited what felt like an hour the previous night. Resident 2 stated she had to wait so long that she had soiled herself. On 3/13/07 at 9:20 AM, monthly Resident Council minutes were reviewed for meetings held 11/7/06 through 3/6/07. As documented, there had been a concern raised in the January, 2007 meeting about needing faster response to call lights. Staff were inserviced. It was documented, at the Resident Council meeting conducted 2/20/07, the second concern discussed was that the call lights were on too long before being answered. Call lights were "Still a problem." As documented in the in the 3/6/07 Resident Council minutes, it was documented that call lights "are better". It was documented that the residents "still have to wait but (nursing assistants) very nice when they do answer the call light." On 3/13/07 at 9:30 AM, a confidential interview was conducted with a group of five alert and oriented residents. Four of the five residents stated that call lights took more than five minutes to be answered.	F 241		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interview it was determined that the facility did not provide maintenance and housekeeping services	F 253		5/1/07

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F 253	Continued From page 4 necessary to maintain a sanitary interior. On 3/14/07 at 10:25 AM, observations in the facility revealed: A shower head lying on the floor (with hose attached to the wall) in the south-east shower and a back flow breaker was not installed on the hose. Two shower hoses with no back flow breakers were found in the north-east shower room. Resident room 112 had a shower hose with no backflow breaker. One shower hose with no back flow breaker was found in the north-west shower room. Two shower hoses with no back flow breakers were found in the south-west shower room. Resident room 212 had a shower hose with no backflow breaker. The maintenance supervisor was interviewed and he stated that there were no back flow breakers on the 8 shower hoses in the building. Back flow breakers prevent contamination present on the shower head from entering the water supply.	F 253		
F 273 SS=B	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 record review it was determined that	F 273		5/1/07

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F 273	Continued From page 5 the facility did not conduct a comprehensive assessment of a resident within 14 calendar days after admission. Resident 7 Findings included: Resident 7 was admitted to the facility on 7/25/06 with diagnoses including brain hemorrhage deep coma, dysphagia, hypertension, bipolar, and schizophrenia. The medical records of resident 7 were reviewed on 3/13/07. There was no comprehensive admission MDS (minimum data set) assessment in the chart. It was due on 8/7/06.	F 273		
F 276 SS=B	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that the facility did not assess a resident using the quarterly review instrument not less frequently than every 3 months. Resident 12 Findings included: Resident 12 was admitted to the facility on 9/1/99 with a readmission date of 7/22/06 with diagnoses including mental retardation, dementia, congestive heart failure, seizure disorder, and depression. A review of resident 12's medical record was	F 276		5/1/07

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F 276	Continued From page 6 done on 3/15/07. A quarterly MDS (minimum data set) was done 5/19/06. The resident was discharged temporarily to the hospital in July 2006. She was readmitted to the facility on 7/22/06. There was no discharge MDS. There was no re-entry MDS. A quarterly MDS assessment was due by 8/19/06. The next quarterly MDS was not done until 10/19/06.	F 276		
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		5/1/07

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F 278	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility did not complete accurate Minimum Data Set (MDS) assessments for 2 of 15 sample residents. Residents 3 and 4. Findings included: 1. Resident 3 was admitted to the facility on 05/03/06 with diagnoses including hyperlipidemia, hypertension, insomnia, glaucoma, anxiety disorder, dysphasia, asthma, and constipation. Resident 3's medical record review was completed on 3/15/07. Resident 3's physician's orders dated July 2006 documented an open area on the resident's coccyx. Zero ulcers were documented on resident 3's MDS (minimum data set) assessment dated 7/31/06 in sections M-1 and M-2. A nutrition risk review progress note for resident 3, dated 10/31/06 documented a stage II pressure ulcer on resident 3's coccyx. Zero ulcers were documented on resident 3's MDS assessment dated 10/30/06 in sections M-1 and M-2. 2. Resident 4 was admitted to the facility 9/12/06 with diagnoses that included malnutrition, pressure ulcer and dysphagia. Resident 4's medical record was reviewed on 12/5/07.	F 278		

