PRINTED: 05/09/2006
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & M' CAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING ______ B. WING ______	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 250 SS=B	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not provide the necessary and appropriate Social Service interventions to attain the residents's psychosocial and highest practical well-being for 2 of 14 sample residents. Resident identifiers 4 and 6. Findings include: 1. Resident 6 admitted 2/15/06 with diagnoses that included chronic skin ulcer, urinary tract infection and multiple sclerosis. Resident 6 was interviewed on 4/11/06. Resident 6 is nearing the end of the medical insurance coverage for this stay and resident 6's medical condition has stabilized. Resident 6 expressed concerns regarding with whom, when and where he/she would be going after discharge. Resident 6's record review shows a psychosocial assessment completed 2/25/06 and a discharge plan dated 2/21/06. There are no further social work follow-up evaluations to address discharge planning issues to assist Resident 6 with any aspect of post discharge needs. 2. Resident 4 was admitted 2/3/06 with diagnoses that included open wound site,	F 250 5/25/06 POC acceptable completion date 6/9/06	This plan of correction constitutes my written allegation of compliance for the deficiencies noted. However, submission of this plan of correction is not an admission that a deficiency exists or that one was noted correctly. This plan of correction is submitted to meet requirements established by State and Federal Law. F 250 In regards to Resident #6, additional meetings were held on 4/28/06 and will be held again on 05/05/06 to discuss further discharge planning. According to the discussion held on 4/28/06, Resident desires to return to home in Nevada for family support and then a move to Wyoming would follow a few months later. A discharge plan will be confirmed with family By 5/11/06, and input will be obtained concerning the discharge. It should be known that this Residents home is already set up for wheel chairs upon arrival; the facility will assist with setting up	6-9-06

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

Administrator | 5-17-06

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.

Utah Department of Health

761253
MAY 20 2006

Bureau of Health Facility Licensing,
Certification and Resident Assessment

other support systems if needed.

If there are any changes from the meeting regarding the discharge plan, an updated discharge note will be made at that time. Discharges will be reviewed by the QA committee weekly at Medicare meeting. The Social Work Consultant will review all discharge plans weekly X 4, thereafter 1 x monthly to ensure that correction is achieved and sustained for the deficiencies cited.

For the second part of the deficiency, Resident #4 was discharged on 4/29/06. Prior to the residents discharge, the Facility talked with the resident and family via phone on 4/24/06 and there was an IDT meeting held on 4/26/06. Social Services assisted with obtaining Home Health and other services required for this residents medical condition.

6-9-06

To ensure that future residents with similar discharge needs are met, the facility will discuss a discharge plan within the first 72 hours of being

admitted to the facility. Within the first 14 days of admission to the facility, a letter will be sent to the family to set up an IDT meeting where Social Services, Therapy, Nursing, Dietary and Activities will review the families discharge plan and make initial recommendations as needed for the discharge goal.
In our weekly Medicare meeting, a discharge meeting will be held in concurrence to discuss all discharges, assess the proximity of a discharge date and to schedule possible future meetings as needed.

Once goals are established they will be reviewed in the discharge meeting with the IDT team weekly and with the Resident Bi-weekly. As changes occur in the long- term goals and health care issues, they will be documented in the Residents chart. The Social Work Consultant will review goals for the 1:1 meetings and IDT meetings.

6.9.06

DEPARTMENT OF HEALTH AND HUMAN 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
	465072	A. BUILDING ______ B. WING ______	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 250	Continued From page 1 bacteremia, pneumonia and quadriplegia. Resident 4 continues to have a complicated and difficult medical condition that requires interventions from all disciplines in the facility. Record review reveals that Resident 4 has difficulty with decisions and can be resistive with cares. Both Resident 4 and the family have expressed concerns regarding their ability and involvement in managing health care choices, services and long term goals. There is no documentation indicating social services intervention or assistance with these issues.	F 250		
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 observation it was determined that the facility did not have an effective maintenance system to ensure the residents environment was maintained in good repair. Specifically corridor handrails, resident door's and door frames in need of repair. Findings include: The following corridor walls and resident doors were observed on 4/12/06, from 8:55 AM to 9:15 AM: 1. The following was observed on the first floor:	F 253	F 253 This deficiency is not Resident Specific but a plan of correction will be put into place. All doors, door jambs and handrails mentioned will be repaired. An outside contractor will be obtained to re-finish or touch-up the doors and door jambs. The handrails will be re-finished or touched-up by the facility Maintenance Department. An inspection form will be created and utilized to help the Maintenance Department identify areas in need of repair. Inspections will occur on a monthly basis and the inspection report will be maintained in a Preventive Maintenance binder. The	6-9-06

