PRINTED: 06/12/2006 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ 465101 05/25/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 416 NORTH STATE HURRICANE REHABILITATION CENTER HURRICANE, UT 84737 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION IĐ (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 272 483.20, 483.20(b) COMPREHENSIVE SS=E ASSESSMENTS Hurricane Rehabilitations POC 07/14/06 The facility must conduct initially and periodically F 272 a comprehensive, accurate, standardized reproducible assessment of each resident's Section V on the annual assessment functional capacity. dated 03/22/06 for resident 9 will be completed by 06/26/06. A facility must make a comprehensive Section V on the annual assessment assessment of a resident's needs, using the RAI dated 03/23/06 for resident 4 will be specified by the State. The assessment must completed by 06/26/06. include at least the following: An audit tool will be developed by DON Identification and demographic information; or designee by 06/26/06 to assess Customary routine; comprehensive MDS to ensure section Cognitive patterns: V has been completed. Communication: Audits will be conducted by DON or Vision: designee bi-monthly x 2, monthly x 2 Mood and behavior patterns; and randomly thereafter x 6 months, Psychosocial well-being: Audits will be presented in the QA Physical functioning and structural problems; meetings and changes will be made as Continence: needed to ensure continue compliance. Disease diagnosis and health conditions: The first QA meeting is to be held by Dental and nutritional status; 07/05/06. Skin conditions: Addendur: Activity pursuit; 7/5/06 - Per teteplune coul Medications: Special treatments and procedures: Call & administrator of Discharge potential; DON well attend stal aging opensored MDS harmy in Documentation of summary information regarding

the additional assessment performed through the resident assessment protocols; and

Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:

Based on chart review and interview it was determined that the facility did not make a comprehensive assessment of residents' needs. Specifically, 2 of 10 sample residents did not

(XB) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE toministrator

EP652069708 US

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 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 that these documents are made available to the facility. program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility (D: UT0096

JUN 2 6 2006 continuation short Page 1 of 29

Bureau of Health Facility Licensing, Certification and Resident Assessment

PRINTED: 06/12/2006 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SI COMPLE		
		465101	B. WING _		05/2	5/2006	
	ROVIDER OR SUPPLIER ANE REHABILITATIO	N CENTER		REET ADDRESS, CITY, STATE, ZIP CO 416 NORTH STATE HURRICANE, UT 84737	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	Findings included: 1. Resident 9 was a in September of 19 2006 with diagnose neoplasm of the centypertension and pertension and pertension and pertension and pertensional features. On 5/24/06, a review was completed. Resident 9 had the active chart: 2/3/05 set), 08/04/05 quarm MDS. Section V of the annot completed. The Protocols were not triggered items were care. Resident 4 was add November of 2004 depression, congestypertension, pepti	prehensive minimum data set its. (Resident identifiers: 4, 9.) priginally admitted to the facility 97 and readmitted in April of its that included malignant incum, congestive heart failure, resenile dementia with we of resident 9's active chart following assessments on the quarterly MDS (minimum data terly MDS, 3/22/06 annual mual MDS dated 3/22/06 was a Resident Assessment marked to indicate which re to be included in the plans of mitted to the facility in with diagnoses that included	F 272				
	completed on 5/25/ Section V of the 3/2 completed. The Re	t 4's medical record was 706. 23/06 annual MDS was not sident Assessment Protocols indicate which triggered items	·				
		·					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID; SLDN11

Facility ID: UT0095

If continuation sheet Page 2 of 29

P. 04

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

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	PF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE S COMPLE	
		465101	B. WI	1G		05/2	5/2006
	ROVIDER OR SUPPLIER	ON CENTER		410	EET ADDRESS, CITY, STATE, ZIP COD 6 NORTH STATE JRRICANE, UT 84737		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	IĎ PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	were to be included columns indicating Assessment Docur Planning Decision-plan" were blank. On 5/22/06 at 4:00 (DON) was intervied started working for that prior to this is I home. In addition of 2006 an MDS cowith the MDSs.	d in the plan of care, The the "Location and Date of RAP mentation and the "Care check if addressed in care PM, the Director of Nursing wed. The DON stated that he the facility in June of 2005 and has never worked in a nursing the DON stated that in March onsultant was brought in to help		272	F 275		
	WHEN REQUIRED A facility must condassessment of a revery 12 months. This REQUIREMED by: Based on chart reverence on the comprehensive resembled in the 12 identifiers 1, 2, 3, 4. Findings included: 1. Resident 3 was facility in August of	duct a comprehensive sident not less than once NT is not met as evidenced liew and interview it was added to a seessment every 12 ly, 5 of 10 sample residents thensive assessments assessments assessments assessments assessments assessments assessments assessments.	Г	9	A Comprehensive Medicare Assessment completed 04/found in resident 3's chart of An annual assessment was with an ARD of 03/22/05 for 06/22/2006. An annual assessment was with an ARD of 01/18/05 for 1 on 06/22/2006. An annual assessment was with an ARD of 03/21/05 for 06/21/06. An annual assessment was with an ARD on 01/04/06 for 06/21/06. An annual assessment was with an ARD off 11/29/05 for 06/21/06. An audit tool will be developed or designee by 06/26/06 to annual assessment to ensucomprehensive assessment.	14/06 was on 06/21/06. s completed resident 9 s completed resident 2 s completed resident 7 s completed or resident 4 ped by DON assess ire	07M4/06