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F 278	Continued From page 8 Resident 4 had a quarterly MDS assessment dated 9/25/07. Section R2b had a typed date to indicate that the registered nurse coordinator had signed section R2a on 12/25/06. Section R2a had not been signed.	F 278		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility did not provide wound care in accordance with professional standards of care for 1 of 15 sample residents. Resident 3. Findings included: Resident 3 was admitted to the facility on 05/03/06 with diagnoses including hyperlipidemia, hypertension, insomnia, glaucoma, anxiety disorder, dysphasia, asthma, and constipation. Resident 3's medical record review was completed on 3/15/07. On 3/15/06 at 11:10 AM, a nurse surveyor observed as the facility's wound care nurse, nurse 6, performed a dressing change and wound care procedure for resident 3. Nurse 6 did not prepare a clean (medically aseptic) area for the dressing change supplies, but set them directly on resident 3's unwashed over-bed table. Several clean gloves were set next to resident 3's tissue box. Clean bandages	F 281		5/1/07

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and sterile saline were set next to two blue cups.

Nurse 6 removed the old bandage from resident 3's wound. The adhesive portion of the soiled bandage had been directly over the open portion of resident 3's stage II pressure ulcer. After changing gloves and washing her hands, nurse 6 cleansed the wound with a gauze pad moistened with sterile saline. Nurse 6 pressed the wet gauze over the entire wound, then dabbed at the open portion of the wound, dabbed around the upper edges of the wound, and then dabbed over the open portion of the wound, thus contaminating the wound.

Reference quide, (C. T. Hess, RN, BSN CWOCN. Wound Care Clinical Guide, Pa. Springhouse, third edition, pg 44.)

" For an open wound, moisten a gauze pad with the cleaning agent and squeeze out excess solution. Clean the wound in full or half circles beginning in the center and working toward the outside. Clean to at least 1" (2.5 cm) beyond the end of the new dressing or 2" (5 cm) beyond the wound margins if you aren't applying a dressing. Use a new pad for each circle. "

Reference guide, Fundamentals of Nursing, sixth edition, Prentice Hall Health, (February 2000) pg 633-4, 670.

"In medical asepsis, objects are referred to as clean or dirty. Clean denotes the absence of almost all microorganisms. Dirty (soiled, contaminated) denotes the likely presence of microorganisms, some of which may be capable of causing infection. Aseptic measures are protective as they are designed to reduce the

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F 281	Continued From page 10 number of potentially infective agents."	F 281		
F 286 SS=B	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review, the facility did not maintain all resident assessments completed within the previous 15 months in 2 out of 15 sample resident's active record. Residents 3 and 12. Findings included: Resident 12 was admitted to the facility on 9/1/99 with readmission on 7/22/06 with diagnoses including mental retardation, dementia, congestive heart failure, seizure disorder, depression and shortness of breath. Resident 12's medical record was reviewed on 3/15/07. Resident 12 was discharged in July 2006 and readmitted to the facility on 7/22/06. There was no discharge MDS (minimum data set) or re-entry MDS in the chart. Not all resident assessments were in the resident's active record. Resident 3 was admitted to the facility on 05/03/06 with diagnoses including hyperlipidemia, hypertension, insomnia, glaucoma, anxiety disorder, dysphasia, asthma, and constipation. Resident 3's medical record review was completed on 3/15/07. Resident 3's quarterly MDS for October 2006 was not in the resident's medical record. Not all required resident	F 286		5/1/07

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F 286	Continued From page 11 assessments were in the resident's active record.	F 286		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not ensure that resident's received medications at an error rate of less than 5% (percent). During observation of medication pass on 3/13/07 from 8:00 AM until 9:00 AM, four nurses were observed as they administered residents' medications. Out of 57 opportunities, 4 medication errors were observed, to equal an initial medication error rate of 7%. Later, at 10:50 AM, 1 of the 4 nurses was observed to administer 15 medications to a resident, 2 hours and 50 minutes after the scheduled time of 8:00 AM. The total medication error rate was determined to be 26%, including missed medications, wrong form of a medication, and wrong time of administration. Findings included: As each medication was prepared for each of the residents, the information contained on the medication label was noted. The medication label was compared to the Medication Administration Record (MAR). After the medication administration had been completed, the information obtained during observation was compared with the physicians' orders in each	F 332		5/1/07

