DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2006 FORM APPROVED OMB NO 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL			
		465110	B. WING		05/1	0/2006		
	PROVIDER OR SUPPLIER	E CTR	575	ET ADDRESS, CITY, STATE, ZIP COI EAST 11000 SOUTH NDY, UT 84070	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	PREP & SERVICE	ore prepare distribute and	5 F 371	The Plan of Correction is be submitted with specific requand should not be construct an admission of guilt or agree with any of the deficiencies on the CMMS 2567-L; nor the facility admit to any state	uirements I as cement cited does			
	by: Based on observat	oute, and serve food under	Control of the second	findings, facts, or conclusion form the basis for the allege deficiencies. The facility rethe right to challenge in legal proceedings all conclusions form the basis for the deficient	ns that ed serves al that			
	Findings included: On 5/8/06 at 9:35 A completed in the ki	M, observations were tohen.	30	The plan of correction also serves as a credible allegation of compliance.	Utah Depar He	tment of He 1958		
	rolls of thawed ground no thaw date on an On the same tray wheef, there was a p	igerator had three five pound und beef on a tray. There was y of the rolls of ground beef. with the thawing raw ground lastic bag of cooked sliced in pulled from the freezer and ate.	The state of the s	Tag: F-371 Dietary Services	MAY Bureau of Heal Certification and ted Resident: 67	2 5 2006 th Facility Licen		
	Whip Topping label thaw date on the ca	32 ounce cartons of thawed led keep frozen. There was no artons. The Whip Topping can the refrigerator after thawing.		All residents have potential to l Corrective Action to Prevent Recurrence: 1. Dietary Services Management		ice		
	3. A dietary worker was observed to take twelve clean blue plastic water pitchers from the dish machine. The pitchers were still wet. The worker stacked and nested the wet pitchers and placed them on a storage shelf in the kitchen. When nested, there was no possibility for the pitchers to dry. Dishes, trays and glasses stored wet allow			dietary staff on properly placing the thaw dates on food stored in the facility refrigerator. Dietary staff will also be inserviced on not placing raw meat on the same trey as cooked meat. In-services will be completed by 06/20/2006.				
BORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE Executive Director		(X6) DATE		

program participation.

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

DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(Y3) DATE SI COMPLE	
		465110	B. WING		- 05/1	0/2006
	PROVIDER OR SUPPLIEI		S	STREET ADDRESS, CITY, STATE, 575 EAST 11000 SOUTH SANDY, UT 84070	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 371	the possibility for environment and contamination. 4. On the spice sopen allowing the the product. On 5/9/06 at 6:50 completed in the 5. Clean goblets tray above the diswater droplets insitems are stored shelf, there is no 6. The flour bin licenter exposing the white pepper 8. Clean, wet trays and were used to residents. The mwas set directly on line service was of AM. All the clear 9. At approximate the kitchen and cwet, nested blue the kitchen. She	bacteria to multiply in a moist cause possible cross shelf, the white pepper lid was a possibility of contamination of AM, observations were kitchen. were stored upside down on a sh machine area. There were side the goblets. When wet upside down on a solid tray or possibility for them to dry. id had a 4 inch opening at the he flour. shelf, the ground allspice lid and lid were open. ys were stacked on top of each com. At approximately 7:40 were set next to the tray line hold the breakfast meals for the heal included a banana half that in the wet tray. The entire tray observed from 7:40 AM to 8:45	F 37	The Plan of Correct submitted with spec and should not be come an admission of gui with any of the deficiencies. The facility admit to findings, facts, or coform the basis for the deficiencies. The father right to challeng proceedings all conform the basis for the plan of correctiserves as a credible of compliance. 2. Dietary Services M dietary staff on prodates on food store refrigerator by 06/3. Dietary Services M dietary staff on propitchers on trays. It placed individually of one another, on It will allow the pitch will lower the risk of in a moist environd be completed by 06/4. Dietary Services M dietary staff on propon open spice contatther isk of contamir	ion is being differ requirements on strued as It or agreement ciencies cited IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	

DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/OUTPLIER/OLIA IDENTIFICATION NUMBER:			1	ULTIP	OLE CONSTRUCTION	COMPLETED	
		465110	B. Wit	۷G		05/10	0/2006
	ROVIDER OR SUPPLIER ANDS HEALTH CARI	E CTR		57	EET ADDRESS, CITY, STATE, ZIP CODE 75 EAST 11000 SOUTH ANDY, UT 84070		
(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 AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	dietary manager or thawing ground bee pull date. There wa the tray. The cook directly on the plast pointed out to her.	ge 2 ne cook on 5/8/06 and the 5/9/06, they both said that the ef should have had a thaw or as no tag on the packages or took a black marker and wrote ic packages when this was They also said that cooked e on the same tray with raw	F	371	The Plan of Correction is be submitted with specific requand should not be construed an admission of guilt or agriculture with any of the deficiencies on the CMMS 2567-L; nor the facility admit to any state findings, facts, or conclusion form the basis for the allege deficiencies. The facility rethe right to challenge in legiproceedings all conclusions form the basis for the deficiencies.	direments I as eement cited does tements, ns that ed eserves al that	
F 463 SS=D	resident calls throu from resident room facilities. This REQUIREMED by: Based on observatidetermined that the a functioning commercident room. Findings included: 1. On 5/8/06 at 12: observed to be in have resident 10 stated on for "awhile and room." The following observeyor:	must be equipped to receive gh a communication system s; and toilet and bathing NT is not met as evidenced on and interview it was a facility was not equipped with nunication system from one 20 PM, resident 10 was er room laying in bed, that she has had her call light	F	463	The plan of correction also serves as a credible allegatic of compliance. 5. Dietary Services Manager was Dietary staff on properly pla on trays after they have been The goblets will be placed on liner. This will allow the go appropriately. Inservice will by 06/20/06. 6. Dietary Service Manager plants for new food storing bins on This will eliminate the 4-ince all food storage bins. Inservice completed by 06/20/06. 7. Please refer to #4 listed above will be completed by 06/20/06. 8. Dietary Service Manager will dietary staff on how to prope trays, which will allow trays dry appropriately. Inservice completed by 06/20/06. 9. Please refer to #3 listed above Inservice will be completed by 06/20/06.	vill inservice ucing goblets a washed. In bar-mat blets to dry let be completed aced an order 105/19/2006. In opening in vice will be ve. Inservice 06. It inservice erly stack to drain and will be ve.	

Facility ID: UT0019

DEPARTMENT OF HEALTH AND HUT IN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	COMPLETED	Y
		465110			05/10/20	06
	ROVIDER OR SUPPLIER		5	REET ADDRESS, CITY, STATE, ZIP CODE 75 EAST 11000 SOUTH SANDY, UT 84070	00/10/20	00
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COM	(X5) IPLETION DATE
F.463	resident 10's door c. There was no a the nurse's station At 12:30 PM, the registered nurse (I resident 10's call li went into resident off and then had the back on. The call	ght signal in the hallway above hudible signal being relayed to hurse surveyor informed the RN) caring for resident 10 that ght was not working. The RN 10's room turned the call light he resident turn the call light light still did not have a light ay and there was no audible	F 463	The Plan of Correction is being submitted with specific require and should not be construed as an admission of guilt or agreen with any of the deficiencies cit on the CMMS 2567-L; nor doe the facility admit to any stater findings, facts, or conclusions form the basis for the alleged deficiencies. The facility resente right to challenge in legal proceedings all conclusions the form the basis for the deficient. The plan of correction also serves as a credible allegation.	ment ed es ents. that eves at cy.	
