PRINTED: 06/21 2006 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465162	B. WING	<u> </u>	06/08/2006	
	PROVIDER OR SUPPLIER	ON		STREET ADDRESS, CITY, STATE, ZIP (1430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE	ON
F 167 SS=B	RESULTS A resident has the resident has the research or State succorrection in effect. The facility must may examination and meacessible to reside their availability. This REQUIREMENT by: Based on observation determined that the most recent survey that was readily acceptain to ask a staff. Findings include: An on-site recertification 6/07/06 to 6/08/0 and only accessible code on a keypad under the most recent file.	ation survey was conducted 6. The facility is a locked unit by punching in a number pon entering or exiting.	a bound of h		ts will the ori and neve residents, ers and	3
	last survey results c	ne initial tour of the unit, the ould not be found posted on posting of it's availability be	F	155	rtment of Health タンシ 17 2006	
AROPATOR	conducted with RN nurse, regarding wh were posted. She s administrators office	AM, an interview was 1 (Registered nurse) charge ere the unit's survey results tated that, "It's kept in the "." ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		lith Facility Licensing, d Resident Assessment	

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined the 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 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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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLE		
		465162	B. WIN	IG		06/0	8/2006	
	ROVIDER OR SUPPLIER	ON		14	REET ADDRESS, CITY, STATE, ZIP CODE 430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5 COMPLE DAT	ION
F 167		AM, an interview was	F '	167				
	was aware of where	dent 5. When asked if she the unit's survey results were that she didn't know that they d.				*		
	conducted with the regarding where the posted. She stated didn't know that the	5 AM, an interview was facilities administrator, e unit's survey results were that, "To be honest with you, I first survey countedso I vesterday and put it out in the						
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465162	B. WII	NG _		06/08/2006	
	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 279 SS=E	A facility must use to develop, review comprehensive plate The facility must deplan for each reside objectives and time medical, nursing, an eeds that are ideassessment. The care plan must to be furnished to highest practicable psychosocial well-o483.25; and any be required under due to the resident o483.10, including under o483.10(b) (and the complete of the care plan must be required under due to the resident o483.10, including under o483.10, including under o483.10(b) (and the complete of the complete	evelop a comprehensive care lent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive at describe the services that are attain or maintain the resident's e physical, mental, and being as required under services that would otherwise o483.25 but are not provided t's exercise of rights under the right to refuse treatment	F		Notifician Care Plans and in Cour vesidents about the communicate Plan is generated from Care Plan is generated from Strelicensed Durse is confident adming the Care Plan with that admings in freatment to Shall include the actual of and the vicinsed Durses in the audit of the vesidents of the care plan to evisual of the care plan to evisual contained therein is curred blow care plans have been add to the plan of care to infection, a fall or attred Durse, this is to be initiated where. Effective 71.1100	ponsibit for infoemation langs in condition wis infoemation wings the date states or poratain to a cord a veriew a updates are the information and checken ain shin integrity in down integrity in down integrity in down integrity in down integrity.	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\