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F 332	Continued From page 12 resident's medical record. 1. At 8:15 AM, nurse 1 was observed to prepare resident 16's medications. Resident 16's MAR revealed the medications were to be crushed and mixed with applesauce or strawberry jam. Five of the medications were crushed and mixed with applesauce. A Fluoxetine 20 mg (milligrams) capsule (not delayed release) was placed, whole, in a plastic medication cup while the other medications were crushed. Nurse 1 put applesauce on the capsule and mixed in the crushed medications. Nurse 1 administered the capsule whole with the other medications and applesauce, in one heaping spoonful. Nurse 1 stated that she had forgotten to empty the medication powder from the capsule in the applesauce mixture. Nurse 1 stated that resident 16's medications needed to be crushed because the resident experienced difficulty swallowing. Review of resident 16's medical record revealed the resident had hemiparesis and swallowing problems secondary to a cerebral vascular accident. In addition, the record revealed an addendum that resident 16 did not like applesauce and was to receive his medications mixed in strawberry jam. 2. Nurse 4 was observed at 8:30 AM to prepare and administer resident 8's medications. Resident 8 was to have received Prilosec 40 mg, 30 minutes before breakfast. Breakfast was served at 8:00 AM. The medication was not located and nurse 4 documented that it was "not in" and not administered. 3. Nurse 2 was observed at 9:05 AM to prepare	F 332		

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and administer resident 13's medications. Resident 13 was to have received Coreg 3.125 mg and Synthroid 88 mg. The medications were not available for resident 13 and were not given. Nurse 2 documented the medications had not been given by circling her initials on the MAR. Nurse 2 stated she would order the medications from the pharmacy.

On 3/14/07 at 8:30 AM, the MAR for resident 13 was reviewed. There was no documentation that the missed medications had been given late. At that time, medications in the nurse's medication cart were observed. Resident 13's new containers of Coreg and Synthroid were in the cart. None of the medications were missing from the containers, revealing the medications had not been given late on 3/13/07.

4. On 3/13/07 at 10:50 AM, nurse 2 was observed to administer medications to resident 3. The surveyor asked nurse 2 which medications resident 3 was receiving. Nurse 2 showed the MAR to the surveyor and indicated the 15 medications being administered to resident 3. The surveyor asked nurse 2 if the 15 medications had been scheduled to be given to resident 3 at 8:00 AM. Nurse 2 stated that they were.

5. Nurse 5 was interviewed on 3/14/07. Nurse 5 stated that when a resident had about 7 days of medications remaining, the label was to be pulled from the container and faxed to the pharmacy for delivery that same evening. Nurse 5 stated that on Fridays, they would review the medications in the medication cart. Nurse 5 stated that additional orders were faxed to the pharmacy on Fridays for any medications that had been missed and could run out over the weekend.

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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 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 interviews and reviews of records, the facility did not provide specialized rehabilitative services as required in the residents' comprehensive plan of care for 4 of 15 sampled residents. Resident identifiers: 1, 10, 11, and 12. 1. Resident 1 was admitted to the facility on 7/10/80 with diagnoses which included dementia, mental retardation, cerebral palsy, anxiety disorder, depression, and dysphagia. A review of resident 1's medical record was completed on 3/14/07. Resident 1's evaluation for SRS (specialized rehabilitative services) documented that resident 1 was approved for Specialized Rehabilitative Services. Resident 1 was identified on the Trinity Mission Provo SRS for MR (mentally retarded) Residents List as participating in SRS since 5/19/04 through the present. The facility received	F 406		5/1/07

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a daily add-on rate of $20.99 per day to provide specialized services for resident 1 to learn new skills.

Data collection sheets indicated that Resident 1 had some goals to work on. Goal 2b and Goal 3a were reviewed.

