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
	465055	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHABILITATION AND NURSING	41 SOUTH 900 EAST SALT LAKE CITY, UT 84102

(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 252 SS=B	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based upon observation, it was noted that the facility did not provide a safe, clean, or homelike environment. Findings include: 1. Observations from 7/31/06 to 8/3/06, of the first and second floor resident rooms, bathrooms, and common areas revealed doors in need of repair: -The door to room 123 had a 32 inch gouge. -The door to room 121 displayed a prominent gouge. -The door to room 112 was gouged and the bathroom door was marred. -The door to room 204 had a 18 inch scratch and the bathroom door had numerous scratches spanning the width of the door along the bottom 1/4 of the door. -The hall door to room 202 had multiple scratches, most of which were at least 30 inch. -The hall door to room 201 displayed numerous scratches on the bottom 1/4 of the door. One prominent gouge measured 26 inch x 2 inch. -The door to room 206 had a 30 inch x 2 inch marred area. -The door to room 219 had a worn finish and numerous scratches.	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F252 **Corrective Action:** The following room doors will be repaired. Room 112,121,123,201,202,204,206,219. The hole in the ceiling in room 119 was repaired during the survey. This was incorrectly stated on the 2567 as room 219. There was no hole in room 219 ceiling. The faucet in room 119 will be replace. This was also incorrectly stated on the 2567 as room 219. **Residents that could be affected:** All residents could be affected by an environmental problem. **Measure to prevent recurrence:** Maintenance supervisor will do weekly rounds to check for any issue that needs repair. We also have maintenance logs at each nursing station to report any repairs that need to be done. These are checked each weekday by the maintenance supervisor or his designee.	9/19/06

8/30/06 POC acceptable completion date 9/19/06 Quambarke RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (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 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 252	Continued From page 1 2. The ceiling in room 219 had a hole approximately 18 inch x 8 inch. 3. The bathtub faucet in the bathroom in room 219 was corroded and broken, exposing a sharp edge.	F 252	**Monitoring/ quality assurance:** The maintenance supervisor will report to the PI committee, (Quality Assurance Committee), for four months to monitor the progress and outcomes of the weekly rounds. The P.I Committee will then determine if further audits are need . **Responsible Party:** The Maintenance supervisor or his designee will monitor.	
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, it was determined that the facility did not ensure that it was free of medication error rates of five percent or greater. There were 46 opportunities for medication error, 4 medication errors occurred, which represents a facility medication error rate of 8%. (Resident identifiers: 1, 20, and 21). The medications that were administered to residents during survey observations were assessed further through medical record review and interviews with the staff. The medication administration was observed as facility nurses prepared and delivered morning medications on August 1, 2006 and August 2, 2006. As each medication was put into each individual medication cup, the information contained on the medication container was noted. Then, as well as after, the label was also checked against what the Medication Administration Record (MAR) had	F 332	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F 332 E **Corrective action for identified problem** Resident # 20 Medication Variance Incident Report completed on 08/01/06. RN 1 counseled on 08/28/06	