DEPARTMENT OF HEALTH AND HUMAN 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
	465072	A. BUILDING ____ B. WING ____	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 253	Continued From page 2 Room 102 door is gouged , scratched and marred also the right side of the door has a 6 inch by 1/2 inch area of veneer missing, Room 104, and 105 doors are marred and gouged, Room 106 doors are marred, gouged and the right side of the door frame has a section of wood that is broken and splintered, Room 110, 111, and 112 doors are marred and scratched, Room 117 door frame is badly gouged and marred down to bare wood, Room 118 door has a 4 inch by 2 1/2 inch area where the veneer has peeled off and the lower section of the door is marred and scratched, Room 122 door on the left side has a 4 inch area where putty has been placed on it, has not been sanded or painted. Handrail between room 101 and the day room is splinted and scratched, Handrail next to room 103 has putty present, has not been sanded or painted and the putty as cracked, Handrail across from room 109 was loose, Handrail next to Storage 3 was rough and splintered. 2. The following was observed on the second floor: Room 202, 203, 205, 207, 208, and 209 doors were marred and gouged and the door frames were marred and gouged down to bare wood, Room 211, 212, and 215 doors were scratched, marred and gouged, Room 216, 217, 220 and 222 doors were marred	F 253	Maintenance Supervisor will monitor. The inspection report will be reviewed at the facilities QA meeting which is held on a monthly basis.	6-9-06

DEPARTMENT OF HEALTH AND HUMAN 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
	465072	A. BUILDING _____ B. WING _____	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 253	Continued From page 3 and gouged Handrail next to room 210 on the corner was splintered, Wood railing across from room 211 and by storage door was splintered on the end.	F 253		
F 281 SS=E	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 record review and observation, it was determined that services provided by the facility did not meet professional standards of quality, specifically for 3 of 14 sample resident's tube feeding procedures. Resident identifiers 2, 4, 8. References: Postgraduate Medicine http://www.postgradmed.com issues 2004/, Tube Feeding in the elderly, the technique, complications, and outcome page 5: ..."Gastric residuals should be checked periodically to detect stasis and assess risk of aspiration. For continuous feeding, gastric residuals are monitored while the infusion is in progress; for bolus feedings, residuals should be checked l hour after feeding has ended. In general, a residual of less than 150 mL, or less than twice the rate of continuous feeding, is acceptable. Residual checks are recommended every few	F 281	F 281 The facility provides services that meet professional standards. Licensed Nurses are checking for placement prior to administering medications and flushes to Resident #2. Resident #2 is being flushed with 30 cc of H2O before and after medications. Resident #2 has residuals checked approximately 1 hour after continuous tube feeding is completed. Resident #4 has Licensed Nurses checking for placement prior to medications and flushes. Flushes include 100 cc H2O QID (5 – 20 cc before and after medications and feedings). Residuals are being checked prior to medications, feedings and flushes as well as placements.	6-9-06