Goal 2b. "[Resident 1] will improve her social skills by doing a one on one activity." The data sheet dated Sept. 2006 indicated the frequency of task was 1 x (time) per month. The responsible person was the QMRP (qualified mental retardation professional). This one on one activity goal was not accomplished during the months of September, October, November and December 2006. The SRS Progress Reports for resident 1 for the period 10/1/06 to 12/31/06 documented "transportation issues" in each month's Data Summary for this goal. According to the QMRP, resident 1 was frustrated because her choice of one on one activity was going in the van and it had not occurred. In an interview with the QMRP on 3/15/07, he said that the facility had problems with a driver for the van from October through December 2006. Resident 1's data collection sheet of Goal 2b for September 2006 was reviewed. It was blank.

Goal 3a. "[Resident 1] will improve her personal living skills by brushing her teeth morning and night." The data sheet indicated the frequency of task was 2 x day. The responsible person was SRS aide or CNA (certified nursing assistant.) From interviewing staff, it was determined that there was no "SRS aide" so the data would have to be collected by the CNA. The data collection sheet for September 2006 had one of possible 60 times marked. The goal 3a has 6 steps. The only

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step marked was "[Resident 1] goes with CNA to the shower room" on 9/12/06 AM. For the four month period from September 2006 through December 2006, the QMRP's Progress Report documented "No ADL data sheet was provided for this month." The January 2007 Goal 3a. Data Sheet had data collected once for 1/19/07 PM and once for 1/23/07 AM. Data was collected two out of a possible 62 times. There were no data sheets for February 2007 or March 2007 provided for review.

2. Resident 10 was admitted to the facility on 6/18/97 with diagnoses including mental retardation, convulsions, gastrointestinal hemorrhage, senile cataract, asthma, reflux and gout.

A review of resident 10's medical record was completed on 3/15/07.

Resident 10 had four SRS goals as follows:

Goal 1. Improved Motor Skills: [resident 10] will improve his fine motor skills by practicing writing letters five days per week. Responsible staff: Direct Care Staff. Data collection 5 x/week. There is a place at the bottom of each data collection sheet for "Signatures of staff running program:" This area is blank on every data collection sheet. There are no signatures. There are three steps to the program. "1-[Resident 10] gathers his writing supplies. 2- [Resident 10] selects a person to write a letter or note to (or to write in his journal). 3- [Resident 10] writes a letter or note."

Goal 2. Improved Personal Living Skills: [Resident 10] will improve his self-directing skills

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by pursuing leisure activities of interest to him. Responsible staff: Direct Care Staff. Data collection 3 x/week.
There are 2 steps to the program: choose and participate 15 minutes. Staff document activity.

Goal 3. Improved Personal Living Skills: [Resident 10] will improve his personal living skills by learning to complete his Activities of Daily Living (ADLs) more independently. Responsible staff: Direct Care Staff. Data Collection 5 x/week. There are 4 steps to the program: shave, brush teeth, put on shirt, and comb hair.

Goal 4. Improved Community Living Skills: [Resident 10] will improve his community living skills by learning to plan and participate in community activities. Responsible staff: Direct Care Staff. Data collection 2 times a month.

The SRS Progress Report for 9/1/06 to 9/30/06 was signed by the QMRP on 10/14/06. It did not summarize any data.

The SRS Progress Report for 10/1/06 to 10/31/06 was signed by the QMRP on 11/19/06. It documented for Goal 1 that "[resident 10] required a great deal of physical assistance from staff to write letters." The November 2006 SRS Progress Report documented for Goal 1 that the resident "had been very lazy about doing the actual writing. He often convinced staff to do most of the writing for him which defeats the whole purpose of the goal." The December 2006 Data Sheet for Goal 1 indicated that resident 1 gathered writing supplies and selected person to write to on 20 days. However, there was no documentation that any writing occurred or whether he required any assistance. Data Sheets

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for Goal 1 for January through March 2007 documented that resident 10 required physical assistance with the writing on each trial. The Data Sheet for February 2007 indicated 18 trials with 2 days refusing. He refused on 2/7/07 and 2/9/07. In the column to document resident 10's response to the activity that day, the word "enjoys" was written on 2/7/07 and 2/9/07. "Enjoys" was also written on 15 other days of participation. It was not possible to determine from the data collection sheets of October 2006 through March 2007 whether resident 10 had improved his fine motor skills, Goal 1.

