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ALPINE VALLEY CARE

@ 002/002 PAGE 82/28

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/16/2006 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER. (XZ) MULTIPLE CONSTRUCTION OMB NO. 0938-0391 COMPLETED A. BUILDING NAME OF PROVIDER OR SUPPLIER 465088 A WING ALPINE VALLEY CARE CENTER STREET ADDRESS, CITY, STATE, 21F CODE 08/03/2006 26 EAST ALPINE DRIVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PLEASANT GROVE, UT 84062 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRUSS-REFERENCE) TO THE APPROPRIATE PREFIX CONFLETION D∧T¢ F 241 DEFICIENCY 483.15(a) DIGNITY \$S=0 F 241 F-241 The facility must promote care for residents in a manner and in an environment that maintains or Two lower tables were enhances each resident's dignity and respect in purchased on August 22, 2006 full recognition of his or her individuality. to ensure residents 18 and other residents as needed will have a This REQUIREMENT is not met as evidenced dignified dining environment. Resident 15 was discharged Based on observations, it was determined the August 3, 2006. facility did not provide 4 of 11 sample residents a dignified dining environment; thus, placing residents at risk for diminished self-esteem and self worth. Resident identifiers: 15, 16, 17 and 18. And inservice on assisting residents during mealtime will Findings included: be conducted by DON or designee for the nursing On 8/01/06 at 8:00 AM the following observations assistants by August 25, 2006 were made in the East dining room; 1. Resident 18 was observed to be sitting at a An audit tool will be developed table that was located at her chin level. Resident, by the DON or designee on 18 was faciling herself. Resident 18 's plets was assisting residents at meal times at nose level. by August 25, 2006 2. Resident 15 was observed to be sitting at a table that was located at her chin level. Resident Audits will be conducted by the 15 was feeding herself. Resident 15 's plate was at nose level. DON or designee bi-weekly x 2, 3. Resident 17 was observed to attempt to open a weekly x 2 and randomly x 6 packet of jam, using her fingers, her knife and her months to ensure continued teeth for 10 minutes. Resident 17 ata the rost of her breakfast and then tried again to open the compliance jam for 7 minutes: the aide from another table helped her open the jam at that point. Audits will be evaluated in the monthly QA meeting, with the On 6/03/06 the following observations were made first QA meeting to be held , in the East dining room; September 14, 2006. Changes 1 8:00 AM Resident 18 was observed to be will be made as necessary to CORATORY THREE PORS OF PROVIDER/SUPPLIER OF PRESENTATIVE'S SIGNATURE ensure continued compliance. PRIDATE

delicioney statement ending with an extensic (*) denotes a delicizardy which the institution may be excused from correcting providing it is determined that it safes provide sufficient protection to the petitions (See instructions.) Except for nursing homes, the findings stated above are disclosable on days with the date of survey whether or not a class of devicetion is provided. For pursing homes, the show findings stated above the disclosable of days. wing the date of survey whether or hat a plan of correction is provided. For nursing homes, the shove findings and plans of correction are unclosable. 14 so remaind the date liters documents are mode symmetric to the faculty. If deficiencies are cited, an approved plan of correction is requisite to continued

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Evento KOHETE

Facility (b) 17 (0001

Wiconlinualion sheet Page 1 of 10

18017855908

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/16/2006 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 465088 08/03/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALPINE VALLEY CARE CENTER 25 EAST ALPINE DRIVE PLEASANT GROVE, UT 84062 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID 1D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 241 Continued From page 1 F 241 sitting at a table that was at her chin level. Resident 18 's plate was at nose level. At 8:15 AM the aide helped Resident 18 with her jam and ketchup then Resident 18 attempted to feed herself. At 8:35 AM the aide fed Resident 18 her food. 9/1/06 - Per telephone Oll to adm. Oldm Stated crompleton date for all F tap is 9/24/06 added with permission Spasenbank por 2. 8:00 AM Resident 15 was observed to be sitting at a table that was between her nose and her upper lip level. Resident 15 's plate was at eye level. 8:10 AM the side fed 3 bites to Resident 15 then gave her the spoon to feed herself. At 8:17 AM Resident 15 attempted to feed her self but could not get her elbow above the table edge. At 8:37 AM the aide attempted to feed Resident 15. Resident 15 refused to eat and went back to her room without eating the rest of her breakfast 3. Resident 16 was observed at 8:05 AM as he attempted to open a ketchup packet using his fingers, a knife and his teeth. At 8 20 AM Resident 16 stopped trying to open his ketchup packet and ate his hash browns without ketchup on them and then left the dining room.

