DEPARTMENT OF HEALTH AND H AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465088	A. BUILDING ______ B. WING ______	9/15/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE VALLEY CARE CENTER	25 EAST ALPINE DRIVE PLEASANT GROVE, UT 84062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 157 S=G	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident medical records, it was determined that for 2 of 11 sample residents, the facility did not consult with the residents' physician when there was 1) A need to alter treatment significantly; and 2) A	F 157 10/7/04 POC acceptable with addendum completion date 10/25/04 Bownbank RN	-Policy will be established to determine standard for change of condition status -A 24 hour nursing log will be started. On the report the nursing staff will document any changes in physical, mental or psychological status. The nursing staff will notify the MD of changes. -The report will be given to the DON or designee to be reviewed daily for changes in condition. -If changes are present the DON or designee will review the chart for documentation and follow through. -Inservicing on the standards for change of condition and the 24 hour nursing log for the nursing staff will be completed by 10-31-04. -Changes in condition will be reviewed monthly in Q.A. for six months, and then quarterly to maintain compliance. Utah Department of Health OCT 06 2004 Bureau of ... Program ...tion and Resident Assessment	10/25/04

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Allison
TITLE: Administrator
(X6) DATE: 10/6/04

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1	F 157		

significant change in the resident's physical and mental status. Specifically, resident went 34 days without antibiotics after "green drainage" was discovered. There was no documentation that resident 9's physician was ever notified of the "green drainage" or "foul odor" coming from a surgical wound on the resident's left hip. A second resident, resident 1, began "drooling", "leaning" to the left and exhibited "slurred speech". However; resident 1's medical record did not contain documentation that his physician had been notified of this change in status. Resident identifiers: 9 and 1.

Findings include:

Resident 9 was an 85 year old male, admitted to the facility on 2/13/04, with diagnoses which included "open wound of hip and thigh" and "hip infection" (post surgical).

The record of resident 9 was reviewed on 9/14/04 and 9/15/04.

A physician's progress note, dated 6/17/04, documented "[resident 9] walks slowly with a minimal breathlessness and complains of a continuum of pain. It predominates in the L (left) trochanteric area of his hip. This is a region where he had earlier L hip breakdown which has been slowly healing with primary intention. There is a nickel-sized shallow area of granulation tissue with a very small .5" (inch) sinus track of approx (approximately) 4-5 o'clock. Dressing is changed daily with saline cleansing and Q-tip probing. It is covered with Alldress. No instability or large zone of inflammation. . . . Healthy appearing granulation base with minimal sinus track remaining at L trochanteric site." Resident 9's physician did not note any sign or symptom of

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F 157	Continued From page 2 infection regarding the resident's left hip wound. From 6/19/04 through 7/22/04, facility nursing staff made four entries into the nurse's notes of resident 9. The following are excerpts from those entries: a) 6/19/04 - "Using aseptic tech. (technique) pt's (patient's) wound to left hip drsg (dressing) changed. Wound is shallow and 3 - 4 " (inches) long, 2" wide with green drainage. . ." Note: This was the first notation of green drainage, an assessment finding generally indicative of infection, recorded in resident 9's medical record. b) 6/22/04 - "Pt. (patient) c/o (complains of) pain in L hip, dsg (dressing) change done using aseptic tech. Wound approx 1 1/2 in (inches) long, zero odor, some green drainage, approx 1/2 in. tunneling on posterior wound. . ." c) 6/27/04 - "Pt. had wound to left hip. . . Drainage has sl. (slight) green tinge." d) 7/18/04 - "Wound on L hip moist with some white edges, green discharge foul odor. . . Wound is approximately 2 inches long 2 cm (centimeters) wide with 1 inch tunneling in the posterior aspect." Note: an assessment finding of foul odor, emanating from a wound, would generally be indicative of infection. There was no documentation in the nurse's notes to evidence that resident 9's physician was notified of the green drainage and foul odor emanating from the resident's left hip wound. The Weekly Skin Integrity Action Sheets for resident 9, from 6/30/04 through 7/23/04, did not contain a description of the resident's left hip	F 157		

