

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: UT207345	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2009
NAME OF PROVIDER OR SUPPLIER ORCHARD COVE/ BOUNTIFUL RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 485 EAST 500 SOUTH BOUNTIFUL, UT 84010		
(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) COMPLETE DATE
A4100	<p>R432-270-13(1) Service Plan</p> <p>Each resident must have an individualized service plan that is consistent with the resident's unique cognitive, medical, physical, and social needs, and is developed within seven calendar days of the day the facility admits the resident. The facility shall periodically revise the service plan as needed.</p> <p>This Statute is not met as evidenced by: THIS IS A TYPE II DEFICIENCY</p> <p>Based on medical record review and interview, it was determined that 2 of 9 residents did not have an individualized service plan that is consistent with the resident's unique condition. Identifiers: 6 and 7.</p> <p>Findings Include:</p> <p>Resident 6 was admitted to the facility on 6/09/06 with diagnoses that included dementia, HTN (hypertension) and depression and she is currently on hospice services.</p> <p>Resident 6's service plan was last updated on 1/30/09. Her service plan was not individualized or updated to include that she had treatments and physician orders regarding her feet.</p> <p>On 2/10/09, documentation from Orchard Cove IDT (interdisciplinary team) meeting, " Resident slow decline - feet concern not dry between toes - dead skin build up, black area on toes". In resident 6's medical record, it was documented that "toe ticklers" were to file the callous' on resident 6's feet every two weeks. Additionally, a physician order documented that resident 6 was to wear wide and deep toed shoes daily. None of this was documented on the service plan.</p>	A4100 <i>POC accepted 4/15/09</i> <i>Harleen</i> <i>Muller</i>	<p>A4100 R432-270-13(1) Service Plan</p> <p>The service plans of the identified Residents have been updated by the delegating authority:</p> <p>Resident 6 – The type of shoes, the cleaning, drying and placing of cotton between the toes, has been added to the service plan. 'Toe Ticklers' has been added as an additional provider. They are only scheduled to come once a month; therefore, the physician orders have been changed to once a month.</p> <p>Resident 7 – The following has been added to the service plan: (1) Ted hose on when up and off at night (it is on the CNA assignment sheet and they have been reminded to follow the directions as provided); (2) physical therapy for strengthening, transfer and gait, etc.; (3) PT/INR blood draws are by Mountain Star Labs; and, (4) diet changed to mechanical soft.</p>	04/10/09

Utah Department of Health

APR 14 2009

Bureau of Health Facility Licensure, Certification and Resident Assessment

Your Agency Name

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

TG0011

If continuation sheet 1 of 5

Harleen Muller
Director
04/10/2009

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A4100	Continued From page 1 Resident 7 was admitted to the facility on 11/01/08 with diagnoses that included dementia, osteoarthritis, history of a deep vein thrombosis and CVA (cerebral vascular accident). Resident 7's service plan was last updated when she was admitted on 11/01/08. Her service plan was not individualized or updated to include five physician orders that were written between 11/13/08 and 3/10/09. The physician orders included: (1) 11/13/08, "PT (physical therapy) to treat up to 5 times per week for 6 weeks for therapeutic exercise, therapeutic activity for strengthening, transfer training, gait training, sitting/standing balance re-education, safety re-education patient, staff and family". (2) 1/26/09, "wear ted hose when up". (3) 1/28/09, "order PT/INR every three weeks". (4) 2/04/09, PT clarification: PT to treat up to five times a week for six weeks for therapeutic exercise, therapeutic activity, for strengthening, transfer training and gait training, sitting/standing balance re-education". (5) 3/10/09, PT, mechanical soft diet, ted hose when up". On 3/19/09 at 3:05 P.M., resident 7 was observed sitting up in a chair, she had no ted hose on her legs. On 3/19/09 at 3:07 P.M., interview with a facility aide starting her shift at 3:00 P.M., the aide was asked who drew resident 7's PT/INR, she stated, " an outside company comes in and does blood draws for the ortho residents and thinks that they come and draw resident 7's PT/INR also. There was no documentation on the service plan regarding how resident 7 got her PT/INR blood work done including who provided the service and the frequency.	A4100		

