DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2006 FORM APPROVED OMB NO. 0938-0391

CLIVIL	NO FOR WEDICARE	. & MILDICAID SERVICES			ONID NO.	0000 0001
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	MULTIPLE CONSTRUCTION ILDING	(X3) DATE SI COMPLE	
		465146	B. Wil	NG	12/0	7/2006
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP	CODE	
AVALON	VALLEY REHABILIT	ATION CENTER		2472 SOUTH 300 EAST		
				SALT LAKE CITY, UT 84115	POPPEGTION	
(X4) ID PREFIX TAG	! (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	~~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 274		SIDENT ASSESSMENT-	, F.	274 The facility will conduc		1/21/07
SS=D	WHEN REQUIRED		2/	hensive assessment of a		
	A facility may at a and	lust a comprehensive	05	within 14 days after the	facility	<u> </u>
		luct a comprehensive sident within 14 days after the		has determined that ther	re had been	
		or should have determined,	700	a significant change in t	he resident's	
	that there has been	n a significant change in the or mental condition. (For		status.		
		tion, a significant change	6	Resident # 4's records v	vere reviewed	
		cline or improvement in the	-€	and a significant change		
		at will not normally resolve Sintervention by staff or by	ノーツ *	initiated and completed		
		dard disease-related clinical	\leq	initiated and completed	011 12,0,00.	
		nas an impact on more than	27	The Director of Nursing	/ Designee	
	one area of the res	ident's health status, and	ر م م	will perform weekly aud	_	
		linary review or revision of the		that all significant change		;
	care plan, or both.)		_	MDS trigger a significa	_	!
		X 0	٧)	WIDS trigger a significa	in change wide.	
		NT is not met as evidenced	(0)	An in service is schedul	ed on January 8	
	by:	f modical records it was		2006 for all staff involv	ed with the	
		f medical records, it was 2 of 24 sampled residents, the	<u> </u>	MDS process in regards	s to purpose	
		luct a comprehensive	End in	and state regulations for		
	assessment of the	resident within 14 days and		change MDS assessmen	_	
	_	ned, or should have	9			
		ere had been a significant ent's status. (Resident	V	In-service training will	be provided	
	identifiers: 4, 10)	ent's status. (Nesident		annually and as needed	-	j.
	Findings included:			Identified trends will be	reviewed and	06 Licensing,
				reported monthly and as		92 33
	1 Decident Awas	a 62 year old female who was		facility Quality Assuran		2008
		a 62 year old female who was :ility on 8/31/06 with diagnoses		lesser frequency is deen		
		renal failure, diabetes,		in the state of th	3	\%\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
		nia, transient ischemic attack		Resident # 10's records	were reviewe	
	and major depress			and a significant change		্ ড় 🔁 😸
	Decite of the state of the stat			initiated and completed		Z an
	Resident 4's medic	al record was reviewed on		minated and completed	4 4 12 12 100 4	Bureau
LABORATOR	: RY DIRECTOR'S OR BROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN.	ATURE	TITLE	_	(X6) DATE
5, 5 (1 0 (1	/ / h	1-11		Administrat		12-29.0
		m. III		Maninista	ØN .	/ F - F-1./

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.