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T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1					
	465162	B. WI	NG		06/	08/200	
PROVIDER OR SUPPLIER	DN		143	30 EAST 4500 SOUTH	· · · · · · · · · · · · · · · · · · ·		
(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL			(EACH CORRECTIVE ACTION S	SHOULD BE	COMPI DA	
5/05/06 with the foll heart failure, hypert depression, hip fract anemia. On 6/07/06, resident reviewed. Resident 3's careplate the problem area of "Potential for incont debility" Goals were docume "Will be clean, dry a review date" "Will have no skin b (Bowel and Bladder review" Interventions were of "Reduce stress as n incontinence" "Peri-care with each Documentation was admission nursing a admitted with a Fole No documentation we careplan accurately continence upon admitted with great addressed in the was the following product and stress and the st	owing diagnoses: congestive ension, pace maker, sture, osteoporosis, and at 3's medical record was an dated 5/18/06, addressed incontinence as follows: inent episodes secondary to ented as: and free from odors by next reakdown as a result of B&B incontinence by next allocumented as: and nuch as possible to decrease an incontinence episode" found in resident 8's ssessment that she was y catheter. It was found that resident 8's refected resident 8's refected resident 8's mission to the facility.	F	279				
cath use".	or related to deplify, Poley				I		
	PROVIDER OR SUPPLIER PARK REHABILITATION SUMMARY STAN (EACH DEFICIENCY REGULATORY OR LETTE DESCRIPTION OR LETTE D	PARK REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 5/05/06 with the following diagnoses: congestive heart failure, hypertension, pace maker, depression, hip fracture, osteoporosis, and anemia. On 6/07/06, resident 3's medical record was reviewed. Resident 3's careplan dated 5/18/06, addressed the problem area of incontinence as follows: "Potential for incontinent episodes secondary to debility" Goals were documented as: "Will be clean, dry and free from odors by next review date" "Will have no skin breakdown as a result of B&B (Bowel and Bladder) incontinence by next review" Interventions were documented as: "Reduce stress as much as possible to decrease incontinence" "Peri-care with each incontinence episode" Documentation was found in resident 8's admission nursing assessment that she was admitted with a Foley catheter. No documentation was found that resident 8's careplan accurately refected resident 8's careplan accurately refected resident 8's continence upon admission to the facility. Also addressed in the careplan dated 5/18/06 was the following problem area: "Potential for infection related to debility, Foley"	A. BU 465162 ROVIDER OR SUPPLIER PARK REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 5/05/06 with the following diagnoses: congestive heart failure, hypertension, pace maker, depression, hip fracture, osteoporosis, and anemia. On 6/07/06, resident 3's medical record was reviewed. Resident 3's careplan dated 5/18/06, addressed the problem area of incontinence as follows: "Potential for incontinent episodes secondary to debility" Goals were documented as: "Will be clean, dry and free from odors by next review date" "Will have no skin breakdown as a result of B&B (Bowel and Bladder) incontinence by next review" Interventions were documented as: "Reduce stress as much as possible to decrease incontinence" "Peri-care with each incontinence episode" Documentation was found in resident 8's admission nursing assessment that she was admitted with a Foley catheter. 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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	IULTIP LDING	LE CONSTRUCTION	(X3) DATE COMPI		
		465162	B. WII	1G		06/	08/2006	
	PROVIDER OR SUPPLIER	ON		14:	ET ADDRESS, CITY, STATE, ZIP COD 30 EAST 4500 SOUTH ALT LAKE CITY, UT 84117			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPL TION DATE	_
F 279	Continued From pa	ge 4	F2	279				
	,	al record had documentation ley catheter had been 4/06.						
į	3's careplan had be	could be found that resident een updated to reflect that her been discontinued as of				·		
	4/24/06 with the following	admitted to the facility on owing diagnoses: fractured acement, Alzheimer, and						
	On 6/07/06, residen reviewed.	t 4's medical record was						
	Resident 4's careplathe following problem	an dated 5/05/06, addressed m area as follows:						
į	"Potential for infection and debility".	on related to Foley cath use,						
		an telephone orders r dated 5/24/06 to discontinue atheter.						
		l's nurse's notes dated at resident 4's Foley catheter led.						
	4's careplan had be	ould be found that resident en updated to reflect that her been discontinued as of						
į.	C. Resident CL8 v	was admitted to the facility on						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IULTIP ILDING	LE CONSTRUCTION	(X3) DATE : COMPL		
		465162	B. Wii	NG		06/	08/200	
	PARK REHABILITATION	ON		14:	ET ADDRESS, CITY, STATE, ZIP CODI 30 EAST 4500 SOUTH LLT LAKE CITY, UT 84117			:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X COMPL DA	TION E
	congestive heart fai fracture of the femo diabetes mellitus, at depression, and uring Resident 8's closed on 6/08/06. Resident 8's careple the following problem "Potential for inconting debility in mobility, in Goals were docume "Will be clean, dry a review date" "Will have no skin burinary incontinence "Perineal care AM a incontinence" "Reduce stress as mincontinence" Documentation was admission nursing a admitted with a Fole No documentation was careplan accurately continence upon admitted with a fole not careplan accurately continence upon admitted with a fole not careplan accurately continence upon admitted with a fole not careplan accurately continence upon admitted with a fole not careplan accurately continence upon admitted with a fole not careplan accurately continence upon admitted with a fole not careplan accurately continence upon admitted with a fole not care fair fair fair fair fair fair fair fair	collowing diagnoses: cilure, dementia, closed coral condyle, hypertension, ctrial fibrillation, senile chary tract infection. medical record was reviewed an dated 12/14/05, addressed con area as follows: cinent episodes secondary to coreased confusion." cented as: cond free from odors by next coreakdown as a result of combined by" documented as: cond PM and after each cond in resident 8's cond in resident 8's cond that resident 8's cond resident 8's cond resident 8's conditions are suit of the second and the second a	F	279				
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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPL		
		465162	B. WIN	√IG		06/0	8/2006	
	ROVIDER OR SUPPLIER	DN		1	REET ADDRESS, CITY, STATE, ZIP COD 430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS COMPLI DAT	rion
F 279	deconditioned, has drainage)" The careplan also of Foley was disconting No documentation 68's care planning in	on related to debility, Foley cath to dd (direct documented that resident 8's ued on 1/03/06. could be found that resident terventions had been revised bley catheter had been	F2	279		·		
F 309 SS=D	provide the necessar or maintain the high mental, and psycho	receive and the facility must ary care and services to attain est practicable physical,	F3	309				
	by: Based on clinical reinterviews, it was desampled residents (ensure that the resident accordance with the Specifically, when redecreased, there was	cord review and staff etermined that for 1 of 8 Resident 1), the facility did not dent received the care and the highest practicable in ecomprehensive plan of care, esident 1's oxygen saturation as no documentation in the any interventions had been		The state of the s				

CENTERS FOR MEDICAR	H AND HUN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465162	B. WIN	NG	06/08/2006
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
ASPEN PARK REHABILITAT	ION		1430 EAST 4500 SOUTH SALT LAKE CITY, UT 8411	17
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD BE COMPLITION THE APPROPRIATE COMPLITION DATE
F 309 Continued From p	age 7	F:	309 1) Protor of forchypoxical and is available to H	vas been established he likensed blusses in
4/06/06 with diagn cardiovascular acc stomach dysfuncti and duodenal ulce On 6/07/06, resident reviewed. Review of resident Record" revealed resident 1's oxyge 4/20/06 was 82% (5/14/06 was 88% (5/20/06 was 88% (5/25/06 was 86%	ent 1's medical record was t 1's "Resident Weight/VS that for the following days, n saturation was below 90%: room air room air room air room air could be found that any aken place to increase resident or any of the days which		2) licented Nurses Mai continue to be inte s). The licensed nurse following this protor documentation acco ingravia episode, the the intervention, into fessifs of the inter- ty The unit Manager	rviced on this protocol is responsible for tol and ensumy watch, veflects the ne physical usessment, notification, and the vention wix audit the oxygen are that any Saturation adequate taumentation to rvence

Review of the facilities "Protocol For Hypoxia", revealed the following:

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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,					•
	465162	B. WIN	√G _	.	06/0	8/2006	
ROVIDER OR SUPPLIER	ON	•	1	430 EAST 4500 SOUTH			
(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL			(EACH CORRECTIVE ACTION SHO	OULD BE	(XI COMPL DA	TION E
"1. Any oxygen satirequires nursing into requires nursing into the requires nursing into the requires nursing into the resure adequate on the resure adequate of the resure and the results as to what the was, what intervent was notified, and evaluate assessment. "6" No documentation of the resident of the resi	uration that falls below 90% ervention." sician order for oxygen to 5, place oxygen on patient, eck sats in 10-15 minutes to exygenation." ysician order for oxygen, should reflect in the Nurses e original oxygen saturation ion was performed, that MD vidence of the physical could be found in the nurses ions were implemented on the 1's oxygen saturations fell ARY CONDITIONS - FOOD ore, prepare, distribute, and anitary conditions.						
by:							
	ROVIDER OR SUPPLIER PARK REHABILITATIO SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa "1. Any oxygen sat requires nursing int "2. If there is a phy keep sats over 90% notify MD and reche ensure adequate ox "3. If there is no ph contact MD" "4" "5. Documentation Notes as to what th was, what intervent was notified, and ex assessment. "6" No documentation on notes that intervent days that resident below 90%. 483.35(i)(2) SANITA PREP & SERVICE The facility must sto serve food under sa	ROVIDER OR SUPPLIER PARK REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 "1. Any oxygen saturation that falls below 90% requires nursing intervention." "2. If there is a physician order for oxygen to keep sats over 90%, place oxygen on patient, notify MD and recheck sats in 10-15 minutes to ensure adequate oxygenation." "3. If there is no physician order for oxygen, contact MD" "4" "5. Documentation should reflect in the Nurses Notes as to what the original oxygen saturation was, what intervention was performed, that MD was notified, and evidence of the physical assessment. "6" No documentation could be found in the nurses notes that interventions were implemented on the days that resident 1's oxygen saturations fell below 90%. 483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	ROVIDER OR SUPPLIER PARK REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 "1. Any oxygen saturation that falls below 90% requires nursing intervention." "2. If there is a physician order for oxygen to keep sats over 90%, place oxygen on patient, notify MD and recheck sats in 10-15 minutes to ensure adequate oxygenation." "3. 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If there is a physician order for oxygen to keep sats over 90%, place oxygen on patient, notify MD and recheck sats in 10-15 minutes to ensure adequate oxygenation." 13. If there is no physician order for oxygen, contact MD" 14" 15. Documentation should reflect in the Nurses Notes as to what the original oxygen saturation was, what intervention was performed, that MD was notified, and evidence of the physical assessment. 16	ABUILDING 465162 ABUILDING 8. WING COMPLETED 06/08/2008 ROVIDER OR SUPPLIER PARK REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 8 "1. Any oxygen saturation that falls below 90% requires nursing intervention." "2. If there is a physician order for oxygen to keep sats over 90%, place oxygen and patient, notify MD and recheck sats in 10-15 minutes to ensure adequate oxygenation." "3. If there is no physician order for oxygen, contact MD" "5. 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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	TION	COMPLE	
		465162	B. WIN	G	<u> </u>	06/0	8/2006
	PROVIDER OR SUPPLIER	ON		STREET ADDRESS, (1430 EAST 4500 SALT LAKE CI		, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORRECTOR ACTION SHO ORRECTIVE ACTION SHO FERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DA E
	Based on observation determined that the and serve food und Findings included: The following observation observation observation in the following observation observation of the following observation observation of the following observation observation of the following observation of the following observation of the following observation of the following of the following of the following observation of the following observation observation of the following observation obs	on and interview, it was facility did not store, distribute er sanitary conditions. vations were made during the vation on 6/07/06 at 8:45 AM. was observed to be sitting on counter, eating and drinking. as uncovered. egs not labeled or dated. tomatoes not dated. iner of garlic not dated. f white sliced cheese not f yellow sliced cheese not ead dough not dated. waffles (6 waffles in each	F3	Making Sun and dated. Sinced On Making Su dated and Will audit is labeling items on	while survey of starts were in a vice and foods were start on colors of them is to make survey to make survey to make dating a weekly to so the color of 371 certains of the color of the c	chaboled yell is no about s are yell Wanage to staff ill foods	n
				1			

PRINTED: 06/21 2006 FORM APPR VED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRI			(X3) DATE SURVEY COMPLETED				
		465162	B. WIN	G		06/	08/2006	
	PROVIDER OR SUPPLIER	ON		143	ET ADDRESS, CITY, STATE, ZIP CODE 80 EAST 4500 SOUTH LT LAKE CITY, UT 84117	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPL DA	TION
F 371	3. A large plastic b labeled or dated.4. A plastic bag of dated.	age 10 ag of bread dough (rolls) not potato smiles, not labeled or ag of breadstick dough, not	F3	71		`		
F 514 SS=E	The facility must ma resident in accordar standards and practacurately documer systematically organ. The clinical record rinformation to identification resident's assessments services provided; to the resident of the clinical resident of the clinical record rinformation to identifications.	EAL RECORDS aintain clinical records on each nee with accepted professional tices that are complete; nted; readily accessible; and nized. must contain sufficient ify the resident; a record of the ents; the plan of care and he results of any ening conducted by the State;	F 5	14				
	by: Based on clinical reinterviews, it was desampled residents (facility did not maint complete or accurate Specifically, the facility and 6's of the second	cord review and staff etermined that for 3 of 8 Resident 1,5,and 6), the ain clinical records that were tely documented for. lity did not ensure that clinical record contained their so did not ensure that						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465162	B. WING		06/08/2006
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
ASPEN PARK REHABILITATI	ON		1430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLITION HE APPROPRIATE DA F
accurately reflected Resident Assessm Findings include: A. Resident 1 was 4/06/06 with the fol cardiovascular acc stomach dysfunction and duodenal ulcer on 6/07/06, resident reviewed. 1. Resident 1's add Set) dated 5/02/06 RAP (Resident Assareas which were to the Delirium Cognitive loss Communication Activities of daily live Urinary incontinence Psychosocial well-to Mood state Falls Nutrition Pressure ulcers Psychotropics Documented under problem areas which checked to be care documentation und Assessment Documentation und Assess	record allergy sticker d her allergies, and that her ent Protocol was incomplete. s admitted to the facility on llowing diagnoses: ident, hypertension, arthritis, on disorder, dementia, anemia, rs. nt 1's medical record was mission MDS (Minimum Data d documented the following sessment Protocol) problem riggered:	F 5	of when mos assessments confered his assessments completed his assessments completed his polential on not were sineduce, for what we seem is to ask for assistant to maintain the schedistry the moscoolain with the moscoolain compliance. Mush the moscoolain compliance while resident an assist of admission of any the response record the response to the resident and record the response and record the response and record the resident and the school and waston and the school and waston and waston and waston and notify nuveries the suitable form when vericis in and notify nuveries with in the school and notify nuveries and notify nuveries and notify nuveries in the school and notify nuveries in the school and notify nuveries and notify nuveries in the school and notify nuveries notified notified notify nuveri	tains a calender was aveduc, this colourable mos may redecement there extrangly the completion cervessaniely to the contract of ensure to ensure the contract record! is responsible for any the vesident record in the vesident rely insert in the vesident rely the vector in its entirely there is not rely the vector in its entirely there is any them that wanted in the data of any them that wanted to make in the colour of the mos assisting the vest of the mos assisting the vector of the most assisting the vector of the most and the vector of the most assisting the vector of the most and the vector of the most assisting the vector of the most and the vector of th