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F 332	Continued From page 2 documented. Later, after the medication administration was completed, the information obtained during the observation was compared with the Physician's Orders in each residents Medical Record. Findings include: 1. Resident 20 was admitted to the facility on 6/11/04 with diagnoses including hypertension, dementia, Parkinson's disease, and anxiety. On 8/1/06, during the morning medication pass, RN 1 (Registered Nurse) was observed administering morning medications to Resident 20. Resident 20 took her medications, coughed, and spit out her Lisinopril onto the floor. RN 1 was observed to clean up the floor and sign off the Lisinopril, but she did not administer another dose of the medication. Lisinopril is a medication used in the treatment of hypertension (also known as "high blood pressure"). 2. Resident 21 was admitted to the facility on 5/26/06 with diagnoses including hypertension and fracture. On 8/2/06, during the morning medication pass, LPN 1 (Licensed Practical Nurse) was observed administering Aspirin (81 milligrams) to Resident 21. The order for the Aspirin appeared in the resident's MAR, but could not be found in the resident's Physician Orders. The most recent certification orders, the admission orders, and all the telephone orders were checked, and the order for Aspirin could not be verified. 3. Resident 1 was admitted to the facility on	F 332	Resident #21 admission orders from 06/30/06 were entered in computer on 08/02/06. Orders were then checked by LPN 1 and new medication and treatment sheets were printed with the aspirin order omitted. Medication Variance Incident report complete for Resident # 21 on 08/02/06. Resident 1 -Nurse failed to place copy of order for multi antibiotic eye ointment in chart per policy. LPN 2 counseled on 08/28/06 regarding policy for orders. LPN 2 counseled on Medication pass administration policy and procedure on 08/28/06 related to failure to administer Miralax as ordered. **Identification of residents potentially affected** All residents have the potential to be affected. **Measures to prevent recurrence** The Director of Nursing Services (DNS) or designee will inservice Licensed Nurses on Medication Administration Policy and Procedure By 08/31/06. Triple check will be done monthly on all patients to verify accuracy of medication orders.	

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F 332	Continued From page 3 6/19/03 with diagnoses including stroke, quadriplegia, and seizure disorder. On 8/2/06, during the morning medication pass, LPN 2 administered "Multi ABX" ophthalmic ointment to Resident 1's right eye. The order for the ointment appeared in the resident's Medication Administration Record, however the order could not be found in the resident's Physician's Orders. The most recent certification orders, the admission orders, and all of the telephone orders were investigated, but the order for the ointment could not be verified. 4. Resident 1 was admitted to the facility on 6/19/03 with diagnoses including stroke, quadriplegia, and seizure disorder. On 8/2/06, during the morning medication pass, LPN 2 signed off that she administered the medication, "Miralax" (17 grams) to Resident 1 in the entry in the resident's MAR. She was not observed to administer the medication as ordered. LPN 2 was interviewed and asked why she did not administer the medication, but signed off that she had done so. She acknowledged that she did not give the medication, but signed off that she had done so. She stated that she "should have asked (resident 1) if he wanted" to have the medication that morning.	F 332	24-hour chart check for new orders will be implemented by 09/05/06. **Monitoring/Quality Assurance** The Director of Nursing or designee will develop an audit tool. This audit tool will monitor compliance of 24 hour chart checks and medication administration per Policy and Procedure. The DNS or designee will do weekly random audits on 24 hour chart checks and random audits on Medication administration with Licensed Nurses to determine the level of compliance. Weekly audits will be done for six weeks. At the completion of the audits the DNS or designee will report to the Performance Improvement Committee (Quality Assurance). The DNS will be responsible for continued compliance. Completion date of 19 September 2006.	

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F 368 SS=B	483.35(f) FREQUENCY OF MEALS Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interviews it was determined that the facility was not offering daily bedtime snacks to the residents. Findings Include: 1. During the group meeting 8 out of 14 residents reported that night time snacks were not offered on a daily basis. 2. Confidential interviews held with 5 additional residents resulted with 3 of the 5 residents stating that snacks were not being offered at bedtime. 3. In an interview with the Dietary Supervisor and Administrator, on 8/31/06 at 3:00 PM, she stated that bedtime snacks (fruit) were placed in the	F 368	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F 368 B **Corrective action for identified problem** No individual resident identified. **Identification of residents potentially affected** All residents have the potential to be affected. **Measures to prevent recurrence** The Staff Development Coordinator (SDC) or designee will inservice by 08/31/06 Certified Nursing Assistants (CNA) on offering of HS (bedtime) snacks to residents. CNA will report to the Licensed Nurse (LN) at the end of each HS snack pass whether or not each resident accepted the snack. The LN will record the percentage on the Treatment Sheet starting 09/01/06.	

