STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465146	A. BUILDING _____ B. WING _____	12/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON VALLEY REHABILITATION CENTER	2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 274 SS=D	483.20(b)(2)(ii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on review of medical records, it was determined that for 2 of 24 sampled residents, the facility did not conduct a comprehensive assessment of the resident within 14 days after the facility determined, or should have determined, that there had been a significant change in the resident's status. (Resident identifiers: 4, 10) Findings included: 1. Resident 4 was a 62 year old female who was admitted to the facility on 8/31/06 with diagnoses that included acute renal failure, diabetes, aspiration pneumonia, transient ischemic attack and major depression. Resident 4's medical record was reviewed on	F 274	The facility will conduct a comprehensive assessment of a resident within 14 days after the facility has determined that there had been a significant change in the resident's status. Resident # 4's records were reviewed and a significant change MDS was initiated and completed on 12/5/06. The Director of Nursing / Designee will perform weekly audits to ensure that all significant changes on an MDS trigger a significant change MDS. An in service is scheduled on January 8 2006 for all staff involved with the MDS process in regards to purpose and state regulations for significant change MDS assessments. In-service training will be provided annually and as needed for this process. Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate. Resident # 10's records were reviewed and a significant change MDS was initiated and completed on 12/15/06.	1/21/07

12/07 POC acceptable completion date 1/21/07 Rosenbrink RN

Utah Department of Health
760689
DEC 29 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

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

Administrator 12-29-06

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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F 274	Continued From page 1 12/05/06. Resident 4's quarterly MDS (Minimum Data Set) dated 11/19/06 was signed as completed by two IDT (interdisciplinary team) members and was only partially completed. The partially completed MDS documented that resident 4 had been identified as having a significant change in 8 areas of the quarterly 11/19/06, MDS when compared with the initial MDS dated 9/12/06. It was documented in the initial 9/12/06 MDS, section B-4, that resident 4 was independent in making decisions. It was documented in the 11/19/06, quarterly MDS, section B-4 that resident 4 made poor decisions and required cues/supervision. It was documented in the initial 9/12/06 MDS, section G-1b, that resident 4 needed extensive assistance when transferring. It was documented in the 11/19/06, quarterly MDS, section G-1b, that resident 4 needed limited assistance when transferring. It was documented in the initial 9/12/06, MDS, section G-1c, that resident 4 had not ambulated in her room at all. It was documented in the 11/19/06 quarterly MDS, section G-1c, that resident 4 was able to ambulate with limited assistance in her room. It was documented in the initial 9/12/06, MDS, section G-1e, that resident 4 needed extensive assistance when going from one area of the facility to another. It was documented in the 11/19/06, quarterly MDS, section G-1e, that resident 4 was able to independently travel from one area to another in the facility with no physical	F 274	The Director of Nursing / Designee will perform weekly audits to ensure that all significant changes on an MDS trigger a significant change MDS. An in service is scheduled on January 8 2006 for all staff involved with the MDS process in regards to purpose and state regulations for significant change MDS assessments. In-service training will be provided annually and as needed for this process. Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate.	

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F 274	Continued From page 2 assist. It was documented in the initial 9/12/06 MDS, section G-1h, that resident 4 needed limited assistance in order to eat. It was documented in the 11/19/06 quarterly MDS, section G-1h, that resident 4 was totally dependent on staff for tube feedings. It was documented in the initial 9/12/06 MDS, section G-1j, that resident 4 needed extensive assistance for personal hygiene to be completed. It was documented in the 11/19/06 quarterly MDS, section G-1j, that resident 4 needed limited assistance for personal hygiene needs to be completed. It was documented in the initial 9/12/06 MDS, section G-1i, that resident 4 needed extensive assistance for toileting. It was documented in the 11/19/06 quarterly MDS, section G-1i, that resident 4 needed limited assistance for toileting. It was documented in the initial 9/12/06 MDS, section J-4, that resident 4 had had no accidents/ falls over the previous 180 days. It was documented in the 11/19/06 quarterly MDS, section G-1h, that resident 4 had fallen at least 1 time within the last 30 days and at least one time in the last 31 to 180 days. 2. Resident 10 was a 99 year old female who was admitted to the facility on 3/7/06 with diagnoses that included rheumatoid arthritis, hypertension, hypothyroidism and peripheral vascular disease. Resident 10's medical record was reviewed on 12/05/06.	F 274		