The Goal 2 Data Sheets for resident 10 dated November 2006 through January 2007 showed data collected less than the stated 3 x/week. (December 2006 and January 2007 Data Sheets had one documentation of choosing an activity and participating 15 minutes in each month.) None of these Data Sheets documented the activity or his response to it as requested. The February 2007 Data Sheet for Goal 2 had check marks in the columns instead of following the legend to track his level of independence. In February, 7 of the 9 data collections documented "visit with friends" as the activity. The March 2007 Data Sheet from March 1 to 14 documented "visit with friends" for 3 of 5 activities recorded. The Methodology for Goal 2 stated: "staff will encourage [resident 10] to try new activities and help him pursue those that he enjoys." The Data Sheets do not document that the methodology for Goal 2 was being followed.

Goal 3 was to have data collected 5 x/week since September 2006 to present. There was no data collected in September, October, November, December, February or March. The January 2007

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Goal 3 Data Sheet for resident 10 had two days marked with staff initials, 1/5/07 and 1/15/07. All the blocks for each step were filled with staff initials. Because the legend was not used, there was no way to determine the level of independence that resident 10 exhibited. Without data, it was not possible to know whether resident 10 was completing his ADL's more independently.

The Goal 4 Data Sheets were reviewed with the QMRP on 3/15/07. There was no data collected for resident 10 for Goal 4. The reviewed sheets were dated October 2006, November 2006, January 2007, and March 2007. Each data sheet was blank. The SRS Progress Reports prepared by the QMRP documented no data sheets of resident 10 were provided for Goal 4 for the months of October, November and December 2006. Resident 10 was to be encouraged by staff to plan at least two activities per month.

3. Resident 12 was admitted to the facility on 9/1/99 with re-admission on 7/22/06. Her diagnoses included mental retardation, dementia, congestive heart failure, seizure disorder, depression, edema, shortness of breath, and vomiting.

Resident 12 had a telephone order from her physician to place her on SRS Program dated 12/28/06.

Resident 12 had 3 SRS Goals:

Goal 1. Improved Social and Communication Skills: [resident 12] will improve her communication skills by maintaining contact with her friends at a previous workshop. Responsible staff: SRS aide or CNA. Frequency: 1 x/month.

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F 406	Continued From page 20 Goal 2. Improved Social and Communication Skills: [resident 12] will improve her awareness of herself and her environment by participating in a sensory stimulation. Responsible: SRS staff. Frequency: 5 x/week. Goal 3. Improved Personal Living Skills: [resident 12] will improve her personal living skills by completing her ADLs more independently. Responsible staff: SRS aide or CNA. Frequency: 2 x day. The SRS Progress reports and data collection sheets for resident 12 were reviewed on 3/15/07. Goal 1. No data was provided for this goal for July 2006, November 2006, December 2006, January 2007, or March 2007 (up to March 15). Goal 3. No data was provided for this goal for July 2006, August 2006, September 2006, October 2006, November 2006, December 2006, February 2007, or March 2007. The January 2007 Data Sheet had two days of data: 1/19/07 for PM and 1/23/07 for AM. Data was to be collected 2 times a day for Goal 3. 4. Resident 11 was admitted to the facility on 5/08/02 with diagnoses which included mental retardation and microcephaly. A review of resident 11's medical record was completed on 3/15/07. Resident 11's evaluation for SRS documented that resident 11 was approved for Specialized Rehabilitative Services. Resident 11 was identified on the Trinity Mission Provo SRS for MR Residents List as participating in SRS since	F 406		

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F 406	Continued From page 21 8/08/03 through the present. The facility received a daily add-on rate of $20.99 per day to provide specialized services for resident 11 to learn new skills. Data collection sheets indicated that Resident 11 had 3 goals to work on. Goal 1 and Goal 2 were reviewed. Goal 1. "[Resident 11] will improve his motor skills by playing with toys". The data sheet dated Jan. 2007 indicated the frequency of task was daily. The responsible person was recreation. This motor skills goal was not accomplished during the months of April, May, July, August, September, October, November and December 2006. The SRS Progress Reports for resident 11 for the period 4/1/06 to 12/31/06 documented "No data sheet was provided for this goal" in each month's Data Summary for this goal. In an interview with the QMRP on 3/15/07, he stated that the facility had problems with agency staff turnover and the new staff not taking data. There were no data sheets for the period 4/1/06 to 12/31/06 provided for review. Without data, it was not possible to know whether resident 11 was improving his motor skills. Goal 2. "[Resident 11] will improve his personal living skills by learning to complete his activities of daily living more independently. The data sheet dated Jan. 2007 indicated the frequency of task was daily. The responsible person was recreation. This personal living skills goal was not accomplished during the months of April, May, July, August, September, October, November and December 2006. The SRS Progress Reports for resident 11 for the period 4/1/06 to 12/31/06	F 406		