FORM CMS-2567(02-89) Previous Vorsions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 3 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465101	B. WING		05/2	5/2006
	ROVIDER OR SUPPLIER ANE REHABILITATION		41	EET ADDRESS, CITY, STATE, ZIP CODE 16 NORTH STATE URRICANE, UT 84737		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 275	resistant staph au A review of reside completed on 05// Resident 3 had th (MDS) assessme quarterly, 11/02/0 5/1/05 annual, 07 quarterly. Based on the last 05/01/05, residen MDS assessment No other annual a after 5/1/05. 2. Resident 9 wa 1997, and readmid diagnoses that ince the cecum, conge presentle dement A review of reside completed on 5/2 Resident 9 had th on the active char quarterly, 3/22/06 Based on the last 3/22/06, resident assessment completed completed	tract infection, methicillin reus and hypertension. ent 3's active chart was 23/06. e following minimum data set ints on the active chart: 9/20/04 4 quarterly, 1/30/05 annual, /31/05 quarterly, 10/30/05 annual assessment date of t 3 should have had an annual completed by 4/30/06. essessments were found dated in Service heart failure, hypertension, la with delusional features. ent 9's active chart was 4/06. e following MDS assessments t: 2/3/05 quarterly, 8/4/05 annual. annual assessment date of 9 should have had an annual oleted by 3/22/05. essessments were found dated in the strength of the	F 275	completed in the 12 months to Audits will be conducted by Designee bi-monthly x 2, more and randomly thereafter x 6 roughlish will be presented in the meetings and changes will be needed to ensure continued compliance. The first QA meeting be held by 07/05/06.	OON or othly x 2, nonths. e QA e made as	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6LDN11

Facility ID: UT0098

If continuation sheet Page 4 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLE		
		465101	B, WII	NG	· · · · · · · · · · · · · · · · · · ·	05/2	5/2006	
	ROVIDER OR SUPPLIER	N CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 16 NORTH STATE IURRICANE, UT 84737			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT 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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 275	Continued From pa	ige 4	F:	275				
	September 2001 at 2002 with diagnose condition, osteroard Resident 1's medic 5/23/06. Resident 1 had the assessments on th 10/6/05 and 4/13/0 done on 1/18/06. Eassessment date the annual assessment	admitted to the facility in and readmitted in October of es that included of a brain thritis and fractured femur. al record was reviewed on following quarterly MDS e chart; 4/4/05, 7/4/05, 6. An annual assessment was eased on the annual nere should have been an tidone on 1/18/05. There were nents noted in the chart prior to						
	2003 with diagnose gastrointestinal ble Resident 2's medic 5/24/06. Resident 2 had the assessments on his 7/16/05. An annua 3/21/06. Based on there should have the completed by 3/21/assessment for the 5. Resident 7 was of 2004 and readministration.	following quarterly s chart; 1/16/05, 4/16/05 and l assessment was done on the annual assessment date been an annual assessment 05. There was no annual year 2005. admitted to the facility in May litted in May of 2006 (1 day						
	hospital visit) with d	liagnoses that included ondyle, cerebraliar vascular						

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 5 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		G	COMPLE	
		465101	B. Wil	٧Ġ		05/2	5/2006
	ROVIDER OR SUPPLIER ANE REHABILITATIO	ON CENTER		4	REET ADDRESS, CITY, STATE, ZIP CODE 16 NORTH STATE IURRICANE, UT 84737		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 275	Continued From pa	age 5	F	275			
	disease, diabetes	and atrial fibriliation.					
	Resident 7's media 5/23/06.	cal record was reviewed on					
	assessments on h 10/3/05. A signific completed on 3/21 was not found on t 6. Resident 4 was November of 2004 depression, conge hypertension, pept	e following quarterly is chart; 4/4/05, 7/4/05, cant change assessment was /06. An annual assessment the chart for 1/4/06. admitted to the facility in with diagnoses that included estive heart failure, ic ulcer disease, Alzheimer's ascular accident and					
	A review of resider completed on 5/25	nt 4's medical record was i/06.					
	on the active chart quarterly MDS, 5// 3/23/06 incomplete	e following MDS assessments: 12/2/04 annual MDS, 2/28/05 30/05 quarterly MDS and a annual MDS. An annual lue on or about 12/4/05. No was found.					
	(DON) was intervied started working for that prior to this he home. In addition of 2006 an MDS consists the MDSs becomes a problem. The no other MDSs that	PM, the Director of Nursing ewed. The DON stated that he the facility in June of 2005 and has never worked in a nursing the DON stated that in March consultant was brought in to help cause he realized that there he DON stated that there were not were done for the above or those found on the medical					

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility (D: UT0098

If continuation sheet Page 6 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUBBLIED/CLIA

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPL	
		465101	B. WI	4G _	***************************************	05/2	25/2006
	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 116 NORTH STATE HURRICANE, UT 84737		
(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 CORRE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 276 SS=E	A facility must ass quarterly review in and approved by conce every 3 mon. This REQUIREME by: Based on chart redetermined that thresidents, using thresidents, using thresidents, using thresidents. Resident Specifically, 4 of 1 have quarterly assmonths. Resident Findings included: 1. Resident 3 was facility in August of 2006 with diagn sclerosis, urinary tresistant staph august of 2006 with diagn sclerosis, urinary tresistant staph august of 5/23/6 Resident 3 had the (MDS) assessment quarterly, 11/2/04 5/1/05 annual, 7/3 quarterly. Based on the last of 10/30/05, resident	view and interview it was to facility did not assess to quarterly review instrument, than once every 3 months. O sample residents did not assesments at least every 3 identifiers 2, 3, 4, 9. coriginally admitted to the f 1987, then readmitted in April coses that included multiple ract infection, methicillin reus and hypertension.	F	276	E 276	an ARD an ARD an ARD an ARD an ARD of an ARD o	07/14/06

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465101	B. WIN	G		05/2	5/2006
	ROVIDER OR SUPPLIER ANE REHABILITATIO	N CENTER	,	410	ET ADDRESS, CITY, STATE, ZIP CO 5 NORTH STATE JRRICANE, UT 84737		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 276	Continued From pa	ge 7	F 2	76			
	No quarterly assess between 10/30/05 a	sment was found dated and 1/31/06.					
	facility in February of April of 2006 with d malignant neoplash	originally admitted to the of 1997, and readmitted in iagnoses that included n of the cecum, congestive tension, presentle dementia ures.					
	A review of resider completed on 5/23/	nt 9's active chart was 06.					
		following MDS assessments 2/3/05 quarterly, 8/4/05 nnual.					
	9 should have had	e assessment dates, Resident quarterly assessments out 5/3/05, and 11/4/05.					:
	No quarterly assess before 5/3/05 or 11/	sments were found dated on or /4/05.					
	diagnoses that inclugastrointestinal blee	ed and diabetes.					
	5/23/06.	al record was reviewed on					
	assessments on his	following quarterly MDS s chart 1/16/05, 4/16/05 and assessment was done on					