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F 274	Continued From page 3 Resident 10 ' s quarterly MDS dated 8/19/06 documented that resident 10 had been identified as having a significant change in 4 areas of the quarterly MDS dated 6/6/06. It was documented in the quarterly MDS dated 6/6/06, section G-1b, that resident 10 needed limited assistance when transferring. It was documented in the quarterly MDS dated 8/19/06, section G-1b, that resident 4 needed extensive assistance when transferring. It was documented in the quarterly MDS dated 6/6/06, section G-1a, that resident 10 needed limited assistance with bed mobility. It was documented in the quarterly MDS dated 8/19/06, section G-1a, that resident 10 needed extensive assistance with bed mobility. It was documented in the quarterly MDS dated 6/6/06, section G-1e, that resident 10 needed limited assistance for locomotion on the unit. It was documented in the quarterly MDS dated 8/19/06, section G-1e, that the activity of locomotion on the unit did not occur for resident 10 during an entire 7 day period. It was documented in the quarterly MDS dated 6/6/06, section G-1i, that resident 10 needed limited assistance for toileting. It was documented in the 8/19/06 quarterly MDS, section G-1i, that resident 4 needed extensive assistance for toileting.	F 274		
F 278 SS=B	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278	A registered nurse will conduct and coordinate each assessment with the appropriate participation of health professionals.	1/21/07

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F 278	Continued From page 4 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: Based on record reviews and interviews the Minimum Data Set (MDS) assessments did not accurately reflect the residents' status or were not certified for 6 of 24 sample residents. (Resident identifiers: 1, 2, 4, 8, 16, 18, CL 22) Findings included: 1. Resident 16 was an 80 year old male who was admitted to the facility on 3/20/06 with diagnoses of dementia, diabetes mellitus, and hypertension.	F 278	Resident # 16's records were reviewed and brought current on December 8, 2006 Business office manager/ Designee will perform audits on every admit verifying resident's identifying information with resident or responsible party. All information will be verified with Medicare and Medicaid as it applies to patient. An in-service is scheduled on January 8 2006 for all staff involved with the admissions process. In-service training will be provided annually and as needed for this process Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate. Resident # 2, # 4, and CL # 22, records were reviewed and brought current on December 8, 2006 The Director of Nursing / Designee will perform weekly audits to ensure that all MDS are completed with an RN signature	

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F 278	Continued From page 5 Resident 16's medical record was reviewed on 12/6/06. Each of the MDS for 11/15/06, 8/27/06, 6/8/06 and 3/27/06 record resident 16's birth date as 07/15/1936 in section AA part 3. The history and physical report from Pioneer Valley Hospital dated 3/16/06 records resident 16's birth date as 07/15/1928. One face sheet dated 3/20/06 records resident 16's birth date as 7/15/1928. Another face sheet dated 3/20/06 records resident 16's birth date as 7/15/1936 with the 36 crossed out and 26 added. The physician order for life-sustaining treatment records resident 16's birth date as 7/15/1928. In an interview with resident 16's wife on 12/7/06 at 7:30 AM, she stated that her husbands' birth date was on 07/15/1928. 2. Resident 2 was an 86 year old female who was admitted to the facility on 5/03/04 with diagnoses that included hypertension, hypothyroid disease, dementia and weight loss. Resident 2's medical record was reviewed on 12/05/06. The MDS dated 9/25/06 was not signed by the registered nurse coordinating the assessment in section R2. 3. Resident 4 was a 62 year old female who was admitted to the facility on 8/31/06 with diagnoses	F 278	An in service is scheduled on January 8 2006 for all staff involved with the MDS process in regards to purpose and state regulations for MDS assessments. In-service training will be provided annually and as needed for this process Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate. Resident # 18's records were reviewed and brought current on December 8, 2006 Medical records will keep a log of all correction requests and perform weekly audits to ensure all MDS paperwork is present in current medical record. An in-service is scheduled on January 8 2006 for all staff involved with the MDS process in regards to purpose and state regulations for attestations and correction requests to the MDS assessments. In-service training will be provided annually and as needed for this process	