DEPARTMENT OF HEALTH AND HUMA... SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465146	B. Wil	NG		12/0	7/2006
	PROVIDER OR SUPPLIER I VALLEY REHABILIT	ATION CENTER		247	ET ADDRESS, CITY, STATE, ZIP CODE 2 SOUTH 300 EAST LT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 274	dated 11/19/06 was IDT (interdisciplinar only partially complemented to identified as having areas of the quarter compared with the lit was documented section B-4, that resmaking decisions. In 11/19/06, quarterly 4 made poor decision G-1b, that resmaking decisions. It was documented section G-1b, that resmaking decisions. It was documented section G-1b, that resident 4 needed litransferring. It was documented section G-1c, that resident 4 needed litransferring. It was documented section G-1c, that resident 4 was able assistance in her room at all. It was 11/19/06 quarterly fresident 4 was able assistance when go facility to another. It 11/19/06, quarterly fresident 4 was able resident 4 was able	rly MDS (Minimum Data Set) is signed as completed by two by team) members and was eted. The partially completed that resident 4 had been a significant change in 8 rly 11/19/06, MDS when nitial MDS dated 9/12/06. In the initial 9/12/06 MDS, sident 4 was independent in the MDS, section B-4 that resident ons and required In the initial 9/12/06 MDS, esident 4 needed extensive insferring. It was documented arterly MDS, section G-1b, that mited assistance when In the initial 9/12/06, MDS, esident 4 had not ambulated in the MDS, section G-1c, that to ambulate with limited	F	which the state of	the Director of Nursing / Divill perform weekly audits to at all significant changes of IDS trigger a significant chan in service is scheduled of 2006 for all staff involved with the service of the ser	o ensure on an lange MDS on January 8 with the purpose and ant change evolved his process.	

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(ULTIPI ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465146	B. WII	NG	10.14.6	12/	07/2006
	ROVIDER OR SUPPLIER	TATION CENTER		247	ET ADDRESS, CITY, STATE, ZIP CODE 2 SOUTH 300 EAST LT LAKE CITY, UT 84115		31,2300
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 274	Continued From passist.	age 2	F	274			†
	section G-1h, that assistance in orde the 11/19/06 quart resident 4 was total feedings. It was documented section G-1j, that rassistance for persident G-1j assistance for persident G-1j assistance for persident G-1j assistance for persident G-1j, that rassistance for toile	d in the initial 9/12/06 MDS, resident 4 needed limited r to eat. It was documented in erly MDS, section G-1h, that ally dependent on staff for tube d in the initial 9/12/06 MDS, resident 4 needed extensive sonal hygiene to be completed. If in the 11/19/06 quarterly, that resident 4 needed limited sonal hygiene needs to be d in the initial 9/12/06 MDS, resident 4 needed extensive reting. It was documented in the MDS, section G-1i, that					
	It was documented section J-4, that refalls over the previdocumented in the section G-1h, that time within the last in the last 31 to 18. Resident 10 was admitted to the fact that included rheur hypothyroidism and	limited assistance for toileting. In the initial 9/12/06 MDS, sident 4 had had no accidents/ous 180 days. It was 11/19/06 quarterly MDS, resident 4 had fallen at least 1 30 days and at least one time 0 days. Is a 99 year old female who was lity on 3/7/06 with diagnoses matoid arthritis, hypertension, diperipheral vascular disease.					
!	Resident 10's med 12/05/06.	ical record was reviewed on		 - 			

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		465146	B. WING		42/07/2006	
ł	PROVIDER OR SUPPLIER N VALLEY REHABILIT	ATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115	12/07/2006	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 274	It was documented to documented in the section G-1a, that reassistance with documented in the section G-1a, that reassistance with documented in the section G-1a, that reassistance with bed lt was documented in the section G-1a, that reassistance with bed lt was documented in the section G-1a, that reassistance with bed lt was documented in 8/19/06, section G-1a, limited assistance for was documented in 8/19/06, section G-1a, locomotion on the urange of the section G-1a, limited assistance for in the 8/19/06 quarted for the 8/19	arterly MDS dated 8/19/06 esident 10 had been identified ant change in 4 areas of the ed 6/6/06. If in the quarterly MDS dated b, that resident 10 needed when transferring. It was quarterly MDS dated 8/19/06, esident 4 needed extensive ansferring. In the quarterly MDS dated a, that resident 10 needed with bed mobility. It was quarterly MDS dated 8/19/06, esident 10 needed extensive mobility. In the quarterly MDS dated extensive mobility. It was quarterly MDS dated extensive mobility.	F 274			
F 278 SS=B	483.20(g) - (j) RESII The assessment muresident's status.	DENT ASSESSMENT ust accurately reflect the	F 278	A registered nurse will conducted coordinate each assessment wappropriate participation of harmonic professionals.	vith the	