DEPARTMENT OF HEALTH AND HUMAN 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
	465072	A. BUILDING ______ B. WING ______	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 281	Continued From page 4 hours in patients receiving continuous feeding...". "feeding tubes should be flushed with at least 30 to 60 ML (milliliters) of water after administration of medications to prevent clogging..." Findings include: 1. Resident 2 was a resident with a Gastric tube (GT) used for enteral feedings and medications administration. On 4/11/06 at 08:40 AM, the surveyor observed a facility licensed nurse (LPN-1), preparing residents 2's medications for administration. Upon entering resident 2's room, nurse 1 stopped the pump that was used to control the resident's enteral feeding infusion, then disconnected the enteral feeding tube from the (GT). Nurse 1 flushed the GT with 20 cc (same measurement as mL's) of water using a piston syringe. Nurse 1 drew up two of resident 2's medications in a piston syringe. Residents 2's GT medications were then pushed by syringe into the resident 2's GT tube. After nurse 1 had administered resident 2's medications she then drew up 20 cc of water in a piston syringe and flushed the GT. Nurse 1 connected the enteral feeding tube to the pump and turned the pump on to infuse the feeding. Prior to administering the resident medications, nurse 1 did not check the GT for placement by auscultation or any other method. Also, prior to administering the resident medications, nurse 1 did not check for residual during any of the infusion process or when administering medications. On 4/11/06 at 3:30 PM, the surveyor observed nurse 1, administer resident 2's GT tube medication administration. Resident 2 had no	F 281	Resident #8 has Licensed Nurses checking for placement prior to medications and flushes. Flushes include 150 cc H2O QID (5 – 20 cc before and after each medication). Residuals are being checked prior to all medications, feedings and flushings. All nurses will be in-serviced on 05/09/06 on proper tube feeding procedures to include checking placement, residual and flushing for continual bolus and gravity bag feedings. The Policy and Procedure for Tube Feedings has been updated and approved by the Facility Medical Director and QA Committee. QA round will be completed weekly x 4 weeks and monthly thereafter by DON to ensure professional standards are met. Findings will be reported to QA committee quarterly.	6-9-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING ____ B. WING ____	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 281	Continued From page 5 continuous enteral feeding infusing at this time. Upon entering resident 2's room, nurse 1 unclamped resident 2's enteral feeding tube, flushed the GT with 60 cc of water using a piston syringe. Nurse 1 drew up two of resident 2's medications in a piston syringe. Residents 2's GT medications were then pushed by syringe into the residents GT tube. After nurse 1 had administered resident 2's medications she drew up 60 cc of water in a piston syringe and flushed the GT. Prior to administering resident 2's medications, nurse 1 did not check the GT for placement by auscultation or any other method. Also, prior to administering the resident medications, nurse 1 did not check for residual when administering medications. On 4/11/06 at 2:35 PM, surveyor reviewed the physician order for administration of medications and flushing resident 2's GT ... " then water flush @ 20 cc/hr QID. " On 4/11/06 at 1:35 PM, nurse 1 was interviewed about resident 2's medication administration. The surveyor asked nurse 1 to explain what her understanding was regarding GT placement, flushing GT tubes and checking for residual. Nurse 1 stated that she was not aware that it was necessary to check placement of GT's, only a naso-gastric tube. The surveyor discussed with nurse 1, the physician order for flushing GT's on resident 1's medication administration record (MAR). Nurse 1 stated that she often gives more water if she feels that the resident is dehydrated. Nurse 1 further went on to say, that on resident 2, it is important to observe the consistency of the residents " spit " ....if the spit is thick, the resident	F 281		

DEPARTMENT OF HEALTH AND HUMAN 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
	465072	A. BUILDING ______ B. WING ______	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 281	Continued From page 6	F 281		

is usually dehydrated so I give more water. "

2. Resident 4 was a resident with a Gastric tube (GT) used for Enteral feedings and medications administration. On 4/12/06 at 7:35 AM, the surveyor observed a facility licensed nurse (LPN-3), preparing residents 4's medications for administration. After preparing the medications, nurse 3 entered resident 4's room. Nurse 3 unclamped the GT and flushed it with 60 cc of water using a piston syringe. Nurse 3 then drew up another 40 cc of water into the piston syringe and flushed GT tube again. Nurse 3 drew up six GT medications with a piston syringe and pushed them through the GT. After nurse 3 had administered resident 4's medications she drew up 100 cc of water into a piston syringe and flushed the GT. Nurse 3 then clamped the GT. Prior to administering the resident medications, nurse 3 did not check the GT for placement by auscultation or any other method. Also, prior to administering the resident medications, nurse 3 did not check for residual.

On 4/12/06 at 2:40 PM, surveyor reviewed the physician orders and MAR's for administration of medications, flushing resident GT, and tube placement verification which states the following: Flush tube ... " 100 cc of water QID, (flush with 5-20 cc water before and after each medication and feeding. " Tube placement ... " Q 12 hours (BID) by aspiration, (chart in cc). "

3. Resident 8 was a resident with a Gastric tube (GT) used for enteral feedings and medications administration. On 4/11/06 at 4:00 PM the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING ____ B. WING ____	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 281	Continued From page 7 surveyor observed a facility licensed nurse (LPN-2), preparing residents 8's medications for administration. Each GT medication was mixed with 5 cc of water. After preparing the medications, nurse 2 entered resident 8's room. Nurse 2 unclamped the GT, filled a piston syringe with air, placed a stethoscope on resident's upper right quadrant (RUQ) and inserted air into the GT. Nurse 2 drew up all six GT medications with a piston syringe and pushed them through the GT. Nurse 2 then poured the Fibersource HN (350 cc) into a Enteral feeding bag located at bedside, cleared tubing with HN, and connected the tubing to Resident 8's GT. Nurse 2 opened the clamp on the tubing and regulated the drip by gravity flow. Prior to administering the resident 8's medications, nurse 2 did not flush the GT tube with water. Also, prior to administering HN she did not check for residual during any of the infusion process. On 4/12/06 at 4:45 PM, surveyor reviewed the physician order written on the (MAR) for administration of medications, flushing resident GT tube and tube placement verification which states the following: Tube irrigation ... " 150 cc of water QID (flush with 5-20 cc water before and after each medication and feeding. " Tube placement ... " Q shift by aspiration, (chart in cc). " On 4/11/06 at 1:35 PM, surveyor interviewed nurse 2 about her understanding regarding medication administration and flushing gastric tubes. Nurse 2 stated that ... " you use 5 cc of	F 281		