Facility 12) Little 16305 CO De at Marke continuation sheet Baset 1: of 14
system when an uses sment has been
completed as well us when the left guide
Who been completed to place in the resident

of theunit manager win audit the resident record on the completed put guidly pay in after admission

on wearing busis to review a ancheric to mos conductor and compenses of stap mides

PRINTED: 06/21/2006 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE S COMPLE		
		465162	B. WIN	G	·	06/0	8/2006	
	PROVIDER OR SUPPLIER PARK REHABILITATIO	DN		143	ET ADDRESS, CITY, STATE, ZIP CODE 80 EAST 4500 SOUTH LT LAKE CITY, UT 84117			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE PROPRIATE	COMPL DA	Ē
F 514	decision-making. Documentation on trevealed that there Nurse) Coordinator Documentation revidated 5/02/06, had assessment being of the Sustaining Treadocumentation underwas "allergic to sulfawhich was posted of clinical record reveation and documented was not documented. B. Resident 5 was a 5/11/06 with the folk fracture, status-post revision, left lower to stenosis, aortic fibril recent right ankle fra disease, and hyperto On 6/07/06 resident reviewed. Upon review of residinitial MDS (Minimur could be found in the	he RAP summary also was no RN (Registered signature. ealed that the admission MDS no RN signature as to the completed. LST (Physician Order For atment), revealed er "Antibiotics" that resident 1 a Resident 1's allergy sticker in the inside of resident 1's alled that her allergy to Sulfad on the sticker. admitted to the facility on owing diagnoses: right hip replacement, left hip obe pneumonia, aortic lation, pulmonary embolism, acture, cardiopulmonary ension. 5's medical record was lent 5's medical record, no in Data Set) assessment erecord.	F 5	114	Tag forth we be reviewed Of meeting-	oill in or 7/1=/01	\tag{2}	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE S	
	ROVIDER OR SUPPLIER	465162 ON	143	ET ADDRESS, CITY, STATE, ZIP 30 EAST 4500 SOUTH LLT LAKE CITY, UT 84117		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X) COMPLETION DATE
F 514	there was no psycon on 6/08/06 at 11:3 conducted with the to where resident careplan were. The "they are late"ar nowand that the C. Resident 6 was 5/16/06 with the foatrial fibrillation, and On 6/07/06 resident reviewed. Upon review of reinitial MDS (Minimould be found in On 6/08/06 at 3:2 conducted with the other resident	illigrams t 5's careplans revealed that hotropic careplan. 30 AM an interview was e MDS Coordinator in regards 5's initial MDS and psychotropic ne MDS Coordinator stated that had she is "working on them y will be done today". s admitted to the facility on ollowing diagnoses: Dementia, and degenerative joint disease. ent 6's medical record was esident 6's medical record, no num Data Set) assessment the record. 5 PM, ann interview was e MDS Coordinator in regards 6's initial MDS was. The MDS d that "I don't have it"it's	F 514			

PRITERO	TOR MEDICARE & MEDICALD OF SEC			, A IO					
	F OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY					
NO HARM W. FOR SNFs AN	/TTH ONLY A POTENTIAL FOR MINIMAL HARM ND NFs	465162	B. WING	COMPLETE: 6/8/2006					
NAME OF PR	ROVIDER OR SUPPLIER ARK REHABILITATION	1430 EAST 4500 SC	STREET ADDRESS, CITY, STATE, ZIP CODE 1430 EAST 4500 SOUTH SALT LAKE CITY, UT						
ID PREFIX FAG	SUMMARY STATEMENT OF DEFICIE	NCIES	. 444-4-1-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4						
F 278	483.20(g) - (j) RESIDENT ASSESSMI	ENT							
	The assessment must accurately reflect	the resident's status.	the resident's status.						
	A registered nurse must conduct or cooprofessionals.	rdinate each assessme	nt with the appropriate participation of	health					
	A registered nurse must sign and certify	y that the assessment is	s completed.						
	Each individual who completes a portion of the assessment.	on of the assessment m	ust sign and certify the accuracy of tha	t portion					
	Under Medicare and Medicaid, an indivistatement in a resident assessment is sul assessment; or an individual who willfu false statement in a resident assessment assessment.	bject to a civil money ally and knowingly cau	penalty of not more than \$1,000 for eacises another individual to certify a mate	ch erial and					
	Clinical disagreement does not constitute a material and false statement.								
	Based on clinical record review, it was o	This REQUIREMENT is not met as evidenced by: Based on clinical record review, it was determined that for 1 of 8 sampled residents (Resident 1), the facility did not ensure that a registered nurse signed and certified that an inital Minimum Data Set assessment was complete.							
	A. Resident 1 was admitted to the facili hypertension, arthritis, stomach dysfunction			ccident,					
	On 6/07/06, resident 1's medical record	was reviewed.							
	Documentation revealed that the admiss being completed.	sion MDS dated 5/02/	06, had no RN signature as to the asses	sment					
	assessment in the resident in 2) Medical records will routin by even into a assessment	if me mos cooldinator must review the mps for the signiture prior to filling the assessment in the resident record while resident records for the engineere by medical records for the engineere							
	with review of the resident	vecouses	on The will	review to					