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F 278	Continued From page 6 that included acute renal failure, diabetes, aspiration pneumonia, transient ischemic attack and major depression. Resident 4's medical record was reviewed on 12/05/06. Resident 4's quarterly MDS dated 11/19/06 was signed by two interdisciplinary team (IDT) members and was only partially completed and not signed by the registered nurse coordinating the assessment in section R2. 4. Resident CL 22 was a 40 year old male who was admitted to the facility on 8/21/06 with diagnoses of hypertension, depression, schizoaffective disorder, diabetes and seizures. Resident CL 22 was discharged from the facility on 10/30/06. Resident CL 22's closed medical record was reviewed on 12/7/06. Resident CL 22's initial MDS dated 9/2/06, was not signed by the registered nurse coordinating the assessment in section R2. 5. Resident 18 was a 91 year old female who was admitted to the facility on 6/23/06 with diagnoses of chronic respiratory failure, depression, esophageal reflux disease, atrial fibrillation and glaucoma. Resident 18's medical record was reviewed on 12/6/06. The MDS correction request form dated 8/3/06, in reference to the initial MDS dated 7/5/06, was not signed by the registered nurse coordinating the	F 278	Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate. Resident # 1's records were reviewed and brought current on December 8, 2006 Director of Nursing/ Designee will compare the working copy of the MDS to the printed copy to ensure that there are not any data entry errors. An in service is scheduled on January 8 2006 for all staff involved with the MDS process in regards to purpose and state regulations for accuracy of MDS assessments. In-service training will be provided annually and as needed for this process Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate. Resident # 8's records were reviewed and brought current on December 8, 2006	

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F 278	Continued From page 7 assessment in section R2. In addition, on the face page of the "Correction Request" form, section AT5 was signed by the facility physical therapist manager. The AT5 section must be signed by the "RN Coordinator" indicating that the corrected MDS was completed. The MDS correction request form dated 9/15/06, in reference to the initial MDS dated 7/5/06, was not signed by the registered nurse coordinating the assessment in section R2. A copy of the entire corrected initial MDS was not found on resident 18' s medical chart and that included the R2 section. In addition, on the face page of the " Correction Request " form, section AT5 was signed by a licensed practical nurse. The AT5 section must be signed by the "RN Coordinator " indicating that the corrected MDS was completed. 6. Resident 1, was a 24 old male, who was originally admitted to the facility on 9/23/05 and then readmitted 7/14/06 following a short stay at the hospital. His diagnoses included osteomylitis, paraplegia, deep vein thrombosis, pressure ulcer, urinary tract infection, and depression. A review of resident 1's medical record was completed on 12/6/06. Residents 1's quarterly MDS dated 10/10/06 was reviewed. It was documented in section J4-c and d, that resident 1 had a hip fracture within the last 180 days as well as another fracture in the last 180 days. A review of physician's orders, treatment orders, care plan, and nurses' notes was completed on 12/6/06. There was no documentation found in the medical record indicating that resident 1 had a	F 278	Director of Nursing/ Designee will perform weekly audits to ensure all MDS are completed by R2b date and signed accordingly. An in service is scheduled on January 8 2006 for all staff involved with the MDS process in regards to purpose and state regulations for accuracy of MDS assessments. In-service training will be provided annually and as needed for this process Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate.	