F 502 SS=E	into resident 10's r in the bathroom was when that occurs to properly. 483.75(j)(1) LABO The facility must poservices to meet the facility is responsible of the services. This REQUIREMED by: Based on interview was determined the timely laboratory services as ordered, 7, 10, 15 and CL	naintenance supervisor went com. He stated that the switch as not lifted up correctly and he call light will not work RATORY SERVICES rovide or obtain laboratory are needs of its residents. The alle for the quality and timeliness NT is not met as evidenced and medical record review, it at the facility did not obtain ervices for 5 of 22 sample and by the physician. Residents 1.	F 502	Monitoring/Quality Assurance Audit tool that addresses #'s 1-9 w developed by Dietary Service Mar monitor proper protocols. Dietary Supervisor will conduct audits on twice a week for six weeks. The Improvement Team (Quality Assureview the results of these audits a actions will be taken, as the comm necessary. Responsible Party: Dietary Service Manger Completion Date: 06/20/2006	vill be mager to y Service #'s 1-9, Performance mance) will and further	
,	Findings include:					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUFFLIEN/CLIA IDENTIFICATION NUMBER:	A. BUILE	LTIPLE CONSTRUCTION DING	COMPLE	ž į
		465110	B. WING	S	05/1	0/2006
	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CO 575 EAST 11000 SOUTH SANDY, UT 84070	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETION DATE
F 502	1. Resident 7 wa 6/8/04 with diagn diabetes, hyperlip A complete reviewas completed or On 1/1/05, a physia HGBA1C (hem (complete metab blood count) evel December. There was no do medical record the were completed to 2005. There was the CBC for June On 10/10/05, a pwhich documente the labs due in June CMP, HgbA1C, lithere was no do was completed. On 10/25/06, a parafasting lipid proorder the fasting 1/16/06. There was no do fasting lipid profil 2. Resident 10 was 6/8/10/10/10/10/10/10/10/10/10/10/10/10/10/	as admitted to the facility on oses which included dementia, bidemia and edema. w of resident 7's medical record in 5/10/06. sician's ordered was obtained for oglobin A1C), lipid, CMP olic panel) and CBC (complete ry 6 months in June and cumented evidence in the fact the HGBA1C, lipid and CMP for June 2005 and December is no documented evidence that a 2005 was completed. hysician's order was obtained and the following, "Please locate une (2005) or draw them. (CBC, pid profile)." cumented evidence that the CBC hysician's order was obtained for file in 12 weeks. Based on this lipid profile would be due around cumented evidence that the ewas completed. vas admitted to the facility on	F 50	Tag: F-463 Resident Call Sy Corrective Action for Identified Resident: The call light switch in reside bathroom was put in the correction was put in the correction was put in the correction of correction as serves as a credible alleg of compliance. Tag: F-463 Resident Call Sy Corrective Action for Identified Resident: The call light switch in reside bathroom was put in the correction as serves as a credible alleg of compliance.	requirements ued as agreement ries cited for does statements, usions that leged y reserves legal riciency. Iso gation restem restem	if the in
		noses which included congestive				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC ... D SERVICES

OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X2) DATE SURVEY COMPLETED	
	465110	B. WING	<u> </u>	05/10/200)6
ROVIDER OR SUPPLIER ANDS HEALTH CARE	ECTR	Ş	STREET ADDRESS, CITY, STATE, ZI 575 EAST 11000 SOUTH SANDY, UT 84070	P CODE	-
(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE COM THE APPROPRIATE	(X5) PLETION DATE
heart failure, hypert dementia and insort A complete review was completed on 8 On 5/19/06, a physia CBC and CMP events of the complete of the	ension, hyperlipidemia, nnia. of resident 10's medical record 5/10/06. ician's order was obtained for very 6 months. mented evidence that the CBC apleted on or around 11/19/05. as admitted to the facility on uses that included diabetes abral vascular accident), and CI 1's medical record was ord documented a physicians (protime/international ratio) to 6. of a PT/INR level could be cal record. Is admitted to the facility on uses that included depression, are fractures. 15's medical record was	F 50	The Plan of Correction aubmitted with specifiand should not be con an admission of guilt with any of the deficient on the CMMS 2567-1 the facility admit to a findings, facts, or conform the basis for the deficiencies. The fact the right to challenge proceedings all conciform the basis for the The plan of corrections serves as a credible at of compliance. Monitoring/Quality Asset SDC will perform audits three weeks, and then one weeks. At the completion SDC or designee will rep Performance Improvemer (Quality Assurance). Any will be determined by the Maintenance Supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of label each resident bathroof "On", "Off", and "Neutralian admitted to the supervisor of the supervisor of the supervisor of the supervisor of t	on is being lie requirements astrued as or agreement encies cited L; nor does my statements, neclusions that alleged sility reserves in legal dusions that deficiency. On also allegation urance: twice a week for three of the audits the nort compliances to the at Committee further audits/reports are Committee. or designee will om call light draws the structure of that	
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa heart failure, hypert dementia and insor A complete review was completed on a On 5/19/06, a physi a CBC and CMP ex There was no docu and CMP were com 3. Resident Cl 1 wa 2/16/06 with diagnor mellitus, CVA (cere multiple fractures. On 5/9/06, resident reviewed. Resident Cl 1's reco order for a PT/INR be drawn on 3/10/0 No documentation located in the medic 4. Resident 15 was 4/14/06 with diagnor anemia and multiple On 5/9/06, resident reviewed. Resident 15's recor order on 4/20/06 wi - Tib/fib Fx".	ROVIDER OR SUPPLIER ANDS HEALTH CARE CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 heart failure, hypertension, hyperlipidemia, dementia and insomnia. A complete review of resident 10's medical record was completed on 5/10/06. On 5/19/06, a physician's order was obtained for a CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP were completed on or around 11/19/05. 3. Resident CI 1 was admitted to the facility on 2/16/06 with diagnoses that included diabetes mellitus, CVA (cerebral vascular accident), and multiple fractures. On 5/9/06, resident CI 1's medical record was reviewed. Resident CI 1's record documented a physicians order for a PT/INR (protime/international ratio) to be drawn on 3/10/06. No documentation of a PT/INR level could be located in the medical record. 4. Resident 15 was admitted to the facility on 4/14/06 with diagnoses that included depression, anemia and multiple fractures. On 5/9/06, resident 15's medical record was reviewed. Resident 15's record documented a physicians order on 4/20/06 which stated "CBC, CMP today"	A. BUILLI ROVIDER OR SUPPLIER ANDS HEALTH CARE CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 heart failure, hypertension, hyperlipidemia, dementia and insomnia. A complete review of resident 10's medical record was completed on 5/10/06. On 5/19/06, a physician's order was obtained for a CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP were completed on or around 11/19/05. 3. Resident C1 1 was admitted to the facility on 2/16/06 with diagnoses that included diabetes mellitus, CVA (cerebral vascular accident), and multiple fractures. On 5/9/06, resident CI 1's medical record was reviewed. Resident C1 1's record documented a physicians order for a PT/INR (protime/international ratio) to be drawn on 3/10/06. No documentation of a PT/INR level could be located in the medical record. 4. Resident 15 was admitted to the facility on 4/14/06 with diagnoses that included depression, anemia and multiple fractures. On 5/9/06, resident 15's medical record was reviewed. Resident 15's record documented a physicians order on 4/20/06 which stated "CBC, CMP today - Tib/fib Fx"	A BUILDING ANDS HEALTH CARE CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 heart failure, hypertension, hyperlipidemia, dementia and insomnia. A complete review of resident 10's medical record was completed on 5/10/06. On 5/19/06, a physician's order was obtained for a CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP were completed on or around 11/19/05. 3. Resident C1 1 was admitted to the facility on 2/16/06 with diagnoses that included diabetes meliture, CVA (cerebral vascular accident), and multiple fractures. On 5/9/06, resident Cl 1's medical record was reviewed. Resident 15 was admitted to the facility on 4/14/06 with diagnoses that included depression, anemia and multiple fractures. On 5/9/06, resident 15's medical record was reviewed. Resident 15 was admitted to the facility on 4/14/06 with diagnoses that included depression, anemia and multiple fractures. On 5/9/06, resident 15's medical record was reviewed. Resident 15 was admitted to the facility on 4/14/06 with diagnoses that included depression, anemia and multiple fractures. On 5/9/06, resident 15's medical record was reviewed. Resident 15's record documented a physicians order on 4/20/06 which stated "CBC, CMP today - Tib/fib Fx"	A BUILDING ANDS HEALTH CARE CTR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SEPRECIEDED BY PULL RECULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 heart failure, hypertension, hyperlipidemia, dementia and insomnia. A complete review of resident 10's medical record was completed on 5/10/06. There was no documented evidence that the CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP ever 6 months. There was no documented evidence that the CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP every 6 months. There was no documented a physicians order of a CBC and CMP every 6 months. There was no documented a physicians order of a CBC and CMP every 6 months. There was no documented a physicians order of a CBC and CMP every 6 months. There was no documented a physicians order of a CBC and CMP every 6 months. There was no documented a physicians order of a CBC and CMP every 6 months. There was no documented ovidence that the CBC and CMP every 6 months. There was no documented ovidence that the CBC and CMP every 6 months. There was no documented ovidence that the CBC and CMP every 6 months. There was no documented ovidence that the CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP every 6 months. There was no documented evidence that the CBC and CMP every 6 months. There was no documented the facility on 4/14/106 with diagnoses that included diabetes months are the right to challenge in legal proceedings all conclusions that form the basis for the deficiencies. The facility of the right to challenge in legal proceedings all conclusions that form the basis for the deficiencies. The Plan of Correction is b

DEDARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC, JD SERVICES

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	OF DEFICIENCIES	(AT) PROVIDER/SUPPLIER/CLIA	(X2) W	ULTI	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	3 <u> </u>		
		465110	B. Wit	۷G		05/1	0/2006
NAME OF P	ROVIDER OR SUPPLIER			l .	EET ADDRESS, CITY, STATE, ZIP CODE		
CROSSL	ANDS HEALTH CAR	ECTR			75 EAST 11000 SOUTH ANDY, UT 84070		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 502	6/17/03 with diagnor dementia, urinary to cardiovascular accordiacement. Resident 4's medication 5/08/06. On 10/18/05 a physica CBC and CMP et September and Market Modocumentation	cal record. admitted to the facility on oses which included senile ract infection, dehydration, ident, and right hip al record was reviewed on sician's order was obtained for very 6 months due in	F	502	The Plan of Correction is being abmitted with specific requirement and should not be construed as in admission of guilt of agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statement findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserve the right to challenge in legal proceedings all conclusions that form the basis for the deficiency. The plan of correction also serves as a credible allegation of compliance.	nts, at	
F 504 SS=E	facility administration missing laboratory administrative staff missing laboratory 483.75(j)(2)(i) LAB The facility must preservices only when physician.	ORATORY SERVICES rovide or obtain laboratory ordered by the attending	F	504	Monitoring/Quality Assurance SDC will perform audits twice a three weeks, and then once a wee weeks. At the completion of the SDC or designee will report cor Performance Improvement Com (Quality Assurance). Any furthe will be determined by the Comm Responsible Party: Staff Development Coordinator	week for ek for three audits the mpliances to mittee er audits/repo mittee.	
	by:	NT is not met as evidenced ecord review and staff			Completion Date: This will be completed by June The SDC will be responsible for	20, 2006. r continued	

on 7 of 22 residents.

interview, it was determined that the facility did

not obtain physician's order before drawing labs

compliance.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC. D SERVICES

	OF DEFICIENCIES OF CORRECTION	I(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	A, BUI		3	COMPLE	· ·
		465110	B. WIN	IG		05/10	0/2006
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(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 504	Findings include: 1. Resident 1 was 4/12/06 with diagnor contusions, closed traumatic fractures On 5/9/06, resident reviewed. Resident 1's recomperformed on 4/20, No documentation located in the media.	admitted to the facility on oses that included Pulmonary head injury, and multiple . t 1's medical record was d documented a PT/INR /06. of a physician's order could be ical record.	F (504	The Plan of Correction is being submitted with specific requirement and should not be construed a an admission of guilt or agreed with any of the deficiencies on the CMMS 2567-L; nor do the facility admit to any states findings, facts, or conclusions form the basis for the alleged deficiencies. The facility reset the right to challenge in legal proceedings all conclusions the form the basis for the deficient. The plan of correction also serves as a credible allegation of compliance. Tag: F-502 Laboratory Ser	rements s ment ited bes ments, s that erves nat ncy.	
	dysrhythmias, eder (cerebral vascular On 5/8/06, resident reviewed. Resident 5's record performed on 4/7/0 performed on 4/11. No documentation located in the median 13. Resident 13 was 10/1/03 with diagnon hypothyroidism, CA and BPH (benign)	t 5's medical record was d documented a PT/INR 06, and an Albumin level 06. of a physician's order could be			Corrective Action for Identified Resident: Resident 7 the physician was informed of the missed HGB lipid, and CMP that were to in June 2005, and the missed done in Oct. 2005, and fastin was to be done in Jan. 2006. has a physician's order to ha HGBA1C, Lipid Panel, and drawn on May 23, 2006 and 6 months in May and Decer Resident 10 physician was in of missed CBC and CMP that be obtained in Nov. 2005. A was obtained to draw a CBC on 5-22-2006.	A1C, be obtained CBC to be g lipid that Resident ve CMP, CBC to be then every ober. Aformed at was to new order	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		G	COMPLE	TED
		465110	B. Wil	√G		05/10	0/2006
	ROVIDER OR SUPPLIER	E CTR	•	57	EET ADDRESS, CITY, STATE, ZIP CODE 75 EAST 11000 SOUTH ANDY, UT 84070		
(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)	OULD BE	(X5) COMPLETION DATE
F 504	reviewed. Resider following lab value 1. A sputum cultur 2. A U/A (urinalysi 3. A CMP, CBC ar Hormone) values; No documentation located in the med 4. Resident 14 wa 6/16/04 with diagn cellulitis, periphera On 5/10/06, resider reviewed. Resident 14's recombained on 4/22/0 No documentation located in the med 5. Resident Cl 1 w 2/16/06 with diagn mellitus, CVA and On 5/9/06, resider reviewed. Resident Cl 1's remobtained on 3/1/06 No documentation located in the med 6. Resident 17 wa 2/9/04 with diagno	nt 13's record documented the s: e obtained on 4/29/06; s) completed on 9/14/05; nd TSH (Thyroid Stimulating drawn on 6/27/06 and 6/29/06. of a physician's order could be lical record. s admitted to the facility on oses that included urosepsis, all neuropathy and dementia. Int 10's medical record was ord documented a urinalysis of a physician's order could be lical record. as admitted to the facility on oses that included diabetes multiple fractures. It CI 1's medical record was cord documented PT/INR's in 3/6/06, and 4/4/06. of a physicians order could be lical record ocumented PT/INR's in 3/6/06, and 4/4/06.	F:	504	The Plan of Correction is being submitted with specific require and should not be construed as an admission of guilt or agreen with any of the deficiencies cit on the CMMS 2567-L; nor doe the facility admit to any statem findings, facts, or conclusions form the basis for the alleged deficiencies. The facility reser the right to challenge in legal proceedings all conclusions that form the basis for the deficience. The plan of correction also serves as a credible allegation of compliance. Resident C1 physician was informed to finish the deficience of missed lab on 3-10-2006 other followed to show no harm. Resident 15 physician was informed of missed CBC and CMP that is have been obtained on 4-20-06, were obtained on 4-21-06 and reto physician. Resident 4 physician informed of CBC and CMP for Sept. 2005. obtained in March 2006. Physic to continue with CBC and CMP every six months in Sept. and M. Identification of Residents with Potential to be Affected: All residents who have laborato order have the potential to be affected:	nents nent nent ned es nents, that ves at cy. ormed er labs ident of missed Lab was cian order to be done farch.	

