STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	08/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHABILITATION CENTER	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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	(X5) COMPLETION DATE
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE	F 253	F 253	

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:

Based on observations and interviews the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior in hallways, a day room, and men's and women's bathrooms.

Findings included:

The annual recertification survey was conducted at the facility on 8/7/06 through 8/10/06. During an initial tour of the facility, observations were made of the facility environment including common areas and resident rooms.

1. A portion of the main hallway continuous surface flooring measuring approximately fifty feet in length was observed to have black stains near the walls on both sides of the hallway floor. The stains were observed to be configured in a side-to-side mopping or sweeping pattern along the length of the hallway. The black stains on the hallway flooring did not maintain an orderly and comfortable interior for residents.

2. The continuous surface flooring was observed to be coved up on the wall approximately 4 inches high on both sides of the hallway. In multiple places along both sides of the length of this portion of the hallway, the surface coving material was observed to be cracked and broken to lengths of 8 inches. The broken coving provided

9/6/06 POC acceptable Completion date 9/8/06

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PM 9/1/06
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Certification and Resident Assessment

Art City Nursing & Rehabilitation strive to maintain a sanitary, orderly and clean interior at all times. 1 & 2 - The continuous linoleum flooring "approximately 50 feet" in the main hall will be replaced with a new floor. Thus maintaining a cleanable surface. The maintenance supervisor will have the housekeeping staff clean the floors on a daily basis and more often as need requires, thus maintaining a clean and safe environment. 3 – The three "dark" areas identified in the day room have been treated and the carpets were shampooed and cleaned. The carpets in all areas of the building are on a regular schedule and turned into the maintenance supervisor who reports to the Quality Assurance Team at a minimum of quarterly in the scheduled meeting. 4 - The maintenance supervisor purchased new adhesive tape and has covered the pipe insulation to assure there is a cleanable surface to protect the insulation as well as the residents from potential health risks associated with the pipes on the ceiling. 5 – The drinking fountains were cleaned and have been placed on a cleaning schedule where they will be cleaned daily. (See Attachment A) The cleaning schedule is turned in daily to the maintenance supervisor and the maintenance supervisor reports to the Quality Assurance Team in regularly scheduled meetings. 6 – smoking has not been and will not be permitted in any part of the building. The cigarette butt was removed from the floor the bathroom was cleaned and the bathroom call cords were cleaned and shortened so as to prevent them from becoming soiled. The bathrooms are also on the daily cleaning schedule and are cleaned in the morning and again in the afternoon prior to the housekeeper going home for the evening. The shower stall was cleaned and has also been placed on the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
C Todd Brandt	Administrator	9-1-06

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.

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	465130	A. BUILDING _____ B. WING _____	08/10/2006

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F 253	Continued From page 1 surfaces that were unable to be maintained in a sanitary fashion. 3. The carpeted floor surface in the facility common area day room was observed to have three dark stained areas approximately 5" X 3" near the right side of the entrance doorway. 4. Observations of the ceiling above the main hallway showed insulated water pipes along the length of the hallway. Paper covering of the insulation was loose in two areas and in one of these areas was hanging down approximately 6 inches into the hallway. 5. Observations were made of two drinking fountains in the facility, one located in the dining room and one located in the common hallway near the rear entrances to the facility. The drinking fountains were both observed to have what appeared to be hard water grime covering the water basin drain surfaces. Tactile observations made by lightly touching along the outer edges of the water drain basin surfaces found that the covering surfaces of both fountains felt greasy to the touch. 6. On the afternoon of 8/7/06 and the morning of 8/8/06, observations were made of the common bath and toilet areas located near the rear entrances of the facility, labeled to indicate use by the male and female residents of the facility. On the morning of 8/7/06, the women's bathroom was observed to have a cigarette butt on the shower stall floor and a cigarette butt in the toilet. The men's bathroom was observed to have a pull	F 253	daily cleaning sheet. The cleaning schedule is turned in daily to the maintenance supervisor who reports to the Quality Assurance Team in regularly scheduled meetings. The administrator and his/her designee along with Safety Committee members will monitor the need for more frequent cleaning of these areas, and that all surfaces are maintained with a cleanable surface and report to the Quality Assurance Team in regularly scheduled meetings. The Quality Assurance Team has developed forms for monitoring the appropriate cleaning is taking place. We allege compliance September 29, 2006.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	08/10/2006