DEPARTMENT OF HEALTH AND HUMA PERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465146	B. WIN	1G _		12/0	7/2006
	ROVIDER OR SUPPLIER	ATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 4	F 2	278	Resident # 16's records were r	eviewed	
	each assessment with the appropriate participation of health professionals.				and brought current on Decem 2006	ber 8,	
	Each individual who assessment must s that portion of the a Under Medicare and willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessment.	completes a portion of the ign and certify the accuracy of			Business office manager/ Desi will perform audits on every a verifying resident's identifying information with resident or responsible party. All informa will be verified with Medicare and Medicaid as it applies to p An in-service is scheduled on a 2006 for all staff involved with admissions process. In-service training will be provannually and as needed for this	dmit stion atient. January 8 the	
	Clinical disagreeme material and false s	nt does not constitute a tatement.			Identified trends will be review and reported monthly and as no		
	by: Based on record rev Minimum Data Set (accurately reflect the	views and interviews the MDS) assessments did not e residents' status or were not			the facility Quality Assurance until a lesser frequency is deen appropriate. Resident # 2, # 4, and CL # 22.	team ned	
	certified for 6 of 24 sample residents. (Resident identifiers: 1, 2, 4, 8, 16, 18, CL 22)			- 1	records were reviewed and bro current on December 8, 2006	ught	į
	Findings included:				The Director of Nursing / Desi	onee	j
, 	admitted to the facili	an 80 year old male who was ty on 3/20/06 with diagnoses as mellitus, and hypertension.		!	will perform weekly audits to e that all MDS are completed wi RN signature	ensure	

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465146	B. WII	NG _	•	12/0	7/2006
	PROVIDER OR SUPPLIER	ATION CENTER	•	2	REET ADDRESS, CITY, STATE, ZIP CODE 2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	Each of the MDS for and 3/27/06 record 07/15/1936 in section. The history and phy Valley Hospital date 16's birth date as 0'. One face sheet date 16's birth date as 7/2 Another face sheet resident 16's birth dicrossed out and 26. The physician order	r 11/15/06, 8/27/06, 6/8/06 resident 16's birth date as on AA part 3. rsical report from Pioneer ed 3/16/06 records resident 7/15/1928. red 3/20/06 records resident 15/1928. red 3/20/06 records resident 15/1928. red 3/20/06 records at as 7/15/1936 with the 36 added.	F	278	An in service is scheduled on 2006 for all staff involved with MDS process in regards to purstate regulations for MDS asset In-service training will be programmally and as needed for this Identified trends will be review reported monthly and as needefacility Quality Assurance tear a lesser frequency is deemed appropriate. Resident # 18's records were reand brought current on Decem 2006	the pose and essments. Vided s process wed and ed to the n until	
	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				Medical records will keep a lo correction requests and performandits to ensure all MDS paper present in current medical records. An in-service is scheduled on a 2006 for all staff involved with MDS process in regards to pur state regulations for attestation correction requests to the MDS assessments. In-service training will be proving annually and as needed for this	n weekly rwork is ord. January 8 or the pose and is and S	

DEPARTMENT OF HEALTH AND HUMA. ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		465146	B. WI	NG .		12/0	7/2006	
	PROVIDER OR SUPPLIER	ATION CENTER			REET ADDRESS, CITY, STATE, ZIP CODE 2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
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			278	Identified trends will be revier reported monthly and as need facility Quality Assurance teallesser frequency is deemed approximately Resident # 1's records were re-	ed to the am until a opropriate.		
	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				and brought current on Decer 2006 Director of Nursing/ Designe compare the working copy of to the printed copy to ensure there are not any data entry e An in service is scheduled on 2006 for all staff involved wi MDS process in regards to pustate regulations for accuracy	t on December 8, y/ Designee will ng copy of the MDS to ensure that nta entry errors. neduled on January 8 volved with the gards to purpose and		
	not signed by the rethe assessment in 5. Resident 18 was was admitted to the diagnoses of chron depression, esophatibrillation and glaud Resident 18's medial 12/6/06. The MDS correction reference to the initial to the diagnoses of chron depression, esophatibrillation and glaud Resident 18's medial 12/6/06.	egistered nurse coordinating section R2. s a 91 year old female who a facility on 6/23/06 with ic respiratory failure, ageal reflux disease, atrial			In-service training will be proannually and as needed for the Identified trends will be reviereported monthly and as need facility Quality Assurance tealesser frequency is deemed at Resident #8's records were rand brought current on December 2006	is process ewed and led to the am until a opropriate.		