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documented "No data sheet was provided for this goal" in each month's Data Summary for this goal. In an interview with the QMRP on 3/15/07, he stated that the facility had problems with agency staff turnover and the new staff not taking data. There were no data sheets for the period 4/1/06 to 12/31/06 provided for review. Without data, it was not possible to know whether resident 11 was completing his ADL's more independently.

An interview with the QMRP was conducted on 3/15/07 at 10:45 am, he stated that he did not attend the IDT (Interdisciplinary Team) meetings where the planning for residents care took place. When asked if he trained the CNA's to collect the required data, he stated it was hard to keep up their training. He was frustrated to train the CNA's and then see them leave for other employment. The QMRP also stated that the "SRS in this facility is not being run as well as it is supposed to be."

An interview was held with the facility social worker, who is also a QMRP, on 3/15/07 at 8:45 AM. When asked who collects data of the active treatment and runs the programs, the social worker said that the Recreation Therapist collected data for the activities portion and the restorative aid collected data for ADL's (activities of daily living). The social worker said that the QMRP put progress reports in her office. The QMRP reported to the social worker. When asked if she reviewed the progress reports, she replied, "For the most part, no." She said one of the residents on SRS had his IDT done last month. The social worker said she did not have a recognition of his SRS program. When the social worker was asked how the progress of the SRS

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F 406	Continued From page 23 residents was being measured due to lack of data collection she said, "I have no answer." The restorative aid was interviewed on 3/15/07 at 10:00 AM. He said that he did not collect data for the QMRP and did not run ADL programs. He provided a copy of a wellness program tracking that was a service goal including passive and active ROM (range of motion).	F 406		
F 496 SS=D	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the	F 496		5/1/07

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F 496	Continued From page 24 individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility did not receive registry verification before allowing an individual to provide direct resident care as a nursing assistant for 2 of 5 employees whose records were reviewed. Two nursing assistants had lived out of state within the five years previous to their having been employed at the facility, but the distant States' Registries had not been contacted. Nursing Assistant Identifiers: 4 and 5. Findings included: Employment applications were reviewed for five staff who had been hired within the six months prior to the survey, including two Certified Nursing Assistants, two Nursing Assistants and one Dietary Staff. Nursing assistant 4 was hired 1/17/07. Nursing assistant 4 had signed a release for a background check that included information that the nursing assistant had lived outside of Utah from December, 2005 through October 2006. There was no evidence that the facility had contacted the State Registry in nursing assistant 4's previous state of residence prior to allowing the nursing assistant to begin working with residents. Nursing assistant 4 had signed, on 1/17/07, a a statement that, "I, [nursing assistant 4] am currently registered and entitled to practice as an Certified Nurse's Assistant in the state of	F 496		

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F 496	Continued From page 25 Utah." The Utah Registry had been checked and there was no match found for nursing assistant 4. Nursing assistant 5 was hired 2/19/07. Nursing assistant 5 had signed a release for a background check that included information that the nursing assistant had lived in two states other than Utah until June, 2005. There was no evidence that the facility had contacted the State Registries in nursing assistant 5's previous states of residence prior to allowing the nursing assistant to begin working with residents. On 3/14/07 at 4:45 PM, a meeting was conducted with facility department heads and corporate consultants. The Regional Director had not been aware that out of state Nurse Aide Registries were required to be checked in addition to the Utah Registry for potential nursing assistants who have resided out of Utah within five years of employment. The facility stated that National criminal records were reviewed for new employees. It was explained that not all negative findings for nursing assistants appeared in criminal records.	F 496		
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.	F 514		5/1/07

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview it was determined that the facility did not maintain clinical records on each resident that are complete and accurately documented for 4 out of 15 sample residents.