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F 253	Continued From page 2	F 253		

cord near the toilet which extended to within approximately 12 inches of the floor. The pull cord was dark brown, discolored and visibly soiled. The shower stall in the men's common bathroom was observed to have stains and water scum areas on the floor surface near the back of the shower stall.

The women's bathroom was observed to have a pull cord near the toilet which extended to and rested on the floor for approximately six inches. The pull cord was dark brown, discolored and visibly soiled. The shower stall in the women's common bathroom was observed to have visible water scum areas near the back of the shower stall. The bathtub was observed to have what appeared to be hair and a slimy substance in the drain screen of the tub.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	08/10/2006

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ART CITY NURSING AND REHABILITATION CENTER	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

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F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT	F 278	**F 278**	

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Resident 4 was admitted to the facility on 10/25/04 with diagnoses including congestive heart failure, edema, depression, and unsteady gait.

The annual MDS dated 11/6/05 and the quarterly MDS dated 5/7/06 did not accurately reflect the

The nurse who was performing the MDS Assessment recently left the employ of Art City Nursing and Rehabilitation and a new nurse was hired. This nurse has spent three days training with the corporate nurse learning the correct procedures for completing the MDS as well as one day with the administrator. The Resident Assessment Instrument Manual 2.0 has been given to the employee and instruction related to the proper use of and completion of the MDS. The MDS nurse is scheduled to attend a certification class in Las Vegas, Nevada on September 11-13. The Director of nursing will bring a random sample of 20% of MDS assessments completed to the Quality Assurance Team meetings for accuracy review for the next quarter. If the team determines a 95% accuracy in the MDS Assessment the QA Team will determine the issue resolved, but will monitor 10% per quarter of the completed MDS Assessments. In this manner we will protect all residents through proper and accurate assessments for all resident including resident 6. We also began weighing all residents beginning in June 2006 on a weekly basis to make sure appropriate and timely interventions are taking place. We allege compliance September 29, 2006.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	08/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 278	Continued From page 4	F 278		

resident's status in Section G. Physical Functioning & Structural Problems, 6. Modes of transfer. Both assessments were checked in a.) Bedfast all or most of time.

Nurses notes in resident 4's chart dated 12/28/05 state: "Ambulating in hallway with walker." Nurses notes dated 2/18/06: "Up ambulating with cane, fairly steady gait." 3/7/06: "Ambulates with cane. 3/22/06: "No recent falls, gait very steady." 5/2/06: "Amb. (ambulates) with use of cane. Gait very slow but steady."

Observations of resident 4 in the facility revealed that he walked with a cane on 8/7/06, 8/8/06, 8/9/06 and 8/10/06. He was seen walking to the dining room for meals while using his cane.

The annual MDS of 11/6/05 for resident 4 was not signed and dated by a registered nurse certifying that the assessment was completed, Section R. Assessment Information.
Based on reviews of records and interviews with the facility Director of Nursing and Administrator, the facility did not complete a resident assessment that accurately reflected the resident's weight and nutritional status, and physical functioning for 2 of 11 sampled residents. Resident identifiers 4 and 6.

Findings included:

Resident 6 was admitted to the facility on 3/30/03 with diagnoses which included dementia, anxiety, hypothyroidism, osteoporosis and a history of falls.