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F 368	Continued From page 5 lobby on the reception desk and resident's could help themselves. Snacks were not verbally offered or passed to individual resident rooms unless ordered by the physician.	F 368	The director of Dietary Services will inservice dietary staff by 21 August 2006 to ensure understanding that an HS snack tray is sent to each unit each evening. **Monitoring/Quality Assurance** The Director of Nursing (DNS) or designee will develop an audit tool. Random interviews will be done with residents to ensure offering of HS snack. Random Audits will be done to determine if a tray of HS snacks is being sent to each Nursing Station. Weekly audits will be done for six weeks. At the completion of the audits, the DNS or designee will report to the Performance Improvement Committee (Quality Assurance). The DNS will be responsible for continued compliance. Completion date of 19 September 2006.	
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview it was determined that the facility did not maintain accurate physician orders or did not have lab and x-ray results on the active charts for 6 of 19 sample residents. Resident identifiers: 1, 3, 7, 8, 10, 21. Findings include: 1. Resident 3 was admitted on 7/29/06 with diagnoses that included epiglottis cancer, chronic obstructive pulmonary disease, hypertension, depression, and cerebral ischemic attacks.	F 514	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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F 514	Continued From page 6 A review of resident 3's medical record was completed on 8/2/06. A physician's order dated 7/31/06 indicated ^ (increase) TF (tube feed) to: 2Cal 45cc (cubic centimeters)/ hr (hour) x (times) 24 (hours). H2O (water) flush to be: 250cc q (every) 6 (hours). No documentation was found on the order indicating that it had been noted. The physicians order was not transcribed to the MAR (medication administration record) until 08/02/06 at 8:55 AM. An interview with a staff LPN occurred on 8/2/06 at 8:35 AM. LPN 2 stated that the type and rate of the tube feeding had not yet been documented on the residents MAR, that the only flush of the gastrostomy tube occurred during medication administration and she was not aware of any other order for flush. 2. Resident 10 was admitted on 11/22/04 with diagnoses that included psychotic disorder, malignant neoplasm of the brain, hemiplegia, esophogeal reflux, bipolar I disorder. A review of resident 10's medical record was completed on 8/1/06. Resident 10's MAR (medication administration record) listed the following medications: KCl (potassium chloride) 20 mg (milligrams) po (by mouth) TID (three times a day), methadone 2.5 mg po BID (two times a day) at 12:00 PM and 6:00 PM, methadone 5 mg po qam (each morning).	F 514	F 514 E **Corrective action for identified problem** Resident # 3 Incident report completed on 08/02/06,now receiving tube feeding as ordered. Resident # 10 Clarification order written for methadone and KCl on 08/02/06. Resident # 10 Incident report completed 08/02/06. Resident # 10 Side rail order written on 08/02/06. Resident # 1 Labs were placed in Medical Record on 07/31/06. Resident # 6 Labs were placed in Medical Record on 08/01/06. Resident # 7 X-Ray results placed in Medical Record on 08/02/06. Resident # 21 Orders for 30 June 2006 Admission were entered in computer on 08/02/06. Orders were then checked by LPN # 1 and medication and treatment sheets were printed with the aspirin order omitted on 08/02/06. Medication Variance Incident Report completed for Resident # 21 on 08/02/06. **Identification of residents potentially affected** All residents have the potential to be affected.	