DEPARTMENT OF HEALTH AND HUMA. DERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		465146	B. WING _		12/07/2006	
	PROVIDER OR SUPPLIER	ITATION CENTER		REET ADDRESS, CITY, STATE, ZIP COE 2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	page of the "Corre AT5 was signed to manager. The AT "RN Coordinator" MDS was completed in reference to the not signed by the the assessment in entire corrected in resident 18's me R2 section. In ad Correction Requesigned by a licens section must be sindicating that the 6. Resident 1, was originally admitted then readmitted 7 the hospital. His paraplegia, deep urinary tract infect A review of residence and the residents 1's quareviewed. It was a d, that resident 1 180 days as well 180 days. A review of physicare plan, and nutries.	ection R2. In addition, on the face ection Request" form, section by the facility physical therapist is section must be signed by the indicating that the corrected eted. It is nequest form dated 9/15/06, was registered nurse coordinating in section R2. A copy of the initial MDS was not found on dical chart and that included the lidition, on the face page of the "est" form, section AT5 was seed practical nurse. The AT5 signed by the "RN Coordinator" is corrected MDS was completed. It is a 24 old male, who was included osteomylitis, wein thrombosis, pressure ulcer, tion, and depression.	F 278	Director of Nursing/ Desig perform weekly audits to e MDS are completed by R2 signed accordingly. An in service is scheduled 2006 for all staff involved MDS process in regards to state regulations for accura assessments. In-service training will be annually and as needed for Identified trends will be rereported monthly and as nefacility Quality Assurance lesser frequency is deemed	on January 8 with the purpose and cy of MDS provided this process viewed and eeded to the team until a	

DEPARTMENT OF HEALTH AND HUMA. JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	ON (X3) DATE SUR COMPLETE	
		465146	B. WIN	IG		12/0	7/2006
	PROVIDER OR SUPPLIER	ATION CENTER		2472	ADDRESS, CITY, STATE, ZIP CODE SOUTH 300 EAST I LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	On 12/6/06 at 11:30 Nursing (ADON) waresident 1 had had 180 days, she state fractures of any kin. 7. Resident 8 was admitted to the facithat included status wound, diabetes chanemia. A review of resident completed on 12/5/ Resident 1 's initial reviewed. Resident the registered nurse in section R-2 on 10 assessment tracking.	AM, the Assistant Director of as interviewed. When asked if any type of fracture in the last d that he had not had any d since admission. a 52 year old male that was lity on 10/19/06 with diagnoses post fasciotomy with open ronic right leg pain and	F2	278			
F 281 SS=D	10/27/06. This was in section R-2. 483.20(k)(3)(i) COM The services provid must meet profession This REQUIREMENT by: Based on observation determined that the services which met quality for 1 out of 2 resident 1's pressur	2 days past the RN signature MPREHENSIVE CARE PLANS ed or arranged by the facility conal standards of quality. IT is not met as evidenced on and interview, it was facility did not provide professional standards of the residents. Specifically, the ulcer treatment was g a dressing change.	F2	Re pro pro	ne services provided or arrange the facility will meet profes and ards of quality. esident # 1's orders, policy a ocedure were reviewed with oviding treatment. Treatment is off were reviewed and up th nurse on 12/8/06.	and n nurse ent skills	1/21/07