On 8/08/06 during the annual recertification

Utah Department of Health
SEP 05 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	08/10/2006

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F 278	Continued From page 5	F 278		

survey of the facility, resident 6's medical record was reviewed, including the "Monthly/Weekly Weight Recap Sheet" for 2006, Minimum Data Set (MDS) assessments dated 12/09/05 and 3/10/05, and dietary progress notes and diet order changes.

Resident 6's Monthly/Weekly Weight Recap Sheet for 2006 revealed the following weights:

January: 162 pounds,
February: 155, a 7 pound weight loss for one month
March: 146, a 9 pound weight loss for a cumulative weight loss of 16 pounds (9.9%) in three months

Resident 6's MDS for 12/09/05 showed entries under Section K. Oral/ Nutritional Status, which recorded resident 6's weight as 159 pounds and indicated no weight gain, weight loss or nutritional approaches in Subsection K. 3 through 5.

Resident 6's MDS for 3/10/05 showed entries under Section K. Oral/ Nutritional Status, which recorded resident 6's weight as 146 pounds and indicated no weight gain, weight loss or nutritional approaches in Subsections K. 3 through 5.

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	465130	A. BUILDING _____ B. WING _____	08/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHABILITATION CENTER	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

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F 325 SS=G	483.25(i)(1) NUTRITION	F 325	**F325**	

Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

This REQUIREMENT is not met as evidenced by:

Based on observations, reviews of record and interviews with the facility Director of Nursing and Food Service Manager, the facility did not ensure that 1 of 11 sampled residents maintained acceptable parameters of nutritional status. Resident identifier 6.

Findings included:

Resident 6 was admitted to the facility on 3/03/03 with diagnoses which included dementia, anxiety, hypothyroidism, osteoporosis and a history of falls.

On 8/08/06 during the annual recertification survey of the facility, resident 6's medical record was reviewed, including the "Monthly/Weekly Weight Recap Sheet" for 2006, laboratory blood test result reports indicating nutritional status, and dietary progress notes and order changes.

Resident 6's Monthly/Weekly Weight Recap Sheet for 2006 revealed the following weights:
A. January: 162 pounds,
B. February: 155 pounds, a 7 pound weight loss for one month
C. March: 146 pounds, a 9 pound weight loss for a significant cumulative weight loss of 16

Art City Nursing & Rehabilitation has completed an audit of all patients charts including a nutritional assessments, weight, skin integrity and laboratory tests on September 5 & 6, recommendations were given to the physician, who reviewed and gave orders according to his knowledge of the patients on July 11, 2002. All new orders were followed and any recommendation not followed by the physician were reported to the Registered Dietician who discussed the recommendations with the nurse and physician and appropriate interventions have been made. Art City Nursing & Rehabilitation has further adopted new dietary Policy & Procedure for the Dietary Department. The Dietary Supervisor attended an in-service held by the Registered Dietician on July 12, 2002. The Registered Dietician has further held in-services with the administrator on July 12, 2002. Another Dietary Supervisor in-service was given August 5, 2002 with the Registered Dietician. The Dietary Supervisor has also spent the month of July becoming familiar with the new Policy & Procedures. The Registered Dietician will continue to make recommendations and follow-up with the dietary supervisor within three days of consultant visit to assure follow-through with recommendations from the dietary supervisor and the physician and make further recommendations as necessary. The Registered Dietician gives a written report to the administrator the ability of the dietary and nursing department to follow through with recommendations and physician orders after each visit. The Administrator and Dietary Supervisor report to the Quality Assurance Team all findings related to patients who have had weight loss or gain outside established parameters. We allege compliance September 29, 2006.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	08/10/2006