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F 514	Continued From page 7 A physician recertification order dated 7/28/06 indicated KCl 20 mg po TID, and methadone 2.5 mg po qd (daily). An interview with a staff LPN occurred on 8/1/06 at 3:15 PM. LPN 4 stated that the potassium chloride that resident 10 was receiving was 20 meq (milliequivalents) TID, and that the recertification order for the methadone was inaccurate LPN 4 stated that a clarification order would be obtained for both the KCl and the methadone. An order dated 8/1/06 stated: Methadone clarification, methadone 5 mg po am qd, methadone 2.5 mg po 12 et (and) 1800 (6 PM), potassium 20 meq po TID. Resident 10 was observed in bed with 1/2 siderails up times 2. Resident 10's bed safety evaluation indicated that the resident was utilizing two 1/2 siderails. No order for siderails was found in resident 10's medical record. An interview with the facility MDS (minimum data set) coordinator occurred on 8/2/06 at 2:15 PM. The MDS coordinator stated that there was no order on resident 10's medical record for siderail use. An order for "Siderails x (times) 2 for positioning / transfers" was obtained on 8/2/06. Resident 1 was admitted on 8/5/06 with diagnoses that included osteoporosis, cerebral vascular accident, hemiplegia, hemiparesis, and seizure disorders.	F 514	**Measures to prevent recurrence** The Director of Nursing Services (DNS) will inservice licensed nursing staff on lab policy, noting of orders and policy and procedure for siderails on 08/31/06. Triple check will be done monthly to verify accuracy of medication orders for all patients. Lab system has been reviewed by DNS. System will be changed to ensure lab results are placed in the medical record timely. **Monitoring/Quality Assurance** The Director of Nursing Services (DNS) or designee will develop an audit tool. Weekly random audits will be done to ensure that lab results are received and placed in the medical record in a timely manner. An additional audit tool will be developed: Weekly, random audits will be done to check that physician's orders are noted. Weekly audits will be done for six weeks. At the completion of the audits, the DNS or designee will report to the Performance Improvement Committee (Quality Assurance). The DNS will be responsible for continued compliance. Completion date of 19 September 2006.	

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F 514	Continued From page 8 Resident 1's medical record was reviewed on 7/31/06. Resident 1 had telephone orders from the primary care physician, dated 7/25/06, for "CBC (complete blood count), CMP (complete metabolic profile), Tegretol level (blood test to measure medication level) ", and another telephone order, dated 7/26/06, for "Zonegram level (blood test to measure medication level) ". Blood was drawn on 7/26/06 and the lab reporting date was 7/29/06. There was no lab results found on resident 1's medical record. Resident 6 was admitted on 5/18/06 with diagnoses that included right femoral neck fracture, diabetes II, rheumatoid arthritis, hypertension, gastric reflux, below the knee amputation and acute renal failure. A review of resident 6's medical record was completed on 8/1/06. A physician's order dated 7/25/06 for a Urinalysis, CBC and CMP was found on the chart. On 8/2/06 when a review of the chart was completed no documentation was found on the chart of the results of these tests. On 8/1/06 at 2:30 PM in an interview with Director of Nurses (DON) she stated that the doctor's request that the laboratory results are to be placed in their facility mail box before being placed on the chart. The lab results were later found and placed on the chart. The CBC and	F 514		

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F 514	Continued From page 9 CMP had been drawn on 7/26/06, results reported on 7/27/06. The Urinalysis had been collected on 7/25/06 with results returned on 7/27/06. Doctor's initials were found on the bottom of the reports acknowledging the results. Resident 7 was admitted on 5/18/06 with diagnoses that included right fractured hip, muscular dystrophy, raynaud's syndrome, scleroderma, and osteoporosis. A review of resident's 7 medical record was completed on 8/1/06. A physician s order dated 7/24/06 for a right hip x-ray was found on the chart. No results for this procedure were located on the chart when reviewed on 8/2/06. On 8/1/06 at 2:30 PM in an interview with DON she stated that the doctor's request that the x-ray results are to be placed in their facility mail box before being placed on the chart. The x-ray results were later found and placed on the chart. The x-ray had been taken on 7/24/06 and the results faxed to the facility on 7/25/06. 3. Resident 21 was admitted to the facility on 5/26/06 with the diagnoses of hypertension, aftercare for fracture, anemia, and constipation. On 8/2/06, a Nurse-Surveyor observed the medication adminstration of resident 21's morning medications. After the medication administration was completed, the information obtained during the observation was compared with the physician's orders in resident 21's medical	F 514		