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F 157	Continued From page 3 wound or note any signs or symptoms of infection (green drainage/foul odor). With each weekly entry, pre-printed questions were included. One of the pre - printed questions was, "MD notified / orders for new problem?" The facility nursing staff did not respond to this question between 6/30/04 and 7/23/04. On 7/23/04, resident 9 was seen by a doctor of podiatric medicine (foot specialist). This doctor documented in a progress note, dated 7/23/04, a concern of "possible cellulitis of the left second toe." The podiatrist then ordered "clindamycin (antibiotic) 300 mg TID (three times daily) X (times) 10 days for cellulitis L 2nd toe." (There was no documentation to evidence that the podiatrist was aware of the resident's left hip wound or the "green drainage" and "foul odor".) On 7/28/04, five days after the Clindamycin (antibiotic) was started for the possible cellulitis in the resident's toe, a nurse documented the following entry in regard to the resident's left hip wound: "dressing change done. No change in tunneling noted. Area look healthy small area on top of wound yellow. No odor. . ." The director of nurses (DON) was interviewed on 9/15/04. She was asked to provide documentation that facility staff had notified resident 9's physician of the left hip wound assessment findings of green drainage and foul odor. The DON stated "It isn't there." 2. Resident 1 was admitted to the facility on 10/7/02. Facility staff completed a Minimum Data Set (MDS) assessment for resident 1 on 12/9/03. Facility staff assessed that resident 1 moved	F 157		

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F 157	Continued From page 4 independently indoors, ambulated independently, had clear speech, did not have periods of lethargy and that his mental function did not vary over the course of the day. The MDS also included documentation that resident 1 had no limitations in range of motion with his arms or legs. On 2/25/04, a facility nurse documented the following nursing note entry in resident 1's medical record: "Res. drooling, amb. (ambulating), restless, lethargic, slurred speech, leaning to lt (left), reaches but misses, sits on arm of chair, very confused. . ." Resident 1's medical record did not include any documentation that the resident's attending physician had been notified of the significant changes in the resident's status. The DON was interviewed on 9/15/04. She was unable to provide documentation that facility staff had contacted the physician concerning the significant changes in resident 1's status, noted on 2/25/04.	F 157		
F 257 SS=B	483.15(h)(6) ENVIRONMENT The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71-81degrees Fahrenheit. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility did not provide for comfortable temperature levels and did not maintain a temperature range between 71-81	F 257	-All staff has been educated to tag F257. In regards to a safe and comfortable temperature levels in the building, the administrator has talked to all charge nurses and other staff members, and educated them to what the appropriate temperature should be. Thermometers have been placed in the corridors, nurses stations, and in the dayrooms. Staff has	10/25/04

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F 257	Continued From page 5 degrees F (Fahrenheit). Findings include: A temperature measurement taken on 9/14/04 at the nurses station between the east and west halls at 9:55AM revealed a temperature of 65 degrees F. During an interview with resident 3, while she was sitting in the west hall waiting for an activity to begin, she stated that she could not sit there for much longer because she was "freezing". When asked if the temperature was like that on any other occasion she stated that it was always cold in the halls and she had to wear a coat even if it was boiling outside. The resident also stated that the cold air blew right into her room at night and she had to make sure she had plenty of covers to keep warm. During a confidential interview with a group of alert and oriented residents on 9/14/04 at 2:30 PM, three of nine residents complained of "cold" and "freezing" halls and rooms.	F 257	been told before turning on the swamp cooler they need to check the temperature to make sure the temperature is within the appropriate range. The staff will again be educated to this tag at in-service which will be held on 10/25/04. This will be monitored by the charge nurse and the administrator. On 10/14/04 this tag will be discussed in our monthly QA meeting to ensure we are in compliance.	
F 309 S=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. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m).	F 309	-Recent survey indicated inconsistencies in nursing documentation. -The nursing staff will be inserviced on proper documentation of wounds. -One nurse will be designated to measure and document the size of skin conditions. -Changes in wounds or new wounds will be documented in the chart and on the 24 hour nursing log.	10/25/04