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 8 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	ILDING	PLE CONSTRUCTION S	(X3) DATE SI COMPLE		
		465101	B. WII	NG		05/2	5/2006	
	PROVIDER OR SUPPLIER ANE REHABILITATIO	ON CENTER		41	EET ADDRESS, CITY, STATE, ZIP CODE 6 NORTH STATE URRICANE, UT 84737			
(X4) ID PRÉFIX TAG	(EACH DEFICIENCY	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 AF DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE	
F 276	3/21/06. There we between the quarte the annual MDS da assessment was de	ere no quarterly assessments erly MDS dated 7/16/05 and ated 3/21/06. A quarterly fue on or about 10/16/05 and ere no other quarterly	F:	276				
	November of 2004 depression, conget hypertension, pepti disease, cerebrova constipation. A review of resident	ic ulcer disease, Alzheimer's ascular accident and nt 4's medical record was						
	on the active chart: quarterly MDS, 5/3/ 3/23/06 incomplete August 30th a quar	i/06. if following MDS assessments: 12/2/04 annual MDS, 2/28/05 io/05 quarterly MDS and a annual MDS. On or about rerly MDS should have been the assessment was found in the						
	(DON) was intervie started working for that prior to this he home. In addition to f 2006 a MDS con with the MDSs becaus a problem. The	PM, the Director of Nursing ewed. The DON stated that he the facility in June of 2005 and has never worked in a nursing the DON stated that in March insultant was brought in to help cause he realized that there he DON stated that there were at were completed for the above						

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 9 of 29

P. 11

		I AND HUMAN SERVICES & MEDICAID SERVICES				FORM	I APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	OMB NO. 0938-039* (X3) DATE SURVEY COMPLETED	
		465101	B. Wit	NG		05/2	25/2006
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1	
HURRICA	ANE REHABILITATIO	N CENTER			16 NORTH STATE !URRICANE, UT 84737		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 276	Continued From pa	ge 9	F:	276			
	residents except for charts.	those found on their medical					
F 278 SS=D	483.20(g) - (j) RES	DENT ASSESSMENT	F2	278	F 278		07/14/06
	The assessment m resident's status.	ust accurately reflect the			A significant change will be comby 06/26/2006 in section P-4 on Quarterly MDS dated 05/30/05,	pleted	1
	A registered nurse each assessment was participation of heal	must conduct or coordinate vith the appropriate th professionals.			Quarterly MDS dated 08/29/05 a Annual MDS dated 03/23/06 to accurately reflect resident 4's st A significant change was complete.	atus	
:	A registered nurse assessment is com	must sign and certify that the pleted.			06/21/06 in section C-1 on Admi MDS dated 03/18/06 to accurate reflect resident 5's status.	ssion	
	Each individual who assessment must s that portion of the a	completes a portion of the ign and certify the accuracy of ssessment.			An audit tool will be developed by or designee by 06/26/06 to asse accuracy of MDS. Audits will be conducted by DON	\$6	
	willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessmen	d Medicaid, an individual who ally certifies a material and resident assessment is ney penalty of not more than essment; or an individual who ally causes another individual and false statement in a all is subject to a civil money than \$5,000 for each			designee bi-monthly x 2, monthly and randomly thereafter x 6 mor Audits will be presented in the Q meetings and changes will be mineeded to ensure continued compliance. First QA meeting to be held by 07/05/06	/ x 2, iths. A	
	Clinical disagreeme material and false s	nt does not constitute a tatement.					

FORM CMS-2557(02-99) Previous Versions Obsolete

by:

This REQUIREMENT is not met as evidenced

Based on record review and observation, it was

Event ID: 5LDN11

Facility |D: UT0096

If continuation sheet Page 10 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPL ILDING	LE CONSTRUCTION	(X3) DATE S COMPLE		
		465101	a. wii	NG		05/2	5/2006	
	ROVIDER OR SUPPLIER ANE REHABILITATI		•	416	ET ADDRESS, CITY, STATE, ZIP CODE S NORTH STATE IRRICANE, UT 84737			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 278	(MDS) were inaccresidents. (Residents findings included 1. Resident 4 was November of 200 depression, congruppertension, pep disease, cerebrov constipation. A review of reside completed on 5/2: A review of reside 3/23/06 documento "Devices and R"0" trunk restraints Observations of reand 5/25/06 revea observed in a whe place. On 5/23/06 at app daughter was intestated that reside because the resident then fall. The daughter was intestated that resident had a lap buddy in A review of the phedated 4/1/2006 required was originally or	ne facility's minimum data sets curate for 2 out of 10 sampled ent identifiers: 4,5) admitted to the facility in 4 with diagnoses that included estive heart failure, tic ulcer disease, Alzheimer's ascular accident and ent 4's medical record was 5/06. ent 4's annual MDS dated ted that in section P-4 pertaining testraints" that resident 4 had	F	278				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0098

If continuation sheet Page 11 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:		IULT PI LDING	LE CONSTRUCTION	(X3) DATE SI COMPLE		
		465101	B. WIN	1G		05/2	5/2006	
	ROVIDER OR SUPPLIER ANE REHABILITATIO	ON CENTER		410	ET ADDRESS, CITY, STATE, ZIP CODE 6 NORTH STATE JRRICANE, UT 84737			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 278	Continued From pa	age 11	F	278				
	of 2006 with diagnorm heart failure, hyper pneumonia. A review of resider 3/18/06 documents resident hears ade On 5/23/06, during asked in a normal Resident 5 replied, loud voice resident his lunch. He replied Resident 5's "Resident 5's "Resident 5's hearing hearing aide was loud A review of a nursi	dent Assessment-Data ated 3/10/06 documented that g was "poor" and that his						
į								