DEPARTMENT OF HEALTH AND HE IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		465110	B. Wil	۷G		05/10	/2006
	ROVIDER OR SUPPLIER		<u> </u>	5	REET ADDRESS, CITY, STATE, ZIP CODE 175 EAST 11000 SOUTH SANDY, UT 84070		
(X4) ID PREFIX TAG	(FACH 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) COMPLETION DATE
F 504	disease. A complete review was completed or A review of the lat (complete blood of 8/4/05, 9/1/05, 10 (basal metabolic of 7/26/05. Physician orders could not be located in a could not be located in a conference of the facility administral missing laborator the facility adminified the missing laterator the facility must be resident in according standards and president in according to the clinical recording information to ideal resident's assess services provided preadmission scrand progress not	or of resident 17's medical record in 5/9/06. coratory results revealed CBC's counts) were completed on 1/6/05 and 11/3/05 and a BMP coanel) was completed on 1/6/05 and 11/3/05 and a BMP coanel) was completed on 1/6/05 and 11/3/05 and a BMP coanel) was completed on 1/6/05 and 11/3/05 and a BMP coanel) was completed on 1/6/05 and 1/6/05 an		514	and should not be construed as an admission of guilt or agreen with any of the deficiencies cit on the CMMS 2567-L; nor doe the facility admit to any statem findings, facts, or conclusions form the basis for the alleged deficiencies. The facility reser the right to challenge in legal proceedings all conclusions that form the basis for the deficience. The plan of correction also serves as a credible allegation of compliance. Corrective Action to Prevent Recurrence: The Licensed nurses and Medical Records staff to be inserviced on May 30, 2006 on new Laboratory This procedure is to include: A. Lab log that is to be every lab order. The include the resident number, type of lab of when lab was draup and when lab reserving the placed to lab. B. The lab log is to be day by each license is to see if labs that day have been draw be placed to lab. C. For routine lab dray i.e. a CBC every 6 orders are checked for the next month	ments ment ed es ents, that ves at cy. procedure. filled out with is lab log will s name, roon os, signature awn and pick sults are rece checked eve d nurse. This t were due or min f not call ws that are or months, whe at the end of the nurse ch	led ived. ry s check n that is to dered, n physician each month ecking will
	This REQUIREM by:	ENT is not met as evidenced			fill out a requisition if due the next more	n form and enth into the la	ab log.

DEPARTMENT OF HEALTH AND THE NI SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		G	COMPLE	i i
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(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Based on medical was determined the clinical records in professional stand complete and acc sampled residents. Findings include: Resident 11's was 12/6/05 with diagr mellitus, hyperten staphylococcus at A review of reside completed on 5/9/00 On 3/28/06, a polycompleted. On 3/positive airway precompleted. On 4/and interpreted the pulmonologist diale obstructive sleep hypoxemia and sepulmonologist ord (centimeters of was pulmonologist ord (centim	record review and interview, it not the facility did not maintain accordance with accepted lards and practices that were urately documented for 1 of 22 s. Resident identifier 11 sadmitted to the facility on loses which included, diabetes sion, and methicillin resistant ureus.	F	514	The Plan of Correction is submitted with specific reard should not be construed an admission of guilt or as with any of the deficiencies on the CMMS 2567-L; not the facility admit to any st findings, facts, or conclus form the basis for the alledeficiencies. The facility the right to challenge in leproceedings all conclusion form the basis for the definition of correction also serves as a credible allegatof compliance. D. After receiving the licensed nurse is to so log that the results hand a copy of the rein the chart. E. After receiving resulticensed nurse is to copy of the physicial order is not in the chart.	results of a lab sign off on the ave been receives that is to be placed by the check the chart, the physical phart, the physical as the check the chart, the physical as the check the chart the check the chart, the physical as the check the chart the check the check the chart the check the che	lab ved aced t for a vsician

DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DI AND PLAN OF COF		IQA) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		HETIP LDING	LE CONSTRUCTION	COMPLETED	
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	DER OR SUPPLIER		_!,	57	EET ADDRESS, CITY, STATE, ZIP CODE 5 EAST 11000 SOUTH ANDY, UT 84070		
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On hav his On con	e a CPAP unit bedside.	nt 11's room was observed to and an oxygen concentrator at PM, an interview was sident 11. He stated that he	F	514	The Plan of Correction is bersubmitted with specific requand should not be construed an admission of guilt or agrewith any of the deficiencies on the CMMS 2567-L; nor of the facility admit to any state findings, facts, or conclusion form the basis for the alleged deficiencies. The facility rether right to challenge in legal proceedings all conclusions form the basis for the deficient. The plan of correction also serves as a credible allegation of compliance. Monitoring/ Quality Assurance The Director of Nursing (DNS) will develop an audit tool to audit for presence in chart of phy Audits will be done once a week times six weeks by the DN with a report to the Performance Committee (Quality Assurance of the audits. Audits and report continue as may be directed by the Responsible Party: Director of Nursing Assistant Director of Nursing Completion date: 06/20/2006	ements as ement cited loes ements, as that d serves l that ency. on e or designee ysician ordere se Improveme at the comples will then	e ent letion

DEPARTMENT OF HEALTH AND H' AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(À.I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(M3) DATE SURVEY COMPLETED 05/10/2006	
		465110				
	ROVIDER OR SUPPLIER	E CTR	5	REET ADDRESS, CITY, STATE, ZIP COD 375 EAST 11000 SOUTH SANDY, UT 84070	E .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION	N
				The Plan of Correction is being submitted with specific requirement and should not be construed an admission of guilt or agree with any of the deficiencies on the CMMS 2567-L; nor defindings, facts, or conclusions form the basis for the alleged deficiencies. The facility results to challenge in legal proceedings all conclusions form the basis for the deficient. The plan of correction also serves as a credible allegation of compliance. Tag: F-504 Laboratory Service Corrective Action for Identified Resident: Resident 1 physician was information and some service and service and service and service and service are serviced.	rements as ement cited ooes ements, s that derves dehat ency.	
!				of PT/INR that was obtained on without physician order in char- aware no harm occurred from o	t. Physician	
•		:		Resident 5 physician was informed on 4-7-2006 and Albert performed on 4-11-06 without pin the chart. Physician aware, n from obtained labs.	oumin level ohysician order	-
		e i		Resident 13 physician was inforculture obtained on 4-29-2006, on 9-14-2005, and CMP, CBC, were completed on 6-27-2005 a without physician order in the caware, no harm occurred from o	UA completed and TSH that and 6-29-2006 thart. Physician	
ARORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

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 ollowing 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 large following the date those decuments are made qualitable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued process.

DEPARTMENT OF HEALTH AND H AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
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				The Plan of Correction is submitted with specific and should not be constructed an admission of guilt or with any of the deficience on the CMMS 2567-L; the facility admit to any findings, facts, or conclusion form the basis for the all deficiencies. The facility the right to challenge in proceedings all conclusion form the basis for the determined the plan of correction all serves as a credible allege of compliance.	requirements rued as agreement cies cited nor does statements, asions that leged y reserves legal ons that ficiency.		
		, g		Resident 14 physician was infobtained without physician or Physician aware, no harm occlab. Resident CL 1 physician was that were obtained on 3-01-204-04-2006 without physician Physician aware, no harm occ Resident was discharged on 5	der in chart. urred from obtain informed of PT/IN 006, 3-6-2006, and order in the chart. ourred from obtain	NR's	
##-				Resident 17 physician was inf were obtained on 8-4-2005, 9 and 11-3-2005, and BMP that 7-26-2005 without physician Physician aware, no harm occ labs. Resident was discharged Resident 10 is referenced in However, there is no inform any missed physician order	-1-2005, 10-6-200 t was obtained on order in the chart. curred from obtain 1 on 5-19-2006. F tag 504 item 4. nation related to	ed	
†				TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days of other safeguards provide sufficient protection is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date those documents are made smalled to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued have approved plan of correction is requisite to continued the patients. modern naminestion