DEPARTMENT OF HEALTH AND F AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 9/23/20(
FORM APPROVE
OMB NO. 0938-039

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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of resident medical records, 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 for 1 of 11 sample residents. Specifically, resident 9 went 34 days without antibiotics after "green drainage" was discovered. There was no documentation that the resident's physician was ever notified of the "green drainage" or "foul odor" coming from a surgical wound on the resident's left hip. There was no documentation that 8 of 24 dressing changes for June 2004 were performed as ordered (from 6/19/04 - 6/30/04). The antibiotics the resident received were ordered by a podiatrist for "possible cellulitis involving the left 2nd toe", not to treat his left hip infection. Resident identifier: 9. Findings include: Resident 9 was an 85 year old male who was admitted to the facility on 2/13/04 with diagnoses which included a "open wound of hip and thigh" and "hip infection" (post surgical). The record of resident 9 was reviewed on 9/14/04 and 9/15/04. a. A physician's progress note, dated 6/17/04, documented "[resident 9] walks slowly with a minimal breathlessness and complains of a continuum of pain. It predominates in the L (left) trochanteric area of his hip. This is a region where he had earlier L hip breakdown which has been slowly healing with primary intention. There	F 309	10/7/04 POC acceptable with addendum completion date -The nursing log will be reviewed daily by the DON or designee to determine if MD was notified and proper documentation is present. -The DON or designee will review treatment sheets to determine if treatments are being recorded and completed. This will be done weekly for 2 months then monthly. -Inservicing on proper documentation for nursing staff will be completed by 10-31-04. -Findings will be reviewed in monthly QA meetings for 4 months and then quarterly.	

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F 309	Continued From page 7 is a nickel-sized shallow area of granulation tissue with a very small .5" (inch) sinus track of approx (approximately) 4-5 o'clock. Dressing is changed daily with saline cleansing and Q-tip probing. It is covered with Alldress. No instability or large zone of inflammation. . . . Healthy appearing granulation base with minimal sinus track remaining at L trochanteric site." Resident 9's physician did not note any sign or symptom of infection regarding the resident's left hip wound. b. From 6/19/04 through 7/22/04, facility nursing staff made four entries into the nurse's notes of resident 9. The following are excerpts from those entries: 6/19/04 - "Using aseptic tech. (technique) pt's (patient's) wound to left hip drsg (dressing) changed. Wound is shallow and 3 - 4 " (inches) long, 2" wide with green drainage . . ." Note: This was the first notation of green drainage, an assessment finding generally indicative of infection, recorded in resident 9's medical record. 6/22/04 - "Pt. (patient) c/o (complains of) pain in L hip, dsg (dressing) change done using aseptic tech. Wound approx 1 1/2 in (inches) long, zero odor, some green drainage, approx 1/2 in. tunneling on posterior wound . . ." 6/27/04 - "Pt. had wound to left hip . . . Drainage has sl. (slight) green tinge." 7/18/04 - "Wound on L hip moist with some white edges, green discharge foul odor . . . Wound is approximately 2 inches long 2 cm (centimeters) wide with 1 inch tunneling in the posterior aspect." Note: An assessment finding of foul odor, emanating from a wound, would generally be indicative of infection.	F 309		

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F 309	Continued From page 8	F 309		

There was no documentation in the nurse's notes to evidence that the physician was notified of the green drainage and foul odor emitting from the left hip wound of resident 9.

c. The "Weekly Skin Integrity Action Sheet" for resident 9 documents the following:

6/30/04 - No area of skin concern is identified by staff. Documentation includes "healing slowly".
7/02/04 - "healing surgical scar"
7/09/04 - no wound description was recorded
7/16/04 - "wound healing slow"
7/23/04 - "red L 2nd toe"

The Weekly Skin Integrity Action Sheets for resident 9 from 6/30/04 through 7/23/04, do not contain a description of the left hip wound or note any signs or symptoms of infection (green drainage/foul odor). With each weekly entry, pre-printed questions were included. One of the pre-printed questions was "MD notified / orders for new problem?" The facility nursing staff did not respond to this question for any of the weeks listed above.

d. The "Skin Log for Non-Pressure Areas", provided to surveyors by the director of nurses on 9/15/04, documented the following:

June 24, 2004 - "Progress/Remarks" regarding resident 9's wound included "improving/smaller". This documentation would not be accurate based on the nurse's notes of 6/19/04 and 6/22/04 describing "green drainage".

e. The "Monthly Nursing Summary" for June 2004, dated 6/21/04, did not mention the green drainage to the left hip wound initially identified by

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F 309	Continued From page 9 another nurse on 6/19/04. f. The "Monthly Nursing Summary" for July 2004, dated 7/22/04, documented regarding the left hip wound, "open wound lt. (left) hip/thigh, increase yellow/green drainage, edges white" and "no change in size, edges white with green/yellow drainage". This nursing summary did not mention that the wound had increased its tunneling depth from 1/2 inch on 6/22/04 to 1 inch on 7/18/04. This nursing summary did not address what was being done to attend to the signs and symptoms of infection including the increased yellow/green drainage, foul odor and increased tunneling depth. g. The June 2004 Treatment Sheet for resident 9 documented physician's orders to perform "twice daily dressing changes". Dressing changes should have been performed twice a day from 6/1/04 through 6/30/04. Per treatment record documentation, between 6/1/04 and 6/18/04, staff performed the dressing change two times daily. Between 6/19/04, the first day the "green drainage" was identified on the left hip wound, and 6/30/04, twenty-four dressing changes should have been performed by facility nursing staff. Per treatment record documentation, there was no evidence that 8 of the 24 dressing changes were performed. h. Facility staff completed a Minimum Data Set (MDS), a mandatory comprehensive assessment, for resident 9 on 7/30/04. Facility staff failed to identify that resident 9 had experienced an infection within the 30 days prior to the assessment date. This would not accurately reflect the wound status of resident 9 based on 7/18/04 nurse's note which describes the left hip	F 309		