Residents 3, 8, 9, Cl 15

Findings included:

1. Cl 15 was admitted to the facility on 11/4/06 with diagnoses including hip fracture, diabetes mellitus non-insulin dependent, hypertension, and congestive heart failure.

Review of Cl 15's closed record was done on 3/15/07. There was a face sheet for a different resident in the closed record of resident Cl 15.
2. Resident 3 was admitted to the facility on 05/03/06 with diagnoses including hyperlipidemia, hypertension, insomnia, glaucoma, anxiety disorder, dysphasia, asthma, and constipation.

Resident 3's medical record review was completed on 3/15/07.

A. A physician's telephone order dated 6/22/06 for resident 3 documented the following order: "Apply DuoDerm to open area on coccyx ...".

A nurses' note dated 6/22/06 for resident 3 documented the following: "Apply DuoDerm to open area on coccyx ... Coccyx reddened (with) small pencil eraser size open sores".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465082	A. BUILDING _____ B. WING _____	03/15/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY MISSION HEALTH & REHAB OF PROVO, LP	1053 WEST 1020 SOUTH PROVO, UT 84601

(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
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Resident 3's physicians orders dated July 2006 documented an open area on coccyx.

A nutritional risk review for resident 3 was completed on 7/11/06. This risk review documented a stage II pressure ulcer on resident 3's coccyx.

Zero ulcers were documented on resident 3's MDS (minimum data set) assessment dated 7/31/06 in sections M-1 and M-2.

B. A nutrition risk review progress note for resident 3, dated 10/17/06 documented a new break down of a stage II pressure ulcer on resident 3's coccyx.

A nutrition risk review progress note for resident 3, dated 10/31/06 documented a stage II pressure ulcer on resident 3's coccyx.

Zero ulcers were documented on resident 3's MDS assessment dated 10/30/06 in sections M-1 and M-2.

C. A nutrition risk review progress note for resident 3, dated 11/14/06 documented a new wound on resident 3's thigh.

A nutrition risk review progress note for resident 3, dated 11/28/06 documented a healing wound for resident 3.

Resident 3's medical record did not document a wound on the resident's thigh again until 12/12/06. A nurse's note for resident 3 dated 12/12/06 documented the following: "... continuing treatment for the sore on upper back side of (right) thigh ... The sore is still red and

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open with drainage."

An interview was conducted on 3/14/07 at 1:20 PM with the facility's wound treatment licensed practical nurse, nurse 6. Nurse 6 stated that resident 3 had a red coccyx area upon admit and that resident 3 wanted the nurses to apply salve to the area, so they did. Nurse 6 stated that she was a floor nurse for resident 3 and, as resident 3's nurse, she did not witness an open wound on the resident's coccyx.

3. Resident 9 was admitted to the facility on 02/06/07 with diagnoses including insomnia, hip fracture, hypertension, and renal insufficiency.

Resident 9's medical record review was completed on 3/15/07.

Resident 9's discharge paperwork from the local hospital to the facility documented the following allergies: Darvon, codeine, sulfa, Valium and percodan. Resident 9's medical chart had a blank "Allergies" sticker on the inside of the front of the chart. Resident 9's medication administration record for the month of March 2006 documented in the section labeled allergies "None Known".

4. Resident 8 was admitted to the facility on 9/14/06 with diagnoses including diabetes mellitus, Parkinson's disease, and chronic renal failure.

Resident 8's medical record review was completed on 3/15/07.

Resident 8's discharge paperwork from the local hospital to the facility revealed resident 8 was

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F 514	Continued From page 29 allergic to Angiotensin-Converting Enzyme (ACE) inhibitors. Resident 8's medical record had a red-bordered sticker on the inside of the front cover as a quick reference of the resident's allergies to medications. The allergy sticker for resident 8 revealed the resident had "NKA" (no known allergies). A second entry on the allergy sticker revealed resident 8 should avoid non-steroidal anti-inflamatory drugs (NSAIDS) due to adverse side effects.	F 514		