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A4110	<p>R432-270-13(2) Service Plan</p> <p>The facility shall use the resident assessment to develop, review, and revise the service plan for each resident.</p> <p>This Statute is not met as evidenced by: Based on review of resident assessments and service plans, it was determined that for 5 of 9 resident records reviewed, the resident assessment had not been used to develop, review and revise the service plans. Resident identifiers: 1, 2, 3, 5 and 9.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on 07/25/08 with diagnoses that included rapid decline, hypothyroidism, hypertension and Alzheimer's Disease.</p> <p>Resident 1's resident assessment, dated 07/25/08, showed documentation that resident 1 was totally dependant for grooming, dressing and bathing.</p> <p>Resident 1's service plan, dated 02/05/09, showed documentation that resident 1 was semi-independent for all ALS (activities of daily living).</p> <p>Resident 2 was admitted to the facility on 03/10/06, with diagnoses that include Alzheimer's disease, coronary artery disease and Hodgkin's Lymphoma.</p> <p>Resident 2's resident assessment, dated 09/22/08, showed documentation that resident 2 was semi independent for bathing, eating, ambulation and transferring, and was totally dependant for grooming, oral care, dressing and</p>	A4110	<p>A4110 R432-270-13(2) Service Plan</p> <p>The service plans of the identified Residents have been updated by the delegating authority:</p> <p>Resident 1 – Assessment was updated to be correct on 3/25/09. The assessment reflects that the resident is limited assisted in the identified areas.</p> <p>Resident 2 – Assessment and service plan have been updated to show that the resident is limited assist in all areas of care.</p> <p>Resident 3 – Assessment and service plan have been reviewed and updated to be correct. Resident is semi-independent.</p> <p>Resident 5 – Service plan was updated to be correct and match the assessment. Resident is semi-independent.</p> <p>Resident 9 – Butt paste has been added to the service plan. Assessment changed to read no gluten. Wheelchair and hospice have been discontinued on the service plan.</p>	04/10/09

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If continuation sheet 3 of 5

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A4110	<p>Continued From page 3</p> <p>toileting.</p> <p>Resident 2's service plan, dated 03/20/07, showed documentation that resident 2 was totally dependant for bathing, dressing and grooming, oral care and toileting.</p> <p>Resident 3 was admitted to the facility on 07/01/08 with diagnoses that included Alzheimer's Disease and hypertension.</p> <p>Resident 3's resident assessment, dated 01/21/09, showed documentation that resident 3 was totally dependant for all ADLs.</p> <p>Resident 3's service plan, dated 07/01/08, showed documentation that resident 3 was semi-independent for all ADLs</p> <p>Resident 5 was admitted to the facility on 02/01/09 with diagnoses that included dementia and insomnia.</p> <p>Resident 5's resident assessment, date 02/01/09, showed documentation that resident 5 was semi-independent for grooming, dressing, oral care and bathing, and was independent for eating, ambulation and transferring.</p> <p>Resident 5's service plan, dated 02/02/09 showed documentation that resident 5 was independent for all ADLs.</p> <p>Resident 9 was admitted to the facility on 09/08/08 with diagnoses to include Alzheimer's, hypertension, celiac disease and dementia due to vascular disease (severe with delusions). Documentation found in a physician order, dated 03/16/09, states, apply butt paste with each brief change every shift. This information was not updated on the service plan or the resident</p>	A4110		

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A4110	Continued From page 4 assessment. The resident assessment dated 09/08/08 states resident 9 is on a regular diet, sensitive to gluten. The service plan, under dietary, documented resident 9 is to have a gluten free diet. The service plan also documented that resident 9 uses a wheelchair and was on home health. The resident assessment did not have documentation to indicate either of these services.	A4110		