TITLE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND H. AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IENCIES (A.I) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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				The Plan of Correction submitted with specific and should not be cons an admission of guilt or with any of the deficient on the CMMS 2567-L; the facility admit to any findings, facts, or conc form the basis for the adeficiencies. The facility the right to challenge in proceedings all conclus form the basis for the of the plan of correction serves as a credible alle of compliance.	requirements trued as r agreement ncies cited nor does y statements, lusions that llleged ity reserves n legal sions that leficiency. also egation		
				Monitoring/ Quality Assured The Director of Nursing (Director of Nursing (Director) and audit tool to audit received labs and having placed for labs in chart. The DNS caudits once a week, time's streport to the Performance In (Quality Assurance) at the Quality Assurance) at the Caudits and reports will then directed by the Committee. Responsible Party: Director of Nursing Assistant Director of Nursing Completion date: 16/20/2006	eNS) or designee wi it compliance of nysicians orders or designee will do ix weeks with a approvement Commi- completion of the au continue as may be	ttee	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that after safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 toys following the date those documents are made available to the facility. If deficiencies are gited, an approved plan of correction is requisite to continued average plan of correction.

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PRINTED: US/12/2000 FORM ADDROVE DEDARTMENT OF HEALTH AND HE - NISHRVILLES UMD MO. 0300-035 (CENTERS FOR MEDICARE & MEDICAID SERVICES ______ STREET CONCINCATION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 8 WING 05/10/2006 465110 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 575 EAST 11000 SOUTH CROSSLANDS HEALTH CARE CTR **SANDY, UT 84070** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG The Plan of Correction is being submitted with specific requirements and should not be construed as an admission of guilt or agreement with any of the deficiencies cited on the CMMS 2567-L; nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings all conclusions that form the basis for the deficiency. The plan of correction also serves as a credible allegation of compliance. Tag: F-514 Clinical Records Corrective Action for Identified Resident: Resident #11 clarification order obtained. Resident now Monitored every night for O2 saturations and documented on treatment administration record. Identification of Residents with Potential to be affected:

All residents with C-PAP /Bi-PAP machines.

Corrective Action to Prevent Recurrence:

DNS or designee will inservice all Licensed nurses on correct transcription or MD orders for C-PAP/BI-PAP machines, and correct documentation of usage of C-PAP/Bi-PAP machines.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 cllowing 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 Tayo following the data those decomants are made excitable to the facility. If deficiencies are nited, an energy and plan of correction is requisite to continued vooran nationation

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1					The Plan of Correction submitted with specific and should not be constrained an admission of guilt or with any of the deficien on the CMMS 2567-L; the facility admit to any findings, facts, or concluding the basis for the all the facility admits a fa	requirements rued as agreement cies cited nor does statements, usions that leged		
,					deficiencies. The facilit the right to challenge in proceedings all conclusi form the basis for the de The plan of correction a serves as a credible alle	legal ions that efficiency.		
					of compliance.	•		
		* f			Monitoring/Quality Assurant DNS or designee will audit Taresidents with C-PAP/Bi-PAP to ensure correct transcription C-PAP/Bi-PAP. Audits will b Q week X 6 weeks.	ARs of all machines of orders for e performed		
	·				with C-PAP/Bi-PAP machine documentation of usage is in be performed Q week X 6 we			
					Audit tools monitoring usage and correct transcription of all residents with C-PAP/Bi-PAP machines will be created. These audits will take place Q Week for 6 weeks to ensure all documentation is correct and in place for C-PAP and Bi-PAP usage. All results from audits will be reported to the Performance Improveme Committee (Quality Assurance). Audits and reports			
ATORY		DER/SUPPLIER REPRESENTATIVE	s signatu	RE	Committee (Quality Assurance will then continue as may be Responsible Party: Utilization Coordinator MDS Coordinator	directed by the C	ommitte	
					Completion Date:			
deficiency s safeguard:	itatement ending witt s provide sufficient p	n an asterisk (*) denotes a deficient rotection to the patients. (See instr or not a plan of correction is provid	by which the	e instituti xcest for	06/30/2006 nursing homes, the findings states	d above are disclose	ble 90 da	

FORM APPROVED

thorain participation