FORM CM3-2567(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 12 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED	
		405404	B. WING		-		
NAMEOEI	PROVIDER OR SUPPLIER	465101				25/2008	
	ANE REHABILITATIO	ON CENTER	4	REET ADDRESS, CITY, STATE, ZIP 116 NORTH STATE HURRICANE, UT 84737	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATÉMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	IĎ PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T) DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 279 \$\$=E	A facility must use to develop, review comprehensive plate The facility must deplan for each reside objectives and time medical, nursing, a needs that are idented assessment. The care plan must to be furnished to a highest practicable psychosocial well-by \$483.25; and any significant be required under \$483.10, including under \$483.10 (b) (4). This REQUIREMENT by: Based on chart revifacility did not deversidents comprehence as urable objectives ident's medical, psychosocial needs	evelop a comprehensive care ent that includes measurable stables to meet a resident's and mental and psychosocial stified in the comprehensive. It describe the services that are stain or maintain the resident's physical, mental, and seing as required under ervices that would otherwise \$483.25 but are not provided is exercise of rights under the right to refuse treatment by. In the right to refuse treatment in the lop, review or revise the ensive plan of care, including was and timetables to meet a nursing, mental and in Specifically, 5 of 10 sample are care plans based on the	F 279		updated care 6/21/06 updated c	07/14/06	
	incomplete. Reside Findings included:	ent identifiers 3, 4, 5, 7, 8.					
	1. Resident 3 was	originally admitted to the					

FORM CMS-2567(02-99) Previous Versions Obsoleto

Event ID; 5LDN11

Facility ID: UT0096

If continuation sheet Page 13 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465101	B. WIN	IG		05/25/2006	
	ROVIDER OR SUPPLIER	N CENTER	STREET ADDRESS, CITY, STATE, ZIE 416 NORTH STATE HURRICANE, UT 84737				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC (DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
F 279	facility in August of of 2006 with diagnosclerosis, urinary the resistant staph aure. A complete review occurred on 05/23/6 Resident 3 had the Assessment Protocoassessment complete Cognitive loss Communication ADL (Activities of Distriction/Rehabilitat Urinary incontinents Palls Nutrition Pressure ulcers Psychiatric drug us. Resident 3 had the active chart: History of hypertens Potential for skin breakdown stabuttocks Nutritional status Alteration in ability to Skin breakdown stabuttocks Nutritional status Alteration in speech Cognitive or disorded MRSA (methicilling pressure uncontained of the composition of the	1987, then readmitted in April pass that included multiple act infection, methicillin aus and hypertension. of resident 3's active chart of. following RAPs (Resident col) generated by the annual atted on 5/1/05: Paily Living) ion potential e/Catheterization e following plans of care on the sion reakdown R/T (related to) ogical function to do ADLs age II pressure ulcer on ered thinking esistant staph aureus)-urinary	F:	279			
	typy for imediatificities	lated to indwelling carneter					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 14 of 29

PRINTED: 08/12/2006 **FORM APPROVED** OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		465101	B. WIN	G	7	05/2	5/2006	
	ROVIDER OR SUPPLIER ANE REHABILITATIO	N CENTER		41	EET ADDRESS, CITY, STATE, ZIP CO 16 NORTH STATE URRICANE, UT 84737			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE					
F 279	conditions Alteration in resp (r pneumonia The following plans include target dates meet residents nee History of hypertens Potential for skin br mobility Alteration in neurok Falls Alteration in ability t Skin breakdown stab buttocks 2. Resident 8 was of in June of 2000 with hypothyroidism, pre A complete review on 5/25/06: Resident 8 had the Assessment Protoc assessment comple Cognitive Loss Communication ADL Functional/Rel Urinary Incontinenc Psychosocial Well-I Mood State Behavioral Sympto Falls	espiratory) status R/T of care for resident 3 did not a, and therefore no timetable to eds: sion reakdown R/T decreased origical function to do ADLs age II pressure ulcer on originally admitted to the facility in diagnoses that included eumonia and hemiplegia. of resident 8 was completed following RAP's (Resident col) generated by the annual eted on 3/23/06: habilitation e and Indwelling Catheter Being	F2	79				
	Resident 8 had the chart.	following plans of care on the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 15 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465101	B. WII	NG _		05/2	5/2006	
NAME OF PROVIDER OR HURRICANE REHAE		N CENTER	STREET ADDRESS, CITY, STATE, ZIF 416 NORTH STATE HURRICANE, UT 84737					
PREFIX (EACH D	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
Bladder In Falls - 11. Alteration Psychotro History of Potential f Altered The Care plan January to not reflect been updated as a complet occurred of Resident Assessment as a complet occurred of Resident Cognitive Communic	cho Sociality in Ability icontinent /13/05 in Bowel pic Medic Depression Skin Bought Proplan "More on the cho April, 20 in the current of the	al - 5/7/06 to do ADL's - 11/13/05 ce - 11/13/05 Function - 11/13/05 cation - 11/13/05 on - 11/13/05 breakdown - 11/13/05 ocesses - 11/13/05 od/Psycho Social" is the only eart that was active from 1006. All other care plans did ent RAP status. They had not scontinued since 3/23/06. admitted on 5/12/04 and 106 (1 day hospital visit) with red femoral condyle, cerebral liabetes and atrial fibrillation. of Resident 7 active chart 6. following RAPs (Resident col) generated by a significant and completed 3/21/06:	F	279				