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F 309	Continued From page 10 wound with "green discharge" and a "foul odor". i. On 7/23/04, resident 9 was seen by a doctor of podiatric medicine (foot specialist). This doctor documented in a progress note, dated 7/23/04, a concern of "possible cellulitis of the left second toe." The podiatrist then ordered "clindamycin (antibiotic) 300 mg TID (three times daily) X (times) 10 days for cellulitis L 2nd toe." Note: There was no documentation to evidence that the podiatrist was aware of the resident's hip wound or the "green drainage" and "foul odor". j. On 7/28/04, five days after the Clindamycin (antibiotic) was started for the possible cellulitis in resident 9's toe, a nurse documented the following entry in regard to the resident's left hip wound: "dressing change done. No change in tunneling noted. Area look healthy small area on top of wound yellow. No odor . . ." k. The director of nurses (DON) was interviewed on 9/15/04. She was asked to provide documentation that facility staff had notified resident 9's physician of the left hip wound assessment findings of green drainage and foul odor. The DON stated "It isn't there." l. An observation of resident 9's wound was performed on 9/14/04. At the time of the observation, the wound was free of redness, swelling, or green drainage. When the resident was asked how things were going for him, he stated "Why won't this heal? It's been nearly a year."	F 309		

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F 371	Continued From page 11	F 371	-All outdated foods have been discarded.	10/6/04
F 371 SS=F	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions. Findings include: During the initial tour of the kitchen on 9/13/04, beginning at 10:25 AM, the following was observed. In the reach-in refrigerator a ½ gallon container of sour cream had dates of August 19 and August 25. The kitchen employee could not clarify which date was correct. In the dry storage area, a large plastic tub contained the following items: (2) Seasoning mixes dated 3/5/03; (1) Buttermilk dressing mix dated 3/5/03; (1) Pie filling mix with no year in the date; (1) Sloppy-Joe mix with no date; (1) Protein powder supplement packet with no date; (1) Vanilla shake mix with no date; and, (5) Instant breakfast mixes dated 5/30/03. On the shelf was an opened one gallon container of soy sauce, dated 6/13/03. In the large reach-in freezer, there were three	F 371	-Labeling of all foods and products will be done properly upon arrival from order, etc. -Frozen meat will have labels affixed properly, with day, month, and year noted. -Food service manager or designee will monitor each delivery upon arrival for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465088	A. BUILDING ______ B. WING ______	9/15/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE VALLEY CARE CENTER	25 EAST ALPINE DRIVE PLEASANT GROVE, UT 84062