DEPARTMENT OF HEALTH AND HUMAN 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
	465072	A. BUILDING ____ B. WING ____	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 281	Continued From page 8 water for each medication " ... " If you have a question about the amount of fluid to use you can call the physician. " The facility policy and procedure was reviewed, on 4/12/06. The steps in the procedure for GT feeding via continuous pump, does not address a procedure or steps for checking placement, administration of water or checking for residual fluid. In an interview, on 4/13/06 at 9:00 AM, with the DON she agreed that the policy and procedure for GT feedings did not address checking for placement and residual fluid.	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 and interviews, it was determined that the facility did not maintain Minimum Data Set (MDS) assessments completed within the previous 15 months in the resident's active record for 2 of 14 sample residents. Resident identifier 3 and 12. Findings include: Resident 3 was admitted to the facility on 7/1/06, with diagnoses that included non-psychotic brain syndrome, diabetes mellitus type II, osteoarthritis,	F 286	F 286 In reference to the findings of Resident #3's MDS dated 9-3-05 is now located in the clinical record. Resident #12s MDS dated 1-13-06 is now located in the clinical record. To eliminate it from happening to other Residents, audits will be performed. The plan the facility will be implementing will include audits on a Monthly basis. The audits will be completed by Medical Records	6-9-06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. BUILDING ____ B. WING ____	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 286	Continued From page 9 hypertension, arthritis, arthropathy and insomnia. Resident 3's clinical record was reviewed on 4/10/06. Resident 3 had a quarterly MDS that was due on or about 9/3/05. This quarterly MDS could not be found in the current clinical record. In an interview, on 4/11/06 at 3:30 PM, with the Assistant Director of Nursing (ADON), it was determined that the quarterly MDS for 9/05 was in the computer and the ADON did not know why the MDS was not printed and placed on resident 3's clinical record. Resident 12 was admitted to the facility on 3/20/02 with diagnoses that included intestinal obstruction, gastric intestinal upset, hypertension, osteoporosis, nutritional deficiency, latent schizophrenia, congestive heart failure, hyperlipidemia, and neurogenic bladder. Resident 12's clinical record was reviewed on 4/13/06 at 08:45 AM. Resident 12 had a quarterly MDS that was due on or about 1/13/06. This quarterly MDS could not be found in the current clinical record. In an interview, on 4/13/05 at 3:30 PM, with the Assistant Director of Nursing (ADON), it was determined that the quarterly MDS for 1/13/06 was in the computer and the ADON did not know why the MDS was not printed and placed on the resident 12's clinical record.	F 286	and the MDS Coordinator on 25% of all Residents. Random audits will also be completed quarterly by the Medical Records Consultant to assure that 15 months of assessments are maintained in each Residents current clinical record. The Assistant Director of Nursing/MDS Coordinator will monitor the performance to ensure that the solutions are sustained. Results of the audits will be reviewed and addressed in monthly QA meetings.	6-9-06

DEPARTMENT OF HEALTH AND HUMAN 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
	465072	A. BUILDING ____ B. WING ____	04/13/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLINGTON HILLS CARE CENTER LLC	165 SOUTH 10TH EAST SALT LAKE CITY, UT 84102

(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 468 SS=B	483.70(h)(3) OTHER ENVIRONMENTAL CONDITIONS - HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not ensure that two areas of the facility were equipped with handrails, thus placing residents at risk of injury. Findings include: The following corridor walls were observed on 4/12/06, from 8:55 AM to 9:15 AM, to have no handrails: First floor corridor across from room 108 there is a wall measuring 50 inches with no handrail. Second floor corridor across from room 208 there is a wall measuring 50 inches with no handrail.	F 468	F 468 New hand rails will be installed in the two locations identified by State Survey Team so as to assist Residents in a safe manner. Once these handrails are in place, this will eliminate the chance of others being affected in any adverse way. The measure put into place will be the inspection form that will be used to monitor the condition of hand rails as discussed in the prior deficiency F 253 POC. The plan that has been developed is the placement of the new handrails in the two locations. The Maintenance Departments Supervisor will monitor for the continued condition and placement of the hand rail. This monitoring will take place on a monthly basis using the inspection report that will be designed and implemented. The QA team will monitor this on a monthly QA meeting.	6-9-06