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F 514	Continued From page 10 record. Refer to F332. The current recertification orders, dated August 2006, displayed in this resident's medical record omitted all of the medications for the resident. During an interview on 8/2/06, with the Assistant Director of Nursing Services (ADON), he acknowledged that all of resident 21's medications had been omitted from the August 2006 recertification orders. He stated at that time that he would follow up on the situation with the Medical Records Department to ensure the recertification orders were correct.	F 514		
~~F 518~~ SS=E	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 interview with staff, it was determined that the facility did not sufficiently train all employees regarding appropriate emergency procedures. Specifically, two nurses and five certified nurses aides (CNA's) were interviewed. One charge nurse and three CNA's could not correctly identify appropriate actions to be taken in an emergency. Findings include:	F 518	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F518 **Corrective Action:** The following staff has completed an inservice on the correct locations of the fire alarm pull stations, and how to activate them. LPN # 3, C.N.A. #1, C.N.A. #2, C.N.A. #3. This was completed by the SDC (Staff Development Coordinator) on 8/29/06 **Residents that could be affected:** Disaster and Emergency Preparedness could affect all residents.	9/19/06

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
	465055	A. BUILDING _____ B. WING _____	08/03/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEDERAL HEIGHTS REHABILITATION AND NURSING	41 SOUTH 900 EAST SALT LAKE CITY, UT 84102

(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 11 1. On 8/1/06, Licensed Practical Nurse 3 (LPN) was interviewed. She could correctly point out the fire alarm lights, but did not know where the pull stations to activate the alarms were located or how to engage the alarm system. 2. On 8/1/06, CNA 1 was interviewed. She did not know where the pull stations to activate the alarms were located and could not describe how to activate the alarm system. 3. On 8/1/06, CNA 2 was interviewed. She stated she was "not sure" where the pull stations for the fire alarms were located and could not describe how to activate the alarm system. 4. On 8/2/06, CNA 3 was interviewed. She stated, "I'm sorry, I don't know that" in response to questioning regarding where the fire alarm pull stations where or how to activate the fire alarm system.	F 518	**Measures to prevent recurrence:** We will continue our ongoing training during the new employee orientation. There will also be a general inservice held on 9/14/06 to review with staff the locations and how to activate the pull stations. **Monitoring/Quality Assurance** Staff Development Coordinator will develop an audit tool. This audit tool will monitor staff knowledge of the fire alarm pull stations. Weekly random audits for six weeks will be done. The Staff Development Coordinator or designee to interview staff's knowledge on the location and operation of fire alarm pull stations. At the completion of the audits the Staff Development Coordinator will report to the Performance Improvement Committee (Quality Assurance Committee). The Committee will determine the need for further audits/reports. The Staff Development Coordinator and Executive Director will be responsible for continued compliance.	

Federal Heights Rehabilitation
and Nursing Center

A Kindred Healthcare Community

Provider/Supplier Identification Number: 465055
Date: 08/29/06
Re: Typographical Error

Page 6 of 12 on the 2567 under this requirement is not met as evidenced by: Resident Identifiers 1,3,7,8,10, 21 are listed.

Findings for this deficiency F 514 on page 9 of 12 identify resident 6.

Resident 6 was admitted on 05/18/06. Resident 8 was admitted on 11/10/98.

Corrective action for identified residents was done for resident 6 for F 514.

Possibly, page 5 of 12 where resident identifiers are listed is a typographical error and included resident 8 instead of resident 6.

On F tag 252 room 219 was incorrectly identified, it was room 119 that had the items which needed correction.

Thank you,

Kelly Snowball Executive Director

41 South 900 East Salt Lake City, Utah 84102
801.532.3539 801.328.3926 Fax

Memorandum to be placed in file

Date: September 19, 2006
From: Greg Bateman
Subject: Administrator's request for an extension to Tag F-252 at Federal Heights, for the survey dated 8/3/2006.

Kelly Snowball requested an extension to Tag F-252 due to time constraints and cost of replacing all the facility doors. I contacted Mr. Snowball on September 19, 2006 and informed him that F-252 was cited at a scope and severity of a "B" and is therefore considered "Substantial Compliance". The impact of this is that this office would not be conducting any follow-up activity to determine if F-252 had been corrected. Therefore, an extension to F-252 is not necessary. Mr. Snowball expressed that the facility would continue with their plans to replace the affected doors.