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	facility on 9/23/05 a diagnoses that included control, paraplegia a. A review of residence of the completed on 12/7/20 It was documented order form dated 11 behind the scrotum irrigated with normal the wound with soal was to be loosely fill nu-gauze and cover dressing was to be b. On 12/6/06 at 11 resident 1's open were controlled.	originally admitted to the and readmitted on 7/14/06 with aded osteomyelitis, pain and pressure ulcer. In a telephone physician's /0/06 that resident 1's wound in the perineal area was to be a saline solution after cleaning of and water. Then the wound led with iodosorb paste on with gauze and Mefix. This	F2		Orders were reviewed with all personnel. Policy and Proceduclean dressing changes were realong with the treatment skills off by all nursing personnel. It was notified Res #1 has been discharged to hospital for flap placement An in-service will be completed January 8, 2006 in regards to pand procedure for treatments and procedure for treatments and dressing changes. All steps in appropriate aseptic technique and dressing changes will be review nursing personnel will complete treatment skills pass off at this Training will be provided to all employees as part of general	ures for eviewed pass MD the ed on policy and clean wed. All te a time.	
	surveyors. The dre- by a facility nurse, w nursing (ADON) and observed parts of the facility nurse stated resident 1 was a "cli The nurse surveyors wipe off a bedside to faucet and a paper of following the physical technique up to the with the medicated of gauze used to cover	ssing change was performed while the assistant director of a unit manager also be dressing change. The sthat the dressing change for ean dressing change. It is observed the facility nurse able with water from the stowel. The facility nurse, ans's orders, used aseptic process of packing the wound gauze. At this point, the stand was then placed over			orientation and completed bi-a and as needed there after. The treatment and dressing change pass off will be completed by a employees prior to first dressin change and annually to all employees of Nursing or designed perform weekly supervised dressing changes until lesser frequency deemed appropriate.	skills all new ag bloyees. e will essing	

DEPARTMENT OF HEALTH AND HUMA PRIVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		465146	B. WIN	G _		12/0	7/2006
	PROVIDER OR SUPPLIER	FATION CENTER		24	REET ADDRESS, CITY, STATE, ZIP CODE 472 SOUTH 300 EAST FALT LAKE CITY, UT 84115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	c. A review of the f dressing changes of following was docu section: "3. Prepare a county of the following was docu section: "3. Prepare a county of the following an overb soap and water, are "4. Create a base of the following of the research of the following	acility's policy for non-sterile was completed on 12/7/06. The imented in the procedure clean field: This may be done ed table with a disinfectant or and drying with a paper towel." arrier - a paper towel may be can table (never place dressing sident's bed)." lies on a clean field." OO AM, the DON (director of Manager (UM) 2 were stated that she saw the nurse, dressing change on resident 1, table with soap and water and side table again with just water, ressing change. Neither of the pserved the facility nurse to table with soap and water. The ver, that the the nurse should auze used to cover the perineal	F 2	281	Identified trends will be revireported monthly and as need facility Quality Assurance te a lesser frequency is deemed appropriate.	ded to the am until	
		f Nursing, sixth edition, h, (February 2000) pg 633-4,				: : ! !	
	clean or dirty. Clea almost all microorg contaminated) den	s, objects are referred to as an denotes the absence of panisms. Dirty (soiled, otes the likely presence of ome of which may be capable					

DEPARTMENT OF HEALTH AND HUMA REVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465146	B. WIN	√G_		12/0	7/2006
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115			Trace C
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282 SS=D	of causing infection protective as they number of potential "The incidence of is significant. Major the respiratory and bloodstream, and support infected clien functions. The nurse must be and modes of transed Microorganisms are ethical obligation to a septic measures support people, and themselves." 483.20(k)(3)(ii) COPLANS The services proview must be provided to accordance with eactordance with eactordance with eactordance medical record, it was a sampled reside.	are designed to reduce the are designed to reduce the ally infective agents." nosocomial infections is sites for these infections are durinary tracts, the surgical or open wounds." ons in healthy or ill persons and asmission of microorganisms at to others are major nursing the knowledgeable about sources smission of microorganisms. The invisible, and nurses have an orensure that appropriate are taken to protect clients, and health personnel, including the properties of the protect clients are taken to protect clients, and health personnel, including the properties of the protect clients. The service in a resident's written plan of the protect clients are taken to protect clients, and health personnel, including the protect clients, and health personnel that for the protect clients are invisible.		281		e with care. reviewed ber 8, will os for	1/21/07