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 pla

The above isolated deficiencies pose no actual harm to the residents

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465162	B. WII	NG		06/0	08/2006
	ROVIDER OR SUPPLIER	ON	•	14	EET ADDRESS, CITY, STATE, ZIP CODE 30 EAST 4500 SOUTH ALT LAKE CITY, UT 84117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRÉCEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLE ON DATE
F 167 SS=B	483.10(g)(1) EXAM RESULTS	IINATION OF SURVEY		167		•	1
	the most recent sur Federal or State su	right to examine the results of rvey of the facility conducted by rveyors and any plan of with respect to the facility.	16				
	examination and m	ake the results available for ust post in a place readily lents and must post a notice of		1	て ケン		
	by:	NT is not met as evidenced	Q				
	determined that the most recent survey	ion and interviews, it was a facility did not ensure that the results were posted in a place cessible to residents, without ff member.	4		Rex		:
	Findings include:			(E Y		
	on 6/07/06 to 6/08/ and only accessible	cation survey was conducted 06. The facility is a locked unit by punching in a number upon entering or exiting.			De la		
	last survey results	the initial tour of the unit, the could not be found posted on a posting of it's availability be			Utah Department of Ho 76/304 JUL 0 5 2006	ealth	
	conducted with RN nurse, regarding w were posted. She administrators office	O AM, an interview was N1 (Registered nurse) charge here the unit's survey results stated that, "It's kept in the ce". DEPISURPLIER REPRESENTATIVE'S SIG	NATIDE		Bureau of Health Facility Licen Certification and Resident Asses	ising, ssment	(X6) DATE

Any deficiency statement enting (with an asterisk (f)) denotes a deficiency which the institution may be excused from correcting providing it is determined the other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 defollowing 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 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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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	E CONSTRUCTION	COMPL		
		465162	B. WIN	NG		06/0	08/2006	
	ROVIDER OR SUPPLIER	ON		143	ET ADDRESS, CITY, STATE, ZIP CODE 10 EAST 4500 SOUTH LT LAKE CITY, UT 84117			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLE DATE	ON
F 167	On 6/08/06 at 9:30 conducted with res was aware of when posted, she stated needed to be posted. On 6/08/06 at 10:30 conducted with the regarding where the posted. She stated didn't know that the	AM, an interview was ident 5. When asked if she e the unit's survey results were that she didn't know that they	F.	167				
								II 1

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLE		
		465162	B. WII	NG		06/0	8/2006	
	ROVIDER OR SUPPLIER	ON	-	14	EEET ADDRESS, CITY, STATE, ZIP CODE 430 EAST 4500 SOUTH ALT LAKE CITY, UT 84117			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE	ONi
F 279 SS=E	A facility must use to develop, review comprehensive plate. The facility must deplan for each reside objectives and time medical, nursing, a needs that are identified by the facility did not revise each resident base identified by the facility did not revise to develop, and revise each resident passes identified by the facility did not revise to develop, and revise each resident base identified by the facility did not revise to develop, and revise each resident passes identified by the facility did not revise to develop.	evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial atified in the comprehensive of the describe the services that are estation or maintain the resident's physical, mental, and being as required under services that would otherwise o483.25 but are not provided by sexercise of rights under the right to refuse treatment of the right to refuse treatment of the comprehensive care plans for each on their individual needs controlled by the careplans for residents: 3,4, the careplans for residents: 3,4,		279				
	accurately reflected	at their continence was d on their careplans.						
	Findings include:							
	A. Resident 3 was	admitted to the facility on						

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465162	' '	LDING	E CONSTRUCTION	COMPL	
	PROVIDER OR SUPPLIER	ON		143	ET ADDRESS, CITY, STATE, ZIP CODE 10 EAST 4500 SOUTH LT LAKE CITY, UT 84117	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLE ON DATE
F 279	5/05/06 with the fol heart failure, hyper depression, hip fraganemia. On 6/07/06, resider reviewed. Resident 3's carepithe problem area of "Potential for incondebility" Goals were docum "Will be clean, dry review date" "Will have no skin I (Bowel and Bladder review" Interventions were "Reduce stress as incontinence" "Peri-care with each Documentation was admission nursing admitted with a Fol No documentation careplan accurately continence upon accurately continence upon accurate following procession and the following procession in the following procession and the follo	lowing diagnoses: congestive tension, pace maker, cture, osteoporosis, and and 3's medical record was lan dated 5/18/06, addressed incontinence as follows: tinent episodes secondary to ented as: and free from odors by next breakdown as a result of B&B r) incontinence by next documented as: much as possible to decrease the incontinence episode" as found in resident 8's assessment that she was ey catheter. was found that resident 8's y refected resident 8's dmission to the facility.	F 2	279			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		465162	B. WII			06/08	3/2006
	ROVIDER OR SUPPLIER		1	14	EET ADDRESS, CITY, STATE, ZIP CODE 330 EAST 4500 SOUTH ALT LAKE CITY, UT 84117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET D DATE
F 279	Continued From pa	age 4	F	279			
		cal record had documentation bley catheter had been 24/06.					
	3's careplan had b	could be found that resident been updated to reflect that her been discontinued as of					
	4/24/06 with the fo	s admitted to the facility on flowing diagnoses: fractured lacement, Alzheimer, and					
	On 6/07/06, reside reviewed.	nt 4's medical record was		:			
		lan dated 5/05/06, addressed em area as follows:					
	"Potential for infect and debility".	tion related to Foley cath use,					
	Resident 4's physic documented a orderesident 4's Foley of	cian telephone orders er dated 5/24/06 to discontinue catheter.					
		4's nurse's notes dated hat resident 4's Foley catheter nued.					
	4's careplan had b	could be found that resident been updated to reflect that her been discontinued as of		:			
	C. Resident CL8	3 was admitted to the facility on					