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0098

If continuation sheet Page 16 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HURRICANE REHABILITATION CENTER ### HURRICANE REHABILITATION CENTER ### HURRICANE REHABILITATION CENTER ### HURRICANE LIT 44737 ### PREEEX ADMARY STATEMENT OF DEFICIENCIES (CENT MIST SEE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### PREEEX TAG ### TAG ### PROVIDER SHAND CORRECTION CORRECTION CORRECTION CORRECTION CORRECTIVE ACTION RHOULD BE CANCELLED TO THE APPROPRIATE DATE OF THE APPROPRIATE COMPLETE OF THE APPROPRIATE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HURRICANE REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES				1			
HURRICANE REHABILITATION CENTER All North STATE HURRICANE, UT BATE COMMITTED			465101				5/2006
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 279 Continued From page 16 Resident 3 had the following plans of care on the active chart: Alteration in ability to do ADL's - 3/06 Risk for Injury related to Falls - 3/06 Impaired Verbal Communication - 8/03/06 The care plan "Impaired Verbal Communication" is the only care plan on the chart that is active after the month of March, 2006. All other care plans had not been updated or discontinued after 3/06 but were RAP generated for the period before and after 3/06. Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. Resident 4 had the following RAP's (Resident Assessment Protocols) generated by the annual assessment: Cognitive Loss Communication ADL (Activities of daily living) Function Urinary Incontinence Psychosocial Well-Being Mood State Behavloral Symptoms		,	N CENTER	41	16 NORTH STATE	DE	
Resident 3 had the following plans of care on the active chart: Alteration in ability to do ADL's - 3/06 Risk for Injury related to Falls - 3/06 Altered Thought Processes Related to Cognitive Memory - 3/06 Impaired Verbal Communication - 8/03/06 The care plan "Impaired Verbal Communication" is the only care plan on the chart that is active after the month of March, 2006. All other care plans had not been updated or discontinued after 3/06 but were RAP generated for the period before and after 3/06. Resident' 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. Resident 4 had the following RAP's (Resident Assessment Protocols) generated by the annual assessment: Cognitive Loss Communication ADL (Activities of daily tiving) Function Urinary Incontinence Psychosocial Well-Being Mood State Behavloral Symptoms	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION CAYE
Activities Falls	F 279	Resident 3 had the active chart: Alteration in ability to Risk for Injury relate Altered Thought Profession of Memory - 3/06 Impaired Verbal Co. The care plan "Impaired Verbal Co. The care pl	following plans of care on the to do ADL's - 3/06 and to Falls - 3/06 occesses Related to Cognitive ommunication - 8/03/06 aired Verbal Communication" on the chart that is active March, 2006. All other care updated or discontinued after generated for the period 06. mitted to the facility in with diagnoses that included ative heart failure, coulcer disease, Alzheimer's scular accident and the 4's medical record was 06. following RAP's (Resident and the strip is generated by the annual aily living) Function ending its properties.	F 279			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UY0098

if continuation sheet Page 17 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465101	B. WING _		05/25/2006	
·	ROVIDER OR SUPPLIER	N CENTER	4	REET ADDRESS, CITY, STATE, ZIP CODE 16 NORTH STATE HURRICANE, UT 84737		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 279	Nutritional Status Pressure Ulcers Psychotropic Drug Physical Restraints Resident 4 had the chart. However, the resident 4 did not in therefore no timeta Cognitive or Disord Hospice Care- Failt Hypertension Anxiety CHF (Congestive H Constipation Incontinence ADLs Altered thought Pro Nutritional Status Weight Loss The care plans did status. They had no	following plans of care on the efollowing plans of care for include target dates, and ble to meet residents needs: lered Thinking tare to Thrive leart Fallure) cesses not reflect the current RAP to been updated or	F 279			
F 281 SS=D	The services provion must meet profession. This REQUIREMED by: Based on observation determined that the	March of 2006. MPREHENSIVE CARE PLANS ded or arranged by the facility ional standards of quality. NT is not met as evidenced ion and interview it was a facility did not provide service al standards of quality for 1 of	F 281	F 281 An in-service will be conducted to licensed nursing staff by DON or designee on catheter irrigation at the Lippincott Manual of nursing Practice eight edition 2006, pg 7 06/23/06 An audit tool will be developed b DON or designee by 06/26/06 or irrigation of indwelling catheters. Audits will be conducted on process.	o7/14/06 is per '56 by by the	

FORM CMS-2587(02-99) Previous Versions Obsolete

Event IO: 5LON11

Facility ID: UT0096

if continuation sheet Page 18 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		465101	B. WI	1G		05/2	5/2006
	PROVIDER OR SUPPLIER	N CENTER		41	ET ADDRESS, CITY, STATE, ZIP CO 6 NORTH STATE JRRICANE, UT 84737		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	10 sample resident received a catheter professional standard identifier: 3.) Findings included: 1. Resident 3 was facility in August of of 2006 with diagnosclerosis, urinary transistant staph auror and began removir positioning resident and began removir positioning resident to the resident. RN 1 inspected the system, then began catheter, that was a 3's urethra, stating placement." No cledone prior to the "content of the system and the drain tubing prior to separation, catheter and instilled.	age 18 as. Specifically, one resident irrigation that did not meet ards of quality. (Resident originally admitted to the 1987, then readmitted in April pass that included multiple act infection, methicillin eus and hypertension. Scheduled catheter irrigation, ard on 5/24/06 at 10:40 AM. Is ands, applied clean gloves, ag resident 3's clothing and at 3, while explaining the activity at catheter and drainage in repeatedly pushing the already in place, into resident that it was to "check eansing of the catheter was sheck placement" procedure. Berile large volume syringe and y of sterile saline. RN1 stated are reused and changed on a junction between the catheter and inserted the syringe into the add the sterile saline. The drain were then reconnected and	F	281	by DON or designee bi- monthly x 2, and randon 6 months. Audits will be presented meeting and changes w needed to continue com first QA meeting is to be 07/05/06	in the QA ill be made as pliance. The	