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F 325	Continued From page 7 pounds (9.9%) for the three month period between January and March D. April : 144 pounds, a 2 pound weight loss for a cumulative loss of 18 pounds (11%) E. May: 140.5 pounds, a 3.5 pound weight loss for a cumulative loss of 21.5 pounds (13%) F. June: 142 pounds, a 1.5 pound weight gain Laboratory reports were reviewed in resident 6's medical record and showed results of a Comprehensive Metabolic Panel (CMP) blood test dated 12/03/05 with values of 6.2 value for total protein with the notation "LOW" and 3.2 for Albumin with the notation "LOW". A CMP laboratory report dated 6/06/06 showed the results of a 5.9 value for total protein with the notation "LOW" and 3.0 value for Albumin with the notation "LOW". The laboratory reference range for total protein was 6.3 to 8.2; the reference range for albumin was 3.5 to 5.0. Resident 6's medical record included a Dietary Progress Note dated 12/5/05 which showed the entry: "very hard to awaken. Is a very slow eater. labs total protein 6.2 (low) albumin (low) 3.2. Will add one scoop protein powder TID (three times per day) to meet needs". Resident 6's medical record was reviewed for indications that resident 6 had received nutritional interventions recommended in the Dietary Progress Note dated 12/5/05. No changes to the dietary orders were noted on resident 6's Medication Administration Record (MAR) which showed "mechanical soft RCS (reduced concentrated sweets) Diet 8 ounces extra H2O	F 325	The facility will assure the protection of resident 9, 26, 29, 16, 17 and all residents by review of weight loss and gain in the bi-monthly skin and weight meeting. The Registered Dietician will review lab values ordered by the physician and calculate protein parameters. The Registered Dietician will include these calculations in the assessments they perform. The assessments are reviewed by the Dietary Supervisor and reported to the Director of Nursing. Any recommendations will be relayed to the physician who will give orders according to their knowledge of the patient and all orders will be followed. The Dietary Supervisor and Director of Nursing will report to the Quality Assurance Committee any irregularities and appropriate action will be taken. We allege compliance September 29, 2006. The Dietary Supervisor will assure that recommendations for laboratory tests made by the Registered Dietician are given to the Director of Nursing and the recommendations are further given to the physician. The Dietary Supervisor will follow up with the Director of Nursing to make sure that the physician will give orders appropriate to their understanding of the patients current condition. The recommendations made by the Registered Dietician will be acted upon within 72 hours of being given. The Dietary Supervisor will report to the Quality Assurance Committee and appropriate actions will be taken to ensure the nutritional needs are met for resident 6 and all residents. We allege compliance September 29, 2006.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	08/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHABILITATION CENTER	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

(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 325	Continued From page 8	F 325		

(water) with meals, hydration cart".

Resident 6's medical record showed a Change of Diet dated 6/7/06 which documented a new diet order of: 1) SNP (special nutrition program) increased protein; 2) SF (sugar free supplement) TID (three times per day); and 3) 1 scoop protein powder TID (three times per day).

On 8/9/06, the facility Director of Nursing (DON) was interviewed regarding weight loss and nutritional interventions for resident 6. The DON stated that in January 2006, resident 6 had shown signs she was experiencing oral pain with eating and had received dental care which resulted in teeth extraction on 01/19/06 and 01/20/06. The DON stated that resident 6 had been ordered a puree diet prior to tooth extraction and resident 6 did not like the puree foods. The DON further stated that resident 6 had suffered "right sided weakness" the day after her last dental appointment that was diagnosed as a symptom of a CVA (cerebral vascular accident) by the facility nurse practitioner.

The facility DON stated that resident 6 had not been referred for a swallowing evaluation but had been assessed for hospice services because the facility staff had noticed resident 6 was increasingly lethargic, hard to arouse at mealtimes and was suffering a general decline. The DON stated a new diet order had been initiated on 6/7/06 after members of the facility Interdisciplinary Team reviewed resident 6's plan of care, laboratory values and a dietician recommendation. The DON further stated that resident 6 had been dining at the assisted dining table for over a year and would continue to