Federal Heights Rehabilitation
and Nursing Center

A Kindred Healthcare Community

September 18,2006

Mr. Greg Bateman
Bureau of Health Facility Licensing
Certification and Resident Assessment
288 North 1460 West
Salt Lake City, UT 84114-4103

REQUEST FOR EXTENSION ON F TAG 252

Dear Mr. Bateman

In our Plan of Correction we identified that we would have the following doors repaired. Room 123,121,112,204,202,201,206,219. Due to a problems with the supplier and the contractor, which we hired to repair the doors. We will not be able to meet our correction date or 9/19/06.
We are requesting a extension of 60 days to complete this project.

We have attached a letter for our Contractor, which show our efforts to get this completed.

If you have any questions regarding this, please contact Kelly Snowball at (801) 532 3539.

Sincerely,

Kelly Snowball
Executive director
Federal Heights Rehab.

41 South 900 East Salt Lake City, Utah 84102
801.532.3539 801.328.3926 Fax

September 18,2006

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Bureau of Health Facility Licensing
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Kelly Snowball
Executive director
Federal Heights Rehab.

CAMERON CONSTRUCTION
573 West 3560 South, Suite 1
Salt Lake City, UT 84115
Phone: 801-268-3584
Fax: 801-268-3678

PROPOSED CHANGE ORDER
No. 00002

COPY

TITLE: 1st & 2nd Floor Door Guards

DATE: 9/7/2006

PROJECT: Federal Heights Rehab Phase II

JOB: 1109

TO: Kindred Care Health Care
10653 South Jordan River Pkwy
Suite 200
South Jordan, UT 84095

ATTN: Joe Briley

DESCRIPTION OF PROPOSAL

Furnish and install plastic door guards on all patios and room doors on the 1st and 2nd floors.

Item	Description	Quantity	Units	Unit Price	Net Amount
00001	Door Guards	65.000	Ea.	$105.00	$7,275.45
00002	Cameron Construction time to install door guards	16.000	M.H.	$40.00	$640.00
00003	Tools and Equipment	1.000	L.S.	$65.00	$65.00
00004	Project Management / Project Admin	2.000	L.S.	$68.27	$136.54
00005	Construction Fee	1.000	L.S.	$810.00	$810.00
				Total:	**$8,926.99**

Under this proposal the contract time will not be changed.

Utah Department of Health

SEP 18 2006

Bureau of Health Facility Licensing,
Certification and Resident Assessment

ACCEPTED:

By: _____ **By:** _____ **By:** John E. Cameron Jr.
Joe Briley Cameron Construction John E. Cameron Jr.

Date: _____ **Date:** _____ **Date:** 9-11-06

ROBERT I. MERRILL COMPANY

801-263-2700 (FX 263-2785), 4049 SOUTH 210 WEST, SALT LAKE CITY, UT 84107 tel: 801-263-2700 FAX: 801-263-2785

Customer:
CAMERON CONSTRUCTION
573 WEST 3560 SOUTH #1

SALT LAKE CITY, UT 84115

Ship to:
Federal Heights Rehab
Attention Steve

BUS: 268-3584
FAX: 268-3678

QUOTATION

Quotation No : 29756
Date : 06 SEP 2006
Account : CARCON
Page No. : 1

Salesperson: RH Ship Via: FOB: Terms: Net 30 days

Qty	Description	Unit Price	Extension
20	Hager kydex armor plates .081 x 36" x 42" dark gray LEAD TIME PROX 5 WEEKS ADDITIONAL FREIGHT WILL APPLY	105.00	2,100.00

Product Sub-total	2,100.00
UTAH @6.600%	138.60
Total	2,238.60

650 ea

$105.00 + 6.6 Tax = $7,275.45

Utah Department of Health

SEP 18 2006

Bureau of Health Facility Licensing,
Certification and Resident Assessment

Ross Hyle

The above prices are quoted subject to acceptance within 30 days and credit approval by an officer of our company. State and local taxes are not included unless specifically noted. Material will be billed proportionately as shipped.
Full amount of invoice due when rendered--retainage not acceptable. On shipments made by common carrier consigned to the customer, all claims for damages in transit must be filed by consignee. We do not include costs of unloading, storage or protection of material at jobsite.