PRINTED: 06/12/2006 **FORM APPROVED** OMB NO. 0938-0391

F 281 Continued From page 19 the nurse observed for return. RN1 aspirated the remaining sterile saline, using the same large volume syringe, separated the junction between the catheter and the drain tubing, no cleansing was conducted prior to separation, inserted the syringe into the catheter and instilled the sterile saline (total of 100 milliliters of saline). The drain tubing and catheter were then reconnected and the nurse observed for return. Per the Lippincott Manual of Nursing Practice, eighth edition 2006, pg. 755: To trigate the catheter 1. Wash hands. Put on gloves. 2. Using aseptic technique, pour sterile Irrigating solution into sterile container. 3. Clean around catheter and drainage tubing connection with sterile gauze pads soaked in providone-lodine solution. 4. Disconnect catheter from drainage tubing. Cover tubing with a sterile cap. 5. Place a sterile drainage basin under the catheter. 6. Connect a large-volume syringe to the catheter and irrigate catheter using prescribed amount of sterile irrigant. 7. Remove syringe and place end of catheter over drainage basin, allowing returning fluid to drain into basin. 8. Repeat irrigation procedure until fluid is clear or according to physician's directives. 9. Disinfect the distal end of the catheter and end			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU(LE CONSTRUCTION	(X3) DATE S COMPLE		
HURRICANE REHABILITATION CENTER ### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### PAPER ID CONTINUED From page 19 the nurse observed for return. RN1 aspirated the remaining sterile saline, using the same large volume syringe, separated the junction between the catheter and the drain tubing, no cleansing was conducted prior to separation, inserted the syringe into the catheter were then reconnected and the nurse observed for return. Per the Lippincott Manual of Nursing Practice, eighth adition 2006, pg. 756: To irrigate the catheter 1. Wash hands, Put on gloves. 2. Using aseptic technique, pour sterile Irrigating solution into sterile container. 3. Clean around catheter and drainage tubing connection with sterile gauze pads soaked in providone-lodine solution. 4. Disconnect catheter from drainage tubing. Cover tubing with a sterile cap. 5. Place a sterile drainage basin under the catheter and Irrigate catheter using prescribed amount of sterile irrigant. 7. Remove syringe and place end of catheter over drainage basin, allowing returning fluid to drain into basin. 8. Repeat irrigation procedure until fluid is clear or according to physician's directives. 9. Disinfact the distatle not fit the catheter and end			465101	B. WIN	IG		05/2	5/2006	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 281 Continued From page 19 the nurse observed for return. RN1 aspirated the remaining sterile saline, using the same large volume syringe, separated the junction between the catheter and the drain tubing, no cleansing was conducted prior to separation, inserted the syrings into the catheter and instilled the sterile saline (total of 100 milliliters of saline). The drain tubing and catheter were then reconnected and the nurse observed for return. Per the Lippincott Manual of Nursing Practice, eighth edition 2006, pg. 756: To irrigate the catheter 1. Wash hands. Put on gloves. 2. Using asseptic technique, pour sterile irrigating solution into sterile container. 3. Clean around catheter and drainage tubing connection with sterile gauze pads soaked in providone-lodine solution. 4. Disconnect catheter from drainage tubing. Cover tubing with a sterile cap. 5. Place a sterile drainage basin under the catheter. 6. Connect a large-volume syringe to the catheter and irrigate catheter using prescribed amount of sterile irrigant. 7. Remove syringe and place end of catheter over drainage basin, allowing returning fluid to drain into basin. 8. Repeat irrigation procedure until fluid is clear or according to physician's directives. 9. Disinfect the distal end of the catheter and end			ON CENTER	416 NORTH STATE		NORTH STATE			
the nurse observed for return. RN1 aspirated the remaining sterile saline, using the same large volume syringe, separated the junction between the catheter and the drain tubing, no cleansing was conducted prior to separation, inserted the syringe into the catheter and instilled the sterile saline (total of 100 milliliters of saline). The drain tubing and catheter were then reconnected and the nurse observed for return. Per the Lippincott Manual of Nursing Practice, eighth edition 2006, pg. 756: To Irrigate the catheter 1. Wash hands. Put on gloves. 2. Using aseptic technique, pour sterile irrigating solution into sterile container. 3. Clean around catheter and drainage tubing connection with sterile gauze pads soaked in providone-lodine solution. 4. Disconnect catheter from drainage tubing. Cover tubing with a sterile cap. 5. Place a sterile drainage basin under the catheter. 8. Connect a large-volume syringe to the catheter and irrigate catheter using prescribed amount of sterile irrigant. 7. Remove syringe and place end of catheter over drainage basin, allowing returning fluid to drain into basin. 8. Repeat irrigation procedure until fluid is clear or according to physician's directives. 9. Disinfect the distal end of the catheter and end	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
of drainage tubing; reconnect the catheter and tubing. Remove gloves. Wash hands. According to facility policy for urinary catheters:	F 281	RN1 aspirated the the same large voljunction between the tubing, no cleansing separation, inserted and instilled the stamilliliters of saline) were then reconnected for return. Per the Lippincott leighth edition 2006 To irrigate the catholic 1. Wash hands. For a connection with step connection with step rovidone-lodine solution into sterile and connection with step rovidone-lodine solution into sterile and connect catholic 2. Connect a large catheter. Cover tubing with a solution of sterile in the connection with step connect and irrigate amount of sterile in the catholic 2. Remove syring over drainage basing drain into basin. Repeat irrigation or according to phy 9. Disinfect the disof drainage tubing; tubing. Remove gli	remaining sterile saline, using ume syringe, separated the he catheter and the draining was conducted prior to did the syringe into the catheter erile saline (total of 100). The drain tubing and catheter exted and the nurse observed. Manual of Nursing Practice, 3, pg. 756: letter. Put on gloves. Exchnique, pour sterile irrigating exchnique, pour sterile irrigating exchnique, pads soaked in colution. In the form drainage tubing, a sterile cap. Irrigating except the except and place end of catheter except and place end of catheter in, allowing returning fluid to an procedure until fluid is clear excican's directives. It is also and place end of catheter and end reconnect the catheter and end reconnect the catheter and oves. Wash hands.	F2	281				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

if continuation sheet Page 20 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