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 371	Continued From page 12 frozen packages of meat that had no label for identification and no year in the date. In the small reach-in freezer, there were three frozen packages of meat with no label for identification and no dates. During an initial inspection of the kitchen on 9/13/04, at 10:15 AM, the dish machine rinse cycle was noted to have a water temperature of 170 degrees Fahrenheit. On 9/14/04, beginning at 7:55 AM, two dish wash rinse cycles were observed. The water temperature for the first rinse cycle was 170 degrees Fahrenheit. The dietary staff member removed the dishes from the dish washer and put them away for later use. A second rinse cycle was observed, which yielded a water temperature of 177 degrees Fahrenheit. The dietary staff member again removed the dishes from the dish machine and put them away for later use. In an interview with the dietary manager on 9/14/04, she stated that the dish machine did not have chemical sanitation. She also stated that they had been having some trouble with the water temperature of the dish machine. There was no evidence to show that the facility had pursued alternative methods of dish sanitation while experiencing difficulties (rinse temperatures less than 180 degrees) with their dish machine. The temperature of the rinse cycle in spray-type warewashers [that do not use chemicals to sanitize] may not be less than 180 degrees Fahrenheit. Reference guidance: U.S. Public Health Service FDA 1999 Food Code, page 101.	F 371	-Dishwasher has been fixed. Temperatures are over 180 degrees now. (Invoices attached) -Temperatures are monitored and recorded three times a day. -Employees will be inserviced on protocol for three compartment sink washing in the event that dish machine does not function at proper temperature. (Protocol is attached) -Inservice to include proper record of temperature for dish machine and notification immediately to food service manager with any problems. -Will review at Q.A. monthly meetings times 4 and then quarterly.	10/22/04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465088	A. BUILDING ______ B. WING ______	9/15/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE VALLEY CARE CENTER	**25 EAST ALPINE DRIVE** **PLEASANT GROVE, UT 84062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 371	Continued From page 13	F 371		
F 387 SS=E	483.40(c)(1)&(2) PHYSICIAN SERVICES The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on comments from 3 of 9 residents in a confidential group inteview, and review of resident's medical records, it was determined that the facility did not ensure 5 of 11 sample residents were seen by a physician at least once every 60 days. Resident identifiers: 1, 2, 6, 7, and 10. Findings include: A confidential resident group interview was held on 9/14/04 at 2:30 PM. Nine alert and oriented residents were present in the group. Three of the 9 resident made expressed concerns that it was difficult to see the doctor. One resident stated that it had been "quite a while" since he had seen his physician. Resident records were reviewed 9/13/04 - 9/15/04. 1. Resident 1 was admitted to the facility on 10/07/02. As evidenced by physician progress notes, resident 1 was last seen by a physician on	F 387	-All residents determined to be out of compliance by the survey have been seen by their physician. -All charts will be reviewed for last physician visit and residents will be scheduled to see their physician to maintain compliance. -A log will be kept by medical records to monitor physician visits. -A list of residents who need to be seen by the physician will be given to the DON or designee to set up MD visits. This list will be completed at least 2 weeks before visit is required to allow for emergencies. -New residents will be encouraged to stay will their PCP and appointments will be made in the office. This will decrease the amount of residents the medical director will need to see. -The physician visit log will be reviewed by the DON or designee monthly to make sure physicians are in compliance. -MD visits will be reviewed monthly in QA meetings for four months and then quarterly.	10/6/04 10/25/04

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465088	A. BUILDING ______ B. WING ______	9/15/2004

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE VALLEY CARE CENTER	**25 EAST ALPINE DRIVE** **PLEASANT GROVE, UT 84062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 387	Continued From page 14 6/17/04. Resident 1 should have been seen by a physician on or around 8/17/04. 2. Resident 2 was admitted to the facility on 5/8/03. As evidenced by physician progress notes, resident 2 was last seen by a physician on 5/20/04. Resident 2 should have been seen by a physician on or around 7/20/04. 3. Resident 3 was admitted to the facility on 10/11/02. As evidenced by physician progress notes, resident 3 was last seen by a physician on 6/17/04. Resident 3 should have been seen by a physician on or around 8/17/04. 4. Resident 7 was admitted on 10/4/01. As evidenced by physician progress notes, resident 7 was last seen by a physician on 6/25/04. Resident 7 should have been seen by a physician on or around 8/25/04. 5. Resident 10 was admitted on 6/2/02. As evidenced by physician progress notes, resident 10 was last seen by a physician on 5/23/04. Resident 10 should have been seen by a physician on or around 7/23/04.	F 387		

Dear Ms. Busenbark,

The following elements were completed to make the facility's Plan Of Correction acceptable.

1. Deficiency 0157

The Medical Director (who is also the resident's primary care physician) attended the Quality Assurance Meeting which was held September 19, 2004. At that time this deficiency was discussed in detail. We reviewed the wound for resident 9 and discussed resident 1 change of condition. We will set a standard as to when a significant change occurs and when to notify the physician. This standard will be reviewed with the Medical Director when completed.

2. Deficiency 0309

The date of the inservice for nurses concerning this deficiency has been scheduled for 9/12/04. The date on the previous Plan of Correction of 10/31 '04 was in error.

3. Deficiency 0257

A log has been created to monitor temperatures in the facility. Temperatures will be recorded 2 times per day. The administrator or designee will monitor for compliance.

4. Deficiency 0257

The administrator or designee will monitor the log daily for 1 month to assure compliance. After 30 days, if temperatures remain in acceptable range, the log will be monitored weekly for the next 4 months

The log will be reviewed at QA meetings monthly for 4 months and then quarterly.

We appreciate your time in helping us complete our plan of correction.

Sincerely,

Bruce Allison, Administrator
Alpine Valley Care Center