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	465130	A. BUILDING _____ B. WING _____	08/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 325	Continued From page 9 receive assistance with dining and special nutrition program supplementation. The facility Food Service Manager was interviewed on 8/9/06 regarding the implementation of a special nutrition program for resident 6 on 6/7/06. The facility was not able to provide evidence that dietary interventions to avoid weight loss and compromised nutritional status had been implemented when first recommended for resident 6.	F 325	**F 371** Art City Nursing & Rehabilitation strive to provide the highest quality meals to its residents in a home-like atmosphere. The Dietary Manager in-serviced each employee September 8, 2006 on the new procedures discarding items that are expired. The administrator will conduct a review of the kitchen on a weekly basis for one month and report in Department Head meetings findings. The Dietary Manager will be instructed on the necessary instruction of employees who are not following the proper procedures. During the month of monitoring if 95% of items expired and procedures are followed. The QA Team will determine that staff are following procedures and the dietary manager will continue to monitor that procedures are followed and report to the QA Team in regularly scheduled meetings.	
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that the facility did not store prepare, distribute, and serve food under sanitary conditions. Findings included: On 8/7/06 at 6:35 AM, observations were made in the kitchen. In the refrigerator the following items were found: Ranch dressing that expired 7/11/06.	F 371	The dietary supervisor make sure that the cleaning schedule for the dietary staff is followed and includes the dusting and cleaning of pipes in the preparation area. The dietary supervisor has in-serviced dietary staff on September 8, 2006 on the cleaning schedule and items to be cleaned. The dietary manager will ensure that all areas in the kitchen are cleaned and report to the Quality Assurance Team in regularly scheduled meetings any problems that need further attention. The seasoning containers were cleaned and are being kept closed the dietary manager has added them to the cleaning schedule and will monitor that they are cleaned and stored properly and report to the Quality Assurance Team in the next regularly scheduled meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. BUILDING _____ B. WING _____	08/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ART CITY NURSING AND REHABILITATION CENTER	321 EAST 800 SOUTH SPRINGVILLE, UT 84663

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F 371	Continued From page 10	F 371		

Pre-cooked thawed diced chicken dated 7/30/06.

Creamy ranch dressing with expiration date of July 2006.

One thawed 4 ounce strawberry Mighty Health Shake with no thaw date. Mighty Shakes must be used within 14 days of thaw date.

In the storage room the following items were found:

One gallon jar of Ranch Litehouse Dressing with seal open; dressing was leaking out of lid, down jar and onto shelf. Expiration date 8/11/06.

One case of Ensure, expiration 1 Aug 2005. One case of Ensure, expiration 1 July 2006.

Five boxes of Carnation Breakfast Sugar Free Variety Pack, 8 packets each; expiration July 2006.

One box regular Carnation Breakfast expired March 2006, hand written date 8/1/05 (delivery date).

One box regular Carnation Breakfast use by (illegible), hand written date 7/18/05 (delivery date).

On 8/8/06 at 7:30 AM, observations were made in the kitchen, storage room and dining room:

Overhead pipes in the kitchen above food preparation areas were greasy and dusty.

and continue to monitor and report to the QA Team.
The freezer labeled #1 has been replaced and the dietary supervisor will inspect the freezers on a monthly basis to ensure that The freezers are in proper working condition and report the findings to the Quality Assurance Team in regularly scheduled meetings of the QA Team

We have held an in-service with the dietary personnel and instructed them on September 8 2006 on the proper mixing of the chemical for sanitizing the tables. At this in-service we also instructed the nursing staff on properly sanitizing of the table before the second meal is served and the proper distribution of beverages to the residents along with food in order to maintain sanitary conditions. This is to include making sure that no employee touches a portion of the glass or bowl that would raise the risk of cross contamination. The Director of Nursing will observe 10 meal administrations before September 20, 2006 and report the findings to the Quality Assurance Team in the next scheduled meeting, if we have less than 2 incidents we will consider the corrective measures appropriate and randomly monitor after that time and report to the QA Team any problems noted. We allege compliance September 29, 2006.

Utah Department of Health

SEP 0 5 2006

Bureau of Health Facility Licensing, Certification and Resident Assessment