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F 278	Continued From page 8 hip or other fracture in the last 180 days. On 12/6/06 at 11:30 AM, the Assistant Director of Nursing (ADON) was interviewed. When asked if resident 1 had had any type of fracture in the last 180 days, she stated that he had not had any fractures of any kind since admission. 7. Resident 8 was a 52 year old male that was admitted to the facility on 10/19/06 with diagnoses that included status post fasciotomy with open wound, diabetes chronic right leg pain and anemia. A review of resident 8 's medical record was completed on 12/5/06. Resident 1 's initial MDS dated 10/25/06 was reviewed. Resident 1's initial MDS was signed by the registered nurse coordinating the assessment in section R-2 on 10/25/06. On the basic assessment tracking form, section 9-f, a facility staff person signed the form and dated it 10/27/06. This was 2 days past the RN signature in section R-2.	F 278		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not provide services which met professional standards of quality for 1 out of 24 residents. Specifically, resident 1's pressure ulcer treatment was contaminated during a dressing change.	F 281	The services provided or arranged by the facility will meet professional standards of quality. Resident # 1's orders, policy and procedure were reviewed with nurse providing treatment. Treatment skills pass off were reviewed and updated with nurse on 12/8/06.	1/21/07

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F 281	Continued From page 9 (Resident identifier: 1) Findings included: 1. Resident 1 was originally admitted to the facility on 9/23/05 and readmitted on 7/14/06 with diagnoses that included osteomyelitis, pain control, paraplegia and pressure ulcer. a. A review of resident 1's medical chart was completed on 12/7/06. It was documented in a telephone physician's order form dated 11/0/06 that resident 1's wound behind the scrotum in the perineal area was to be irrigated with normal saline solution after cleaning the wound with soap and water. Then the wound was to be loosely filled with iodosorb paste on nu-gauze and cover with gauze and Mefix. This dressing was to be changed daily. b. On 12/6/06 at 11:00 AM, a dressing change for resident 1's open wound behind the scrotum in the perineal area was observed by two nurse surveyors. The dressing change was performed by a facility nurse, while the assistant director of nursing (ADON) and a unit manager also observed parts of the dressing change. The facility nurse stated that the dressing change for resident 1 was a "clean dressing" change. The nurse surveyors observed the facility nurse wipe off a bedside table with water from the faucet and a paper towel. The facility nurse, following the physicians's orders, used aseptic technique up to the process of packing the wound with the medicated gauze. At this point, the gauze used to cover the wound was laid directly on the bedside table and was then placed over	F 281	Orders were reviewed with all nursing personnel. Policy and Procedures for clean dressing changes were reviewed along with the treatment skills pass off by all nursing personnel. MD was notified Res #1 has been discharged to the hospital for flap placement An in-service will be completed on January 8, 2006 in regards to policy and procedure for treatments and dressing changes. All steps in appropriate aseptic technique and clean dressing changes will be reviewed. All nursing personnel will complete a treatment skills pass off at this time. Training will be provided to all new employees as part of general orientation and completed bi-annually and as needed there after. The treatment and dressing change skills pass off will be completed by all new employees prior to first dressing change and annually to all employees. Director of Nursing or designee will perform weekly supervised dressing changes until lesser frequency is deemed appropriate.	