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NAME OF PROVIDER OR SUPPLIER ASPEN PARK REHABILITATION (A) ID SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY HUST BE PRECEEDED BY FULL TAGE (TAGE) TAGE (TA		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LDING	E CONSTRUCTION	(X3) DATE:	ETED.	
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 279 Continued From page 5 12/14/05 with the following diagnoses: congestive heart failure, dementia, closed fracture of the femoral condyle, hypertension, diabetes mellitus, atrial fibrillation, senile depression, and urinary tract infection. Resident 8's closed medical record was reviewed on 6/08/06. Resident 8's careplan dated 12/14/05, addressed the following problem area as follows: "Potential for incontinent episodes secondary to debility in mobility, increased confusion." Goals were documented as: "Will be clean, dry and free from odors by next review date" "Will have no skin breakdown as a result of urinary incontinence by" Interventions were documented as: "Perineal care AM and PM and after each incontinence" "Reduce stress as much as possible to decrease incontinence" "Reduce stress as much as possible to decrease incontinence Documentation was found that resident 8's admission nursing assessment that she was admitted with a foley catheter. No documentation was found that resident 8's careplan accurately refected resident 8's continence upon admission to the facility. Also addressed in the careplan dated 12/14/05				<u> </u>	143	30 EAST 4500 SOUTH		08/2006	
12/14/05 with the following diagnoses: congestive heart failure, dementia, closed fracture of the femoral condyle, hypertension, diabetes mellitus, atrial fibrillation, senile depression, and urinary tract infection. Resident 8's closed medical record was reviewed on 6/08/06. Resident 8's careplan dated 12/14/05, addressed the following problem area as follows: "Potential for incontinent episodes secondary to debility in mobility, increased confusion." Goals were documented as: "Will be clean, dry and free from odors by next review date" "Will have no skin breakdown as a result of urinary incontinence by" Interventions were documented as: "Perineal care AM and PM and after each incontinence" "Reduce stress as much as possible to decrease incontinence" Documentation was found in resident 8's admission nursing assessment that she was admitted with a Foley catheter. No documentation was found that resident 8's careplan accurately refected resident 8's careplan accurately refected resident 8's careplan accurately refected resident 8's continence upon admission to the facility. Also addressed in the careplan dated 12/14/05	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE		DΝ
. In the second of the second	F 279	12/14/05 with the ficongestive heart faracture of the femodiabetes mellitus, a depression, and uring Resident 8's closed on 6/08/06. Resident 8's careplethe following probleting in mobility, in mobil	collowing diagnoses: ilture, dementia, closed bral condyle, hypertension, atrial fibrillation, senile inary tract infection. If medical record was reviewed an dated 12/14/05, addressed am area as follows: tinent episodes secondary to increased confusion." ented as: and free from odors by next breakdown as a result of e by" documented as: and PM and after each much as possible to decrease as found in resident 8's assessment that she was ey catheter. was found that resident 8's or refected resident 8's dmission to the facility. the careplan dated 12/14/05	F	279				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	COMPLI		
		465162	B. WIN	IG		06/0	8/2006	
	ROVIDER OR SUPPLIER	ON		143	ET ADDRESS, CITY, STATE, ZIP CODE 30 EAST 4500 SOUTH ALT LAKE CITY, UT 84117			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET D DATE	N
F 279	deconditioned, has drainage)" The careplan also Foley was discontinuous No documentation 8's care planning in	ion related to debility, Foley cath to dd (direct documented that resident 8's nued on 1/03/06. could be found that resident iterventions had been revised oley catheter had been	F2	279				to the company of the
F 309 SS=D	provide the necess or maintain the hig mental, and psycho	or care and the facility must ary care and services to attain hest practicable physical, osocial well-being, in e comprehensive assessment	F	309				
	by: Based on clinical reinterviews, it was disampled residents ensure that the resiservices to maintai accordance with the Specifically, when decreased, there we	ecord review and staff etermined that for 1 of 8 (Resident 1), the facility did not ident received the care and n the highest practicable in e comprehensive plan of care. resident 1's oxygen saturation vas no documentation in the t any interventions had been						
	r munigs include.							- 1

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SU	
IDENTIFICATION IDENTI		A. BUILDIN	· G			
	465162		B. WING _		06/0	8/2006
	ROVIDER OR SUPPLIER	ON	1	REET ADDRESS, CITY, STATE, ZIP CODE 430 EAST 4500 SOUTH GALT LAKE CITY, UT 84117		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLE ON DATE
F 309	Continued From pa	ige 7	F 309			
	4/06/06 with diagnor cardiovascular accistomach dysfunction and duodenal ulcer. On 6/07/06, resider reviewed. Review of resident Record'' revealed to resident 1's oxygen 4/20/06 was 82% resident 1's oxygen 5/14/06 was 88% resident 1's oxygen 88% resident 1's oxygen No documentation interventions had tan 1's oxygen level for resident 1's oxygen level for resident 1's oxygen On 6/08/06 at 9:30 conducted with the regards to why ther any interventions was aturations fell belot there is supposed to nurse's notes If signow, put resident (saturations), according the resident of (saturations), according to the resident of the residen	ident, hypertension, arthritis, on disorder, dementia, anemia, is. Int 1's medical record was 1's "Resident Weight/VS hat for the following days, is saturation was below 90%: It is saturation was below 90%. All is saturation devices a saturation of the days which is fell below 90%. All is saturation of the saturation of the resident 1's oxygen of the polygen of the polygen of the polygen and re-check sats reding to the policies. It is saturation in the policies. It is saturation in the policies. It is saturation in the policies.				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLE	
		465162	B. WING _	. M1-18-81	06/0	8/2006
	ROVIDER OR SUPPLIER	NC	1	REET ADDRESS, CITY, STATE, ZIP CODE 430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	"2. If there is a phy keep sats over 90% notify MD and rechrensure adequate of "3. If there is no phy contact MD" "4" "5. Documentation Notes as to what the was, what intervents	ruration that falls below 90% servention." rsician order for oxygen to 6, place oxygen on patient, eck sats in 10-15 minutes to	F 309			
F 371 SS=B	notes that intervent days that resident below 90%. 483.35(i)(2) SANIT. PREP & SERVICE The facility must sto serve food under sa	could be found in the nurses ions were implemented on the 1's oxygen saturations fell ARY CONDITIONS - FOOD ore, prepare, distribute, and anitary conditions.	F 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETI					
		465162	B. WIN	N G		06/0	8/2006	<u> </u>
NAME OF PROVIDER OR SUPPLIER ASPEN PARK REHABILITATION				14:	EET ADDRESS, CITY, STATE, ZIP CODE 30 EAST 4500 SOUTH ALT LAKE CITY, UT 84117			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLE DATE	ON
F 371		,	F;	371				
	determined that th	tion and interview, it was e facility did not store, distribute der sanitary conditions.						
	Findings included:							
	The following obse	ervations were made during the ervation on 6/07/06 at 8:45 AM.					ſ	
		r was observed to be sitting on counter, eating and drinking.						
	2. The sugar bin v	was uncovered.						
	Walk in refrigerato	or:						
	1. A plate of turke	y legs not labeled or dated.		:				
	2. A plate of slice	d tomatoes not dated.						
	3. A 5 pound conf	tainer of garlic not dated.						
	4. 1/2 of a 5 poun	d block of cheese not dated.						
	5. A large section labeled or dated.	of white sliced cheese not						
	6. A large section labeled or dated.	of yellow sliced cheese not						
	Freezer:							
	1. A container of	bread dough not dated.						
	2. Two packages package), not labe	of waffles (6 waffles in each eled or dated.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 3	(X3) DATE SI COMPLE			
		465162	B. WIN	IG		06/0	8/2006		
	NAME OF PROVIDER OR SUPPLIER ASPEN PARK REHABILITATION			14	EET ADDRESS, CITY, STATE, ZIP CODE 430 EAST 4500 SOUTH ALT LAKE CITY, UT 84117	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	!	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLE DATE	ON	
F 371	labeled or dated.4. A plastic bag of dated.5. A large plastic b	age 10 bag of bread dough (rolls) not potato smiles, not labeled or bag of breadstick dough, not	F	371					
	labeled or dated. 6. A bag of cinnam	non rolls not dated.							
F 514 SS=E	resident in accorda standards and practacurately docume systematically orga. The clinical record information to identify resident's assessm services provided;	aintain clinical records on each ince with accepted professional ctices that are complete; nted; readily accessible; and inized. must contain sufficient tify the resident; a record of the ents; the plan of care and the results of any ening conducted by the State;	F	514				The state of the s	
	by: Based on clinical reinterviews, it was desampled residents facility did not main complete or accura Specifically, the facresidents 1 and 6's	ecord review and staff etermined that for 3 of 8 (Resident 1,5,and 6), the tain clinical records that were stely documented for. cility did not ensure that clinical record contained their llso did not ensure that							