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Event ID; KOHB11

Facility ID: UT0001

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 08/16/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVÉY COMPLETED	
		465088	B. WIN	G	08/	03/2006
	PROVIDER OR SUPPLIER VALLEY CARE CENT	ER		STREET ADDRESS, CITY, STATE, 25 EAST ALPINE DRIVE PLEASANT GROVE, UT 8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SMOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 314 SS=D	Based on the compresident, the facility who enters the facility who enters the facility who enters the facility who enters the facility were unavoided pressure sores receives to promote prevent new sores. This REQUIREME by: Based on observative review, it was determined to be a serviced of existing pressure of existing pressure residents. Specific been assessed, training pressure residents.	orehensive assessment of a must ensure that a resident dity without pressure sores the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and	·F3	14		
	Resident 5 was re- temporary hospitali	mitted to the facility 7/19/02. admitted 5/23/06, following a zation, with diagnoses that multiple sclerosis, and a ulcer.				
	7/31/06 and 8/3/06 A comprehensive Massessment, dated					
		cumented that resident 5 did				

18017855908 ALPINE VALLEY CARE DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/16/2006 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <u>OMB NO. 0938-039</u>1 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING B. WING 465088 NAME OF PROVIDER OR SUPPLIER 08/03/2006 STREET ADDRESS, CITY, STATE, ZIP CODE ALPINE VALLEY CARE CENTER 25 EAST ALPINE DRIVE PLEASANT GROVE, UT 84062 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREF!X (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 314 Continued From page 3 F 314 not ambulate. They documented resident 5 was bedfast and totally dependent upon staff for bed mobility and transfers between surfaces. The IDT documented that resident 5 did not have pressure ulcers, foot problems, or any bruises or abrasions when the resident returned from the hospital. The podiatrist examined resident 5's feet on 6/27/06. The podiatrist documented, that resident 5 "presented for some blistering on the distal F-314 aspects of the left second and third digits. Nursing staff is unsure where the blisters came Podiatrist notes were obtained from. The patient is bed-bound and does not for his visit on 7/10/06 and wear any shoes." The physician noted that, at placed in the chart 8/4/06 that time, "The bed sheets did not apply that much pressure to the ends of the toes." The Nurses will be inserviced on physician documented that he "Aspirated blisters on the left second and third digits." The physician documentation of treatments on prescribed daily dressing changes and a daily basis. This will be documented that resident 5 was to have a follow completed by 8/31/06 by the up in one to two weeks. DON or designee There was no documentation of a podiatry follow up in resident 5's medical record. An audit tool was developed by the DON to assess A physician's order, dated 6/27/06, was written for documentation on treatment the daily dressing changes to resident 5's toes. sheets. The audits will be The order was to apply Betadine solution to completed biweekly x 2, weekly blisters on left 2nd and 3rd toes daily and to cover with a dry dressing. x 4, the randomly for 6 months to monitor continued Resident 5's Treatment sheets revealed the compliance. podiatrist's treatment orders had been carried over from July 2006 to August 2006, but there

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were no nurses' initials to document that the

Resident 5's Treatment sheets for July 2006 and

dressings had been done in August.

Event ID: KOH811

Facility ID: UT0001

14, 2006.

If continuation sheet Page 4 of 10

The audit tool will be reviewed

in monthly QA with the first meeting to be held September

18017855908 PAGE 05/28 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/16/2006 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (XZ) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER. (X3) DATE SURVEY A. BUILDING COMPLETED B WING 465088 NAME OF PROVIDER OR SUPPLIER 08/03/2006 STREET ADDRESS, CITY, STATE, ZIP CODE ALPINE VALLEY CARE CENTER 25 EAST ALPINE DRIVE PLEASANT GROVE, UT 84062 (NA) (D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION DATE TAG DEFICIENCY) Continued From page 4 F 314 F 314 Weekly skin assessments will be August 2006 revealed the resident's last skin conducted by the nurse as per assessment had been done on 7/28/06. There current protocol. Resident 5's was no nursing documentation of a more recent assessment. There was no documentation in nursing assessment was resident 5's medical record that any nurse had scheduled on Thursdays. It was assessed resident 5's coccyx wound or obtained completed by the nurse on treatment orders for the wound. Thursday, August 4, 2006 as Resident 5's Care Plan was dated 5/30/06. The scheduled. Care Plan included a problem that resident 5 was at risk for skin breakdown related to her decreased mobility and dependence for positioning. The goal of the Care Plan was that resident 5 would have no skin breakdown. Nursing interventions to prevent breakdown included: Monitor pressure areas such as heefs, coccyx area and elbows and to encourage the resident to avoid prolonged pressure in these areas. Monitor for redness. Help keep off pressure Skin assessments with interventions as needed. . Keep the residents skin as dry as possible. Wears pad for protection, (Resident 5 had a supra pubic catheter and a colostomy with continued bowel incontinence.) If breakdown occurs, initiate dietary interventions. A surveyor and two nursing assistants observed resident 5's skin on 8/2/06, after the resident had been showered. Resident 5 had 3 blackened areas on the distal (end) and plantar (upper)