AMME OF PROVIDER OR SUPPLIER WURRICANE REHABILITATION CENTER ### SUMMANY STATEMENT OF DEPOSACES PROVIDER REACH PERCENTAGE AND A PROVIDER PROVIDER PROPERTY RATE PROPERTY REACH OF DEPOSACES PAUL REGULATORY OR LSC IDEMTRYING INFORMATION) F 281 Continued From page 20 **F 281 Continued From page 20 **F 281 Continued From page 20 **This regulation is necessary, disinfect tubing junction before disconnecting. Using aseptic technique, irrigate with a sterile syringe and sterile solution. Discard unused solution." Aseptic technique was not utilized, the tubing junction was not disinfected and per the RN's statement, a sterile syringe is not utilized during each irrigation. F 367 SS=D Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation, it was determined that the facility did not give 1 out of 10 sampled residents their physician ordered prune juice every day (QD). (Resident identifiers: 4) Findings included: Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart fallure, hypertension, peptic ulcer diseases, Alzheimer's diseases, carebrovascular accident and constipation. A review of resident 4* s medical record was completed on 5/25/06. A review of the physician's recertification orders **This REQUIREMENT** *			(X1) PROVIDER/SUPPLIER/CLIA (X2) ML IDENTIFICATION NUMBER: A. BUIL			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HURRICANE REHABILITATION CENTER SUMMARY STATEMENT OF DEPICIENCIES PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATION OF LOC IDENTIFIANG INFORMATION) F 281 Continued From page 20 "If irrigation is necessary, disinfect tubing junction before disconnecting. Using aseptic technique, irrigate with a sterile syringe and sterile solution. Discard unused solution." Aseptic technique was not utilized, the tubing junction was not disinfected and per the RN's statement, a sterile syringe is not utilized during each irrigation. F 367 SS=D Therapeutic diets must be prescribed by the attending physician. F 367 Residents will receive therapeutic diets as per MD order. An in-service will be conducted for the kitchen staff by the dietary manager or designee on therapeutic diets by 06/23/08. An audit tool will be developed by dietary manager or designee by 06/23/06 to compare meals with therapeutic diets. Audits will be conducted by dietary manager or designee bi-weekly x 2, monthly x 2, and randomly therewater x 6 months. A review of resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulicer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/08.			465101	B. WIN	1G		05/2	25/2006
FREENX TAA RECULATORY OR LSC IDENTIFYING INFORMATION) F 281 Continued From page 20 "If irrigation is necessary, disinfect tubing junction before disconnecting. Using aseptic technique, irrigate with a sterile syringe and sterile solution." Aseptic technique was not utilized, the tubing junction was not disinfected and per the RN's statement, a sterile syringe is not utilized during each irrigation. F 367 A83.35(e) THERAPEUTIC DIETS Therapeutic diets must be prescribed by the attending physician. F 367 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation, it was determined that the facility did not give 1 out of 10 sampled residents their physician ordered prune juice every day (QD). (Resident identifiers: 4) Findings included: Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/08.			N CENTER		41	6 NORTH STATE	+	
"If irrigation is necessary, disinfect tubing junction before disconnecting. Using aseptic technique, irrigate with a sterile syringe and sterile solution. Discard unused solution." Aseptic technique was not utilized, the tubing junction was not disinfected and per the RN's statement, a sterile syringe is not utilized during each irrigation. F 367 SS=0 Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation, it was determined that the facility did not give 1 out of 10 sampled residents their physician ordered prune juice every day (QD). (Resident identifiers: 4) Findings included: Residents will receive therapeutic diets as per MD order. An in-service will be conducted for the kitchen staff by the dielarny manager or designee to therapeutic diets by 06/23/06. An audit tool will be developed by dietary manager or designee by 06/26/06 to compare meals with therapeutic cliets. Audits will be conducted by dietary manager or designee by 06/26/06 to compare meals with therapeutic cliets. Audits will be conducted by dietary manager or designee by 06/26/06 to compare meals with therapeutic cliets. Audits will be conducted by dietary manager or designee by will be made as needed to ensure continued compliance. The first QA meeting is to be held by 07/05/06	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE '	COMPLETION
Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation, it was determined that the facility did not give 1 out of 10 sampled residents their physician ordered prune juice every day (QD). (Resident identifiers: 4) Findings included: Resident 4 was admitted to the facility in November of 2004 with diagnoses that included depression, congestive heart failure, hypertension, peptic ulcer disease, Alzheimer's disease, cerebrovascular accident and constipation. A review of resident 4's medical record was completed on 5/25/06. Residents will receive therapeutic diets as per MD order. An in-service will be conducted for the kitchen staff by the dietary manager or designee on therapeutic diets by 06/23/06. An audit tool will be developed by dietary manager or designee by 06/26/06 to compare meals with therapeutic diets by 06/23/06. An audit will be conducted by dietary manager or designee by 06/26/06 to compare meals with therapeutic diets by 06/23/06. An audit tool will be developed by 06/26/06 to compare meals with therapeutic diets by 06/23/06. An audit will be conducted for the kitchen staff by the dietary manager or designee by 06/26/06 to compare meals with therapeutic diets by 06/23/06. An audit will be conducted by dietary manager or designee by 06/26/06 to compare meals with therapeutic diets by 06/23/06. An audit will be conducted by dietary manager or designee by 06/26/06 to compare meals with therapeutic diets by 06/23/06. An audit will be conducted by dietary manager or designee by 06/26/06 to compare meals with therapeutic diets by 06/26/06 to compare meals with therapeutic diets as per MD order. An audit woll be developed by 06/26/06 to compare meals with therapeutic diets as per MD order. An audit woll be developed by 06/26/06 to compare meals with therapeutic diets. Audits will be presented in the QA meeting and changes will be made as needed to ensure continued compliance. The first	· F 281	"If irrigation is nece before disconnectir irrigate with a steril Discard unused so Aseptic technique junction was not dis statement, a sterile	essary, disinfect tubing junctioning. Using aseptic technique, e syringe and sterile solution. lution." was not utilized, the tubing sinfected and per the RN's	F	!81			
		Therapeutic diets in attending physician. This REQUIREMEI by: Based on interview observation, it was not give 1 out of 10 physician ordered procession (Resident identifier. Findings included: Resident 4 was administration, congestive the sident of 2004 depression, congestive the sident of the	NT is not met as evidenced The record review, and determined that the facility did a sampled residents their prune juice every day (QD). The record review, and determined that the facility did a sampled residents their prune juice every day (QD). The record to the facility in with diagnoses that included stive heart failure, a culcer disease, Alzheimer's scular accident and the the record was 14's medical record was 16.	F	167	Residents will receive theraper as per MD order. An in-service will be conducted kitchen staff by the dietary man designee on therapeutic diets to 06/23/06. An audit tool will be developed dietary manager or designee bo 06/26/06 to compare meals with the the therapeutic diets. Audits will be conducted by die manager or designee bi-weekly monthly x 2, and randomly there 6 months. Audits will be presented in the meeting and changes will be meeded to ensure continued compliance. The first QA meeting	for the hager or by by by h tary / x 2, eafter x QA ade as	07/14/06
DRM CMS 2587/01 DD Pervious Charles								