PRINTED: 06/21/2 006 FORM APPRO ED OMB NO. 0938-0 391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		465162	B. WING		06/0	08/2006
NAME OF PROVIDER OR SUPPLIER ASPEN PARK REHABILITATION			14:	ET ADDRESS, CITY, STATE, ZIP C 30 EAST 4500 SOUTH LLT LAKE CITY, UT 84117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETON DATE
F 514	accurately reflected Resident Assessing Findings include: A. Resident 1 way 4/06/06 with the forcardiovascular accurated and duodenal ulcestomach dysfunction and duodenal ulcestomach dysfunction and duodenal ulcestomach dysfunction and duodenal ulcestomach dysfunction and duodenal ulcestomach divident Asset) dated 5/02/0 RAP (Resident Assert) dated 5/02/0 RAP (Resident Assert) dated for daily life Urinary incontinent Activities of daily life Urinary incontinent Psychosocial well-Mood state Falls Nutrition Pressure ulcers Psychotropics Documented under problem areas which checked to be cardocumentation under the control of the	I record allergy sticker d her allergies, and that her nent Protocol was incomplete. s admitted to the facility on allowing diagnoses: cident, hypertension, arthritis, on disorder, dementia, anemia, ars. ent 1's medical record was Imission MDS (Minimum Data 6 documented the following sessment Protocol) problem triggered:	F 514			

PRINTED: 06/21/2 106 FORM APPRO' ED OMB NO. 0938-0-91

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	A. BUILDING		COMPLETED	
		465162	B. WI	1G		06/0	08/2006
	NAME OF PROVIDER OR SUPPLIER ASPEN PARK REHABILITATION			143	ET ADDRESS, CITY, STATE, ZIP CODE 30 EAST 4500 SOUTH LLT LAKE CITY, UT 84117		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 514	decision-making. Documentation or revealed that there Nurse) Coordinate Documentation redated 5/02/06, had assessment being 2. Resident 1's Pour Life-Sustaining Tradocumentation unwas "allergic to suwhich was posted clinical record revewas not document B. Resident 5 was 5/11/06 with the forfracture, status-por revision, left lower stenosis, aortic fibrecent right ankle disease, and hype On 6/07/06 reside reviewed. Upon review of reside reviewed. Upon review of reside reviewed. Resident 5's June documented the formedication orders Xanax 0.25 milligr	the RAP summary also e was no RN (Registered or signature. Evealed that the admission MDS of no RN signature as to the completed. OLST (Physician Order For eatment), revealed der "Antibiotics" that resident 1 lfa". Resident 1's allergy sticker on the inside of resident 1's ealed that her allergy to Sulfated on the sticker. Is admitted to the facility on ollowing diagnoses: right hip lobe pneumonia, aortic rillation, pulmonary embolism, fracture, cardiopulmonary entension. Int 5's medical record was sident 5's medical record was sident 5's medical record, no um Data Set) assessment the record. 2006 re-certification orders ollowing psychotropic is ams	F	514			
	Remeron 15 millig						

PRINTED: 06/21/2006 FORM APPRO ED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I' '	IULTIPI ILDING	LE CONSTRUCTION	(X3) DATE S COMPL		
		465162	B. WII	N G		06/0	08/2006	
	NAME OF PROVIDER OR SUPPLIER ASPEN PARK REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 1430 EAST 4500 SOUTH SALT LAKE CITY, UT 84117							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE	ON
F 514	Temazepam 15 mil Review of resident there was no psych On 6/08/06 at 11:30 conducted with the to where resident 5 careplan were. The "they are late"and nowand that they C. Resident 6 was 5/16/06 with the foliatrial fibrillation, and On 6/07/06 residen reviewed. Upon review of residential MDS (Minimulational MDS (Mini	ligrams 5's careplans revealed that otropic careplan. O AM an interview was MDS Coordinator in regards is initial MDS and psychotropic MDS Coordinator stated that I she is "working on them will be done today". admitted to the facility on lowing diagnoses: Dementia, id degenerative joint disease. It 6's medical record was dent 6's medical record was medical record. PM, ann interview was MDS Coordinator in regards is initial MDS was. The MDS that "I don't have it"it's	F	514				

REFERENCE TAGE F 483.10(g) (1)

Survey results are posted in a binder in the nurse's station. Administrator will audit to Make sure survey results are always readily available to all staff.

effective 7/1/04

RN signature is required on each MDS. The MDS Coordinator is responsible for the data collection, entry and signature upon completion. Compliance will be enforced through the following means:

- 1) The MDS Coordinator must review the MDS for the signature prior to filing the assessment in the resident record.
- 2) Medical Records will routinely audit active and closed records for the RN signature for each MDS Assessment.
- 3) The Unit Manager will routinely audit the MDS Assessment for the RN signature with review of the resident records.

EFFECTIVE 7/1/06

Comprehensive Care Plans must be maintained on each resident and updated timely with any changes throughout their stay. This requirement will be met through the following:

- Interim Care Plans are placed in each resident record upon admission and replaced when the computerized Care Plan is generated from the 5-Day MDS Assessment.
- 2) The Licensed Nurse is responsible for updating the Care Plan with information that accurately reflects changes in condition and changes in treatment. This information shall include the actual change, the date and the Licensed Nurse's initials.
- 3) The Unit Manager shall incorporate into the audit of the resident records, a review of the Care Plan, to ensure updates are occurring timely and that the information contained therein is current.
- 4) New Care Plans have been developed to add to the plan of care when an infection, a fall, or altered skin integrity occur. This is to be initiated by the Licensed Nurse.

EFFECTIVE 7/1/06

To maintain the highest well-being of the resident, documentation must reflect necessary care and services that are provided in accordance with the comprehensive assessment and plan of care. This will be evidenced by the following:

- 1) Protocol for hypoxia has been established and is available to the Licensed Nurses in written format.
- 2) Licensed Nurses have been and will continue to be in-serviced on this protocol.
- 3) The Licensed Nurse is responsible for following this protocol and ensuring documentation accurately reflects the hypoxic episode, the physical assessment, the intervention, MD notification and the results of the intervention.
- 4) The Unit Manager will audit the oxygen saturations to ensure that any saturation below 90% has had adequate intervention and documentation to support the occurrence.

EFFECTIVE 7/1/06

On 6/7/06 while survey was in the building staffs were in serviced on making sure all foods were labeled and dated. Dietary Manager in serviced on staff on 6/25/06 about making sure all food items are dated and labeled. Dietary Manager will audit to make sure staff is labeling and dating all food items on a weekly basis.

effective 7/1/06

Maintenance of clinical records. The areas of deficiencies have been corrected in the following manner:

Initial MDS Assessment not found in resident record:

- 1) The MDS Coordinator maintains a calendar of when MDS Assessments are due. This calendar will be followed and the MDS Assessments completed timely.
- 2) If the MDS Coordinator determines there is potential for not meeting the completion schedule, for whatever reason, he/she is to ask for assistance from the Director of Health Services to maintain the schedule.
- 3) The Director of Health Services to perform a weekly audit with the MDS Coordinator to ensure compliance.

Missing allergy from resident record: The responsible party had written an allergy (of the resident's) on the POLST form which is not a typical place to list an allergy. The allergy had not been transferred to the allergy list.

- The Licensed Nurse is responsible for asking the resident and the responsible party on admission of any known allergies and record the responses in the resident record.
- 2) The Unit Manager shall review the resident record in its entirety and list all known allergies with admission.
- 3) The Social Worker will review the POSLT form when reviewing Advanced Directives and notify nursing of any items that may have been errantly listed on these forms.

Incomplete Resident Assessment Protocol:

- The MDS Coordinator is responsible for data collection and entry of the MDS
 Assessment. The RAP Guide is generated from the initial MDS Assessment. The
 MDS Coordinator is responsible for completing the RAP Guide in its entirety.
- 2) The MDS Coordinator has a calendar system in place for MDS due dates. The RAP Guides have been added to this calendar system to ensure its timely completion.
- 3) The MDS Coordinator will initial on her calendar when an assessment has been completed as well as when the RAP Guide has been completed to place in the resident record.
- 4) The Unit Manager will audit the resident record for the completed RAP Guide by Day 14 after admission.
- 5) The Director of Health Services will meet with the MDS Coordinator on a weekly basis to review adherence to MDS schedule and completion of RAP Guides.

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ENTERS I	OR MEDICARE & MEDICIND SERVICES									
	OF ISOLATED DEFICIENCIES WHICH CAUSE ITH ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER # 465162	MULTIPLE CONSTRUCTION A. BUILDING B. WING	DATE SURVEY COMPLETE: 6/8/2006						
NAME OF PRO	OVIDER OR SUPPLIER RK REHABILITATION	STREET ADDRESS, CIT 1430 EAST 4500 SC SALT LAKE CITY	OUTH							
ID PREFIX FAG	SUMMARY STATEMENT OF DEFICIE	NCIES								
F 278	483.20(g) - (j) RESIDENT ASSESSM	483.20(g) - (j) RESIDENT ASSESSMENT								
		The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health								
	A registered nurse must sign and certify	y 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: Based on clinical record review, it was determined that for 1 of 8 sampled residents (Resident 1), the facility did not ensure that a registered nurse signed and certified that an inital Minimum Data Set assessment was complete.									
	A. Resident 1 was admitted to the facility on 4/06/06 with diagnoses that included: cardiovascular accident, hypertension, arthritis, stomach dysfunction disorder, dementia, anemia, and duodenal ulcers.									
	On 6/07/06, resident 1's medical record was reviewed.									
	Documentation revealed that the admission MDS dated 5/02/06, had no RN signature as to the assessment being completed.									

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 provide 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 p

The above isolated deficiencies pose no actual harm to the residents

1 of 1