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aspect of her 2nd, 3rd, and 4th toes of her left foot and on the ball of her foot. Resident 5 was observed to have a round, open pressure ulcer in the gluteal crease. The pressure ulcer was

Eventiff, KOHB11

Facility ID: 11T0001

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PRINTED: 08/16/2006 FORM APPROVED OMB NO. 0938-0391

(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MUI, TIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 465088 B. WING _ NAME OF PROVIDER OR SUPPLIER 08/03/2006

PREFIX

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F 314

(X4) ID

PREFIX

TAG

ALPINE VALLEY CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 25 EAST ALPINE DRIVE

PLEASANT GROVE, UT 84062 PROVIDER'S PLAN OF CORRECTION

Continued From page 5 approximately two centimeters in diameter with a bright red area at the deepest part of the wound. There was a trace of yellow/brown colored exudate from the wound. The skin surrounding the wound and the peri area was reddened.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

On 8/3/06, a facility nurse and two surveyors observed resident 5's skin while she was in bed. There were no dressings on any of resident 5's wounds. The bed coverings were tightly tucked in over resident 5's feet and the resident did not have protective footwear on. The bright red area in the open wound on resident 5's coccyx appeared to have increased in size.

On 8/3/06 at 9:30 AM, the nurse providing cares for resident 5 was interviewed. The nurse stated resident 5's coccyx wound had not been there the day before.

On 8/3/06, confidential interviews were conducted with two of the nursing assistants who provided cares for resident 5. The nursing assistants stated they had been routinely using a moisture barrier cream to protect resident 5's buttocks and peri area when her briefs were changed.

One nursing assistant stated that a facility nurse had been notified of resident 5's coccyx wound a few days before, on 7/28/06.

The other nursing assistant stated that a nurse had been aware of the open wound on resident 5's coccyx for several days. The nursing assistant stated that the wound looked worse than it had been the previous day.

A Weekly Skin Condition Assessment for resident

MD notes 8/3/06, states the area of question is not a pressure sore by a reoccurring "central irregular induration with a spot bleed due to Coumadin". Continued treatment of this reoccurring, unavoidable sore will be reviewed with all staff by the DON or designee by August 31, 2006

(BACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

CNA's will be inserviced on reporting changes in skin condition to the charge nurse in a timely manner. This will be conducted by the DON or designee by August 31, 2006

Because it can not be verified which aide reported to the nurse there was a new sore or which nurse it was reported to, an inservice will be given to the CNA's concerning accuracy of reporting changes on the skin /body sheets done with showers checks. This will be completed by the DON or designee by August 31, 2006.

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Event ID: KOHB1:

Facility ID: UTouni

If continuation sheet Page 6 of 10

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PRINTED: 08/16/2006 FORM APPROVED

