PRINTED: 06/22/2006
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465085	A. BUILDING ______ B. WING ______	06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY COUNTY CARE AND REHAB	455 WEST MILL ROAD FERRON, UT 84523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation from 06/05/06 to 06/07/06, it was determined that the facility did not have an effective maintenance system to ensure that the facility was maintained in good repair. Finding include: The handrail in the hallway outside of room 17 was loose. The ceiling above the counter in utility room behind the nurses station was observed to have spots of a brown substance that appeared to have been splattered on it in an area approximately 1 foot x 3 feet. The ceiling vent in the room was observed to have brown stains, and the ceiling around the vent had staining consistent with a water leak. Room 5 revealed the following maintenance problems: a 2 1/2" x 1 1/2" hole in the closet door: an 8' x 1" mark on the ceiling where it appears a curtain rod once hung: five round holes approximately 1 centimeter in diameter in the ceiling by the curtain rod: the top drawer of the dresser/vanity had a worn finish with a 4" x 1" scratch. Room 16 revealed the following maintenance	F 253	F 253 Handrail outside of room 17 was tightened on June 8, 2006. The hole in the closet door and the mark on the ceiling, the five round holes in the ceiling and the top drawer of the dresser/vanity with worn finish and scratch in rooms 5 was repaired on June 8, 2006. The scratches on the bottom of the door to the hallway in room 16 was repaired on June 8, 2006. The gouge in the closet door, numerous dime-size missing paint blemishes in the doorway and into the hallway and bathroom, worn finish and numerous wear lines in the bottom of the doorway into the hallway were repaired on June 8, 2006. The maintenance supervisor has prepared a room/hallway inspection sheet and will check all rooms, hallways and handrails on a monthly basis for preventive maintenance that needs to be done.	6/8/06

Handwritten: 7/13/06 POC acceptable completion date 7/13/06 (Brandenburg RN)

Stamp: Utah Department of Health JUL 03 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6/29/06

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.

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

PRINTED: 06/22/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465085	A. BUILDING ______ B. WING ______	06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY COUNTY CARE AND REHAB	455 WEST MILL ROAD FERRON, UT 84523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 1 problem; numerous scratches on the bottom 2' of the door to hallway, one of which was 2' long. Room 17 revealed the following problems; a 12" x 1/2" gouge in the closet door; numerous dime-size missing paint blemishes in the doorways into the hall and into the bathroom; worn finish and numerous wear lines (scratches) in the bottom 1 1/2' of the doorway into the hallway, the average scratch was approximately 3" long.	F 253	The Quality Assurance team will continue to monitor the maintenance program and a daily rounds check of the building will be done.	7/13/06
F 467 SS=B	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not provide for adequate ventilation for 2 resident restrooms, and a resident shower room. Finding included: Observations of the facilities environment occurred from 06/05/06 to 06/07/06. 1. The ceiling vents in the restrooms in rooms 18 and 20 did not provide adequate air movement to cause a piece of toilet tissue to adhere to the vents. The restroom in room 18 was noted to be very malodorous, with the smell of feces, at the	F 467	F 467 The Vents in rooms 18 and 20 were fixed on June 7, 2006. The vent in the east shower room was uncovered on June 7, 2006. The maintenance supervisor has prepared a ceiling vent checks list for all rooms, and he will check the vents on a monthly basis to ensure that all rooms have appropriate ventilation. The Quality Assurance Team will continue to monitor the ventilation of all interior rooms. Random spot checks will be done by members of the Quality Assurance Team. QCI monthly meetings will continue to follow-up on building ventilation issues.	6/7/06 7/13/06