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 21 of 29

P. 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/12/2006 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES		OWR NO. 0838-038
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	465101	B. WING	05/25/2006
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	

416 NORTH STATE

HURRICA	NE REHABILITATION CENTER		HURRICANE, UT 84737				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAC	"IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 367	Continued From page 21	F	367				
	dated 4/1/2006 revealed that resident 4 had an order for "Prune juice 8 oz. (ounces) by mouth every day."						
	A review of resident 4's diet card revealed that the resident was to be served "8 oz. prune juice" at breakfast everyday.						
	Observations of the breakfast meal on 5/23/06 and 5/24/06 revealed that resident 4 was not						
	served prune juice as ordered by the physician.	·		F 371	07/14/06		
F 371 \$S=E	, , , , , , , , , , , , , , , , , , ,	F	37	approved for food storage was thrown out on 05/24/06. New food was			
	The facility must store, prepare, distribute, and serve food under sanitary conditions.	,		purchased in small quantities. New approved ingredient bins were ordered and received by 06/09/06. The serving area identified was cleaned immediately on 05/25/06. An in-service will be conducted for the	·		
	This REQUIREMENT is not met as evidenced by:	<u> </u>		kitchen staff by dietary manager or designee on storing, preparing, distributing, and serving of food under			
	Based on observation and interview it was determined that the facility did not store, prepare, distribute, or serve food under sanitary conditions. Specifically, bulk foods were stored in bags that			sanitary conditions on 06/23/06. An audit tool will be developed by dietary manager or designee by 06/26/06 to ensure continued sanitary			
	had not been approved for food storage, outdated foods were being stored, cross-contamination of dishes occurred and there was potential for contamination of food due to unclean surfaces.			conditions in the kitchen. Audits will be conducted by dietary manager or designee bi-weekly x 2, monthly x 2, and randomly thereafter x			
	Findings included:			6 months Audits will be presented in the QA			
	Observations of the kitchen/food service area took place 5/22/06 to 5/24/06.			meeting and changes will be made as needed to ensure continued compliance. The first QA meeting is to be held by 07/05/06			

FORM CMS-2567(D2-99) Provious Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 22 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465101	B. WI	NG		05/2	5/2006
,,,,,	ROVIDER OR SUPPLIER	ON CENTER		41	EET ADDRESS, CITY, STATE, ZIP CODE 16 NORTH STATE URRICANE, UT 84737		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			(XS) COMPLETION DATE	
F 371	Continued From pa	_	F	371			
	1. Observations of place on 5/22/06 a	f the dishwashing area took nd 5/23/06.					
	observed using the day shift cook was dishwashing glove; into the washing m shift cook removed while wearing yello sanitizing a cart trawithout sanitizing of On 5/23/06 at 1:00 observed loading of while wearing yello then began putting silverware with the sanitizing or change	the outdoor pantry occurred on					
	Two 8 pound 10 ou Solana enchilada s	unce plastic containers of Casa sauce were observed with September 5, 2005.					
		ces of Imperial Raisins were fore dates of April 1, 2006.					
	containers, were of	, utilized as bulk food storage bserved to be lined with black e bags. The containers held wdered milk.					
	on 5/22/06 at 2:00	ne the dayshift cook occurred PM. The day shift cook stated low where the packaging for the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SLDN11

Facility ID: UT0098

If continuation sheet Page 23 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465101	B. WING		05/2	5/2006
	ROVIDER OR SUPPLIER ANE REHABILITATIO	N CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 416 NORTH STATE HURRICANE, UT 84737		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	An interview with the on 5/22/06 at 5:56 stated that she did bags came from. Sknow where the paregarding approved found. An interview with the 5/24/06 at 5:00 PM he did not know whas, and had been regarding approved. As quoted in Food extension service of Agriculture, Kansas Volume 2, number for food use are transolvent cans, industration, and fiber for nonfood purpos. 3. An observation of place on 5/22/06 at A cupboard, overhalsteam table that food	ation regarding approved uses be found. The evening shift cook occurred PM. The evening shift cook not know where the black she also stated that she did not ckaging or documentation duses for the bags could be administrator took place on . The administrator stated that here the packaging for the bags unable to find documentation duses for the bags. Safety News (A cooperative of US department of a State University) June 1999 3: "Containers not approved shor garbage bags, paint or strial plastics, galvanized barrels that have been used es." of the kitchen tray line took anging the right side of the od was being served from, was	F 37′			
	edge.	ust "bunnies" along it's top				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6LDN11

Facility ID: UT0096

If continuation sheet Page 24 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

ITATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	465101		B. WING			05/25/2006		
NAME OF PROVIDER OR SUPPLIER HURRICANE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 416 NORTH STATE HURRIGANE, UT 84737				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP		OULD BE COMPLÉTION		
F 387 SS=E	The resident must once every 30 days admission, and at thereafter. A physician visit is not later than 10 direquired. This REQUIREMED by: Based on record redetermined that 4 not seen by a physician of the first 9 least once every 6 Identifiers: 3, 4, 6, Findings included: 1. Resident 8 was February of 2003 hypothyroidism, put A review of resident had to 5/6/05, 3/29/06, 4/4. Per documentation Resident 8 was seen or around 7/6/0 as required. There was no docrecord to provide of the resident and to provide of the resident and the feed of the feed of the resident and the feed of the feed o	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 83.40(c)(1)-(2) FREQUENCY OF PHYSICIAN PISITS The resident must be seen by a physician at least ince every 30 days for the first 90 days after dimission, and at least once every 60 days increafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was equired. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was not seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days as required. (Resident dentifiers: 3, 4, 6, 8.) Findings included: 1. Resident 8 was admitted to the facility on February of 2003 with diagnoses that included hypothyroidism, pneumonia and hemiplegia. A review of resident 8's medical record revealed the resident had been seen by a physician on 5/6/05, 3/29/06, 4/25/06 and 5/11/06. Per documentation there was no evidence that Resident 8 was seen by her attending physician on or around 