		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				MAPPRO	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	OMB NO. 0938-03	
			A. BUILDI		COMF	LETED	
ME OF	PROVIDER OR SUPPLIER	465088	B. WING				
			ST	REET ADDRESS, CITY, STATE, ZIP CODE	08/	03/2006	
,,,,,,	VALLEY CARE CENT	ER		23 EAST ALPINE DRIVE			
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		PLEASANT GROVE, UT 84062			
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F 314	Continued From pa	ge 6					
			F 314	Detti Will DE			
1		ntation of the treatments for indo from 6/27/06 through		inserviced on following up	on		
İ	- VO.	15 WOLD GOES-15-1		new area's of skin change	s as		
1	AAAMACO MISIGIS IDS	IT M/OPA "Historia" ac a to to		they are reported by the C	$N \Delta^2 c$		
	Aciona mamade	「竹色 ちにつの のも 「ねっ チュール・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・		This inservice will be con-	lucted]	
	*** * ********************************	7 and 7/30/06	1	by the DON or designee by	V		
1	Graph Wound Asses	ssment Worksheet.		August 31, 2006	,		
	There was no nursing	g documentation or tracking		Audits tool to monitor show			
0	of resident 5's open v	vound on her coccyx.		sheet accuracy will be	уег		
		a silvisi doccyx,		developed by the DON or			
465 483.70(h) OTHER ENVIRONMENTAL			designee buy Asset 24	_			
S=C C	CONDITIONS	VIRONMENTAL	F 465	designee buy August 31, 20	06.		
_	ha F Ho			The tools will be completed			
6	anitary and	ide a safe, functional,	}	the DON or designee biweel	by		
, –	esidents, staff and th	3DIO 08Vico		2, weekly x 2 and then rando	dy x		
	- vivia, etail allo [[]	e bublic.		X 6 months to agree 1	omly		
				x 6 months to assure continu	ed		
T	his REQUIREMENT	is not met as evidenced					
1 -,	•	1		Audit tools will be reviewed	in :		
j Ba	esed on observation	and interview with the		the monthly OA meeting with	h		
(100	anns mannengheice ar	Denicor il		the first to be held September	II		
			1	14, 2006. It will continued to			
				monitored x 6 months to ensu	be		
	sidents, staff and the	public.	İ	continued compliance	Ге		
Fir	ndings Include:						
l l				A tracking sheet was developed			
1.	In the shared bathr	oom between rooms 2 and		on the sore for resident 5's	3 d		
				coccyx area when the treatmen			
	- ' ''' '' '' '' '' '' '' '' '' '' '' ''	DODEO MAGRICIA DE L		nurse became aware of the	nt		
"" (liameter and 2 inche	s deep.	1	problem It will			
2.	The sink in the above	and hadde	l t	problem. It will continued to I	oe		
rooi	ms 1 and 3 was very	ed bathroom between	1	nonitored until healed		j	

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PRINTED: 08/16/2006 FORM APPROVED

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2)	MI (I *	10.5	OMB NO	D. 0938-0391
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		465088	B. Wi	ING _			
	PROVIDER OR SUPPLIER VALLEY CARE CENT	ER] 2	REET ADDRESS, CITY, STATE, ZIP CODE 15 EAST ALPINE DRIVE	08/	03/2006
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	,	F	PLEASANT GROVE, UT 84062		
PREFIX TAG F 465	REGULATORY OR LI	MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ίX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LUC DE	(X5) COMPLETION DATE
	3. The door to the warped and very diff. 4. The door to the inch round hole with. 5. In room 26 the seam between the cathe shared bathroom seam in the linoleum inches of exposed lin black, sticky substantion. 6. The carpeting in in room 18 was loosed door to the bathroom. 7. The bathroom was holes in the wall next. 8. The exterior of the	bathroom in room 5 was ficult to open. bathroom in room 9 had a 2 jagged edges. he vinyl strip covering the arpeting and the linoleum in had slipped 2", exposing the and loose carpeting. The 2 soleum was covered in a ce. front of the bathroom door and prevented opening the lill in room 13 had 2 1/2 inch to an existing shelf.		465	F-465 1. Installed new towel dispin the four holes in the wallboard by Director of Maintenance (DOM) 8/23/2. Plunged and put chemic down drain to open the blockage. Drain now work Completed by DOM on 8/23. DOM fixed hinge to the and was able to tune it so the door closed on 8/23/06 4. DOM repaired door hole 8/25/06 5. DOM removed old vinyl and put in a flat, metal threst that was able to screw down 8/23/06	/06 al s. 23/06 door he s on strip shold	
g a b fa a a flo de se ar we	There were cable and and hanging. These liconcealed behind the concealed behind the concealed behind the councealed behind the councealed behind the councealed behind the accumulations of dead accumulation of trash was near the cower beds in the secue and plants and weeds eason. The flower betound the building were councilled.	telephone lines exposed ines were intended to be moldings. Ile areas of large I leaves, trash, plastic ers on the grounds of the table in the smoking area of dry, dead leaves, weeds eashtray. Vegetable and ired unit area contained of from the previous growing ds and planter boxes appeared untended, full of nowing. The overall			6. DOM oversaw the install of new carpet in room 18 or 8/21/06 7. DOM patched the 2 small holes in room 13 on 8/23/06 8. DOM will hang up the sagging phone lines and cab and will put up missing piec of molding by 8/31/06 9. DOM and administrator cleaned smoking area and garden of dead leaves and puweeds in flower areas on 8/23/06. Weeds had been sprayed pric survey by the DOM on 7/27/06	le es	