DEPARTMENT OF HEALTH AND HUMA. JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 465146 NAME OF PROVIDER OR SUPPLIER AVALON VALLEY REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 2472 SOUTH 300 EAST SALT LAKE CITY, UT 84115 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	CENTERS FOR WILDICARE		T WILDIONID SERVICES	1			T	<u> </u>	
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AVALON VALLEY REHABILITATION CENTER (X4)ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 that the roommate stated that resident 13's aputting (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'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 "Potential for Falls/Entrapment/Other Injury, originally dated 2/28/06, was reviewed. It was documented in the "Potential for Falls/Entrapment/Other Injury, originally dated 2/28/06, was reviewed. It was documented in the "Potential for Falls/Entrapment/Other Injury, originally dated 2/28/06, was reviewed. It was documented in the "Potential for Falls/Entrapment/Other Injury, originally dated 2/28/06, was reviewed. It was documented in the "Potential for Falls/Entrapment/Other Injury, originally dated 2/28/06, was reviewed. It was documented in the "Approaches' section number "that Therapies as ordered" were to be	NAME OF PROVIDER OR SUPPLIER								
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 " bescription of Unusual Cocurrence" section that the resident 13's roommate witnessed resident 13's fall. It was documented in the " Posteription of Unusual Commander of the provided to all departments regarding Interdisciplinary Memos and new process for communication. 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 domination. In-service training will be provided annually and as needed to the facility Quality Assurance team until a lesser frequency is deemed appropriate. A physician's telephone order dated 9/25/06 for 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 "that "Therapies as ordered" were to be	AVALON	VALLEY REHABILIT	TATION CENTER						
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"PT/OT" (physical therapy). On 12/6/06 at 4:00 PM, the facility occupational	F 282	Resident 13 was a 6/17/05 with diagnor withdrawal, hepatit On 12/5/06, reside Record " dated 9/2 documented in the that resident 13 had documented in the Occurrence " se roommate witness documented that the resident 13 "was produced in the Cocurrence of the complete on 12/7 A physician's telepresident 13 was resident 13 was resi	dmitted to the facility on oses that included alcohol is C, seizures and insomnia. Int 13's "Unusual Occurrence 15/06 was reviewed. It was 1 Description of Unusual 15 Description of Unusual 16 Description of Unusual 17 Description of Unusual 18 Description of Unusual 18 Description of Unusual 19 Descri	F	282	perform weekly audits of all interdisciplinary orders to enfollow through until lesser from is deemed appropriate. An in-service will be provided departments regarding Interd Memos and new process for communication. In-service training will be preannually and as needed for the Identified trends will be revier reported monthly and as needefacility Quality Assurance te	ed to all isciplinary ovided his process ewed and led to the am until a		

DEPARTMENT OF HEALTH AND HUMA. JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED		
		465146				12/(/07/2006	
NAME OF PROVIDER OR SUPPLIER AVALON VALLEY REHABILITATION CENTER				2472	T ADDRESS, CITY, STATE, ZIP C SOUTH 300 EAST T LAKE CITY, UT 84115	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 282	on resident 13 and 13. On 12/6/06, UM-10 interviewed. UM-10 concerned about in that most of reside morning. She stat while resident 13 will fell. UM-1 stated to 13.	at she did not do an evaluation d was not familiar with resident (Unit Manager) was 1 stated that she was resident 13's falls. She stated ent 13's falls occurred in the ted that on 9/25/06 at 6:30 AM, was getting himself dressed he that she called resident 13's uested and obtained an order	F 2	282				