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F 281	Continued From page 10 the perineal dressing. This was a break in clean technique. c. A review of the facility's policy for non-sterile dressing changes was completed on 12/7/06. The following was documented in the procedure section: "3. Prepare a clean field: This may be done by wiping an overbed table with a disinfectant or soap and water, and drying with a paper towel." "4. Create a barrier - a paper towel may be used. Place on clean table (never place dressing supplies on the resident's bed)." "6. Place supplies on a clean field." d. On 12/7/06 at 9:00 AM, the DON (director of nursing) and Unit Manager (UM) 2 were interviewed. UM-2 stated that she saw the nurse, who had done the dressing change on resident 1, clean the bedside table with soap and water and then wipe the bedside table again with just water, before doing the dressing change. Neither of the nurse surveyors observed the facility nurse to clean the bedside table with soap and water. The DON stated however, that the the nurse should not have laid the gauze used to cover the perineal wound directly on the bedside table. e. Fundamentals of Nursing, sixth edition, Prentice Hall Health, (February 2000) pg 633-4, 670 "In medical asepsis, objects are referred to as clean or dirty. Clean denotes the absence of almost all microorganisms. Dirty (soiled, contaminated) denotes the likely presence of microorganisms, some of which may be capable	F 281	Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate.	

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F 281	Continued From page 11 of causing infection. Aseptic measures are protective as they are designed to reduce the number of potentially infective agents." "The incidence of nosocomial infections is significant. Major sites for these infections are the respiratory and urinary tracts, the bloodstream, and surgical or open wounds." "Preventing infections in healthy or ill persons and preventing the transmission of microorganisms from infected clients to others are major nursing functions. The nurse must be knowledgeable about sources and modes of transmission of microorganisms. Microorganisms are invisible, and nurses have an ethical obligation to ensure that appropriate aseptic measures are taken to protect clients, support people, and health personnel, including themselves."	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of a resident's medical record, it was determined that for 1 out of 24 sampled residents, the services provided by the facility were not in accordance with the written plan of care. (Resident identifier: 13) Findings included:	F 282	The services provided or arranged by The facility will be provided by qualified persons in accordance with each resident's written plan of care. Resident # 13's records were reviewed and brought current on December 8, 2006 Director of Nursing/Designee will initiate Interdisciplinary Memos for increased communication between departments.	1/21/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465146	A. BUILDING _____ B. WING _____	12/07/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 12 Resident 13 was admitted to the facility on 6/17/05 with diagnoses that included alcohol withdrawal, hepatitis C, seizures and insomnia. On 12/5/06, resident 13's "Unusual Occurrence Record " dated 9/25/06 was reviewed. It was documented in the " Occurrence Type" section that resident 13 had an unattended fall. It was documented in the " Description of Unusual Occurrence ... " section that the resident 13's roommate witnessed resident 13's fall. It was documented that the roommate stated that resident 13 "was putting (on his) shirt and went down". It was documented in the " Resident final disposition or outcome " section "OT to evaluate for ADL (activities of daily living) safety. " A review of resident 13's medical records was completed on 12/7/06. A physician's telephone order dated 9/25/06 for resident 13 was reviewed. It was documented that resident 13 was to be evaluated for occupational therapy (OT) for ADL safety. Resident 13's medical chart was reviewed and no OT evaluation could be found in the resident's chart. On 12/6/06, resident 13's care plan for the "Potential for Falls/Entrapment/Other Injury, originally dated 2/28/06, was reviewed. It was documented in the "Approaches" section number "8" that "Therapies as ordered" were to be provided. The responsible party listed was "PT/OT" (physical therapy). On 12/6/06 at 4:00 PM, the facility occupational therapist was interviewed. The occupational	F 282	Director of Nursing/ Designee will perform weekly audits of all interdisciplinary orders to ensure follow through until lesser frequency is deemed appropriate An in-service will be provided to all departments regarding Interdisciplinary Memos and new process for communication. In-service training will be provided annually and as needed for this process Identified trends will be reviewed and reported monthly and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate.	

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F 282	Continued From page 13 therapist stated that she did not do an evaluation on resident 13 and was not familiar with resident 13. On 12/6/06, UM-1(Unit Manager) was interviewed. UM-1 stated that she was concerned about resident 13 ' s falls. She stated that most of resident 13's falls occurred in the morning. She stated that on 9/25/06 at 6:30 AM, while resident 13 was getting himself dressed he fell. UM-1 stated that she called resident 13's physician and requested and obtained an order for OT related to falls.	F 282		