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

PRINTED: 06/22/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465085	A. BUILDING ____ B. WING ____	06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY COUNTY CARE AND REHAB	455 WEST MILL ROAD FERRON, UT 84523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 467	Continued From page 2 time of the observation. 2. The ceiling vent in the East shower room was observed to be covered by plastic sheeting that had been taped in place. During testing of the hot water temperature in the room, the air became uncomfortably warm, even with the shower room door ajar. 3. An interview with the head of maintenance took place on 06/07/06 at 1603. The maintenance person stated that the vent in the East shower room had been covered because of cold drafts that occurred during the winter. He stated that the shower aide had indicated to him that the vent needed to be uncovered, but he had not yet done so. When asked about the functioning of the vents in the bathrooms in rooms 18 and 20, he stated that he had been working on several of the vents throughout the facility, but was unaware that the vents for rooms 18 and 20 were not functioning.	F 467		
F 518 SS=D	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on interviews, facility record review, and information from underwriters laboratories, it was	F 518		

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

PRINTED: 06/22/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465085	A. BUILDING ______ B. WING ______	06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY COUNTY CARE AND REHAB	455 WEST MILL ROAD FERRON, UT 84523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 3 determined that the facility did not provide adequate training in emergency procedures, for 2 of 3 facility employees. (Employee identifiers: CNA 1, CNA 2) Findings included: 1. An interview with a Certified Nurse Aide (CNA 1) was conducted on 06/06/06 at 4:05 PM. CNA 1 was asked how she would respond if she encountered a fire in a resident's room while the resident was in the room. CNA 1 indicated that she would close the door to the resident's room, with the resident in the room, obtain a fire extinguisher, get someone to help her, and attempt to rescue the resident via the outside window. When asked how to use a fire extinguisher, CNA 1 responded that she would pull the pin, squeeze the handle, and sweep from the top to the bottom of the fire to smother it. CNA 1 stated that her last fire/emergency training occurred in April of 2006. Per An Orientation Manual for Long-Term Care Facilities, Springer, New York. 1993. p140, and utilized in training per the facilities maintenance director, in the event of a fire the RACE procedure is to be used. The RACE acronym indicates: R-rescue, remove patient(s) from danger, close door behind you; A-alarm, pull the nearest fire alarm, execute your fire plan; C-confine, close patient room doors or evacuate as planned; E-extinguish, extinguish if small fire or keep confined. Per underwriters laboratories: To operate a fire extinguisher, remember the word PASS:	F 518	F 518 The facility will continue to train all employees in emergency procedures when they begin to work in the facility. In addition to the existent emergency program, consisting of training during monthly orientation, monthly fire/disaster drills with on the spot training, at least twice a year in-service training, the maintenance supervisor and the administrator will perform random testing of staff, questioning them on emergency procedures for different disaster scenarios. In addition to the random testing the maintenance supervisor has posted signs throughout the building with the **RACE** and **PASS** acronym on them. We have and will continue to meet all of the requirements of section 483.75 (m) (2) of 42CFR, Subpart B, CMS manual. The Quality Assurance Team will continue to monitor the ongoing training program during monthly QCI meetings. Quality Assurance Team members will perform random testing of staff	6/28/06 ongoing training 7/17/06

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

PRINTED: 06/22/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465085	A. BUILDING ______ B. WING ______	06/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERY COUNTY CARE AND REHAB	455 WEST MILL ROAD FERRON, UT 84523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 4 Pull the pin, hold the extinguisher away from you and release the locking mechanism: Aim low, pointing the extinguisher at the base of the fire; Squeeze the lever slowly and evenly; Sweep the nozzle from side to side. 2. An interview with a Certified Nurse Aide (CNA 2) was conducted on 06/07/06 at 3:32 PM. CNA 2 was asked to point out the location of fire extinguishers and pull stations. CNA 2 identified the location of fire extinguishers, but did not know what a pull station was, or where to find a pull station to activate the fire alarm. When asked how she might utilize power provided by the generator, CNA 2 indicated that she did not know where to plug equipment in in the event the facility was on generator power. CNA 2 stated that she received fire/emergency training one month ago. 3. An interview with the maintenance director was conducted on 06/07/06 at 4:03 PM. The maintenance person indicated that inservicing for fire/emergency procedures is conducted on a yearly basis for all employees, and during training for all new hires.	F 518		