PRINTED: 08/16/2006 FORM APPROVED <u>OMB NO. 0938-0391</u>

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION
= : : : •

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465088

B. WING

PREFIX

TAG

F 465

08/03/2006

(X5) COMPLETION

DATE

NAME OF PROVIDER OR SUPPLIER

(X4) ID

PRÉFIX

TAG

ALPINE VALLEY CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 25 EAST ALPINE DRIVE

PLEASANT GROVE, UT 84062

F 465	Continued From page 8					
	appearance of the grounds was that of neglect. In an interview with the maintenance supervisor (S5) on 8/2/06 it was stated that there were many ongoing projects in the facility and the grounds were not a priority.					
E 467	493 70/15/05 0-1					

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEEDED BY FULL

REGULATORY OR LSC (DENTIFYING INFORMATION)

F 467 483.70(h)(2) OTHER ENVIRONMENTAL SS=C | CONDITIONS - VENTILATION

> The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two

This REQUIREMENT is not met as evidenced by:

Based on observation and interview with the facility maintenance supervisor, it was determined that the facility did not maintain adequate outside ventilation by means of windows, or mechanical ventilation in 4 of 6 shared bathrooms on the West hall and 6 of 9 bathrooms on the East half.

Findings Include:

- 1. Shared bathrooms in rooms 1/3; 2/4; 5/7; and 6/8 on the West hall had mechanical ventilation systems in the ceilings that falled to provide adequate movement of air to cause a piece of toilet tissue to adhere to the vent.
- 2. Bathrooms in rooms 13, 24 and 25 and shared bathrooms in rooms 16/18; 17/19; 21/23; and 26/28 on the East hall had mechanical ventilation systems in the ceilings that failed to provide air to cause a piece of toilet tissue to adhere to the

DOM and administrator have a contract to have the lawn mowed and edged. Lawn services were completed 8/4/06.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

Daily maintainace log will be posted by the nursing station for staff to report recent problems. The DOM or designee will review the log 5 days per week and date when the project is complete. The staff will be inserviced on this log by the DOM or designee by August 31, 2006

The DOM will use the General Building Inspection tool to monitor the building monthly for problems. The findings from this tool will be reviewed in monthly QA, with the first meeting to be scheduled 9/14/06. It will be reviewed x 6 and then prn to maintain compliance.

Audit tool will be developed by administrator or designee on the environmental condition of the outside of the building by 8/31/06

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Event ID. KOHB11

Facility ID: UT0001

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				D: 08/16/2006
ISTATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/GLIA			OMB N	M APPROVED 0. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			MULTIPLE CONSTRUCTION	COMP	SUKVEY LETED	
		485064		NG	1	
NAME OF	PROVIDER OR SUPPLIER	465086				03/2006
ALPINE	VALLEY CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COD 25 EAST ALPINE DRIVE PLEASANT GROVE, UT 84062	Ē	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	QI I	PROVIDER'S PLAN OF CORR	ECTION	
TAG	REGULATORY OR LE	MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	PREF TAG	IX (EACH CORRECTIVE ACTION S	HOULD BE	COMPLETION DATE
F 467	Continued From pag	ge 9	4 65	Audit to al ill to a		
	vent.	r	,	Audit tool will be developed administrator or designe	oped by	
	3. Mechanical ventii	ation systems in the shared		environmental condition	e on the	1
ļ	valinooms in rooms	9/11 and 20/22 were		outside of the building b	y	
	functional but very n	oisy.		8/31/06	•	
				Audits will be conducted	4 L	
				DOM weekly x 4 and rai	ndomiv	
				thereafter x 6 months	.idomny	
				Andita mill be been		
				Audits will be evaluated QA meeting with the firs	in the	
į				meeting to take place on	ı QA	
		}		September 14, 2006, Ch.	anges	
				will be made as needed to	ວັ	
				continue compliance		
			F-467	F-467		
			-101	DOM COMMENCED WITH CH	unther	
				Comfort Air to install ne	w fans	
				in all bathrooms. Supplibe obtained 9/5/06 and the	es will	
				project is to be completed	d hv	
				9/26/06		
				DOM will inspect the far	18	
				monthly along with the g	eneral	
				building inspection using audit tool titled "General	the	
				Building Inspection"		
!				Evaluation and progress of	of the	
VI CMS-256710	12-89) Previous Versions Obse	Note		project and tool will be re	viewed	
~~		Picto Event ID: KOHB11	Facility	in monthly QA meetings the first meeting to be hel	with Pa	ga 10 of 10
				September 14, 2006 and	a	
				monthly x 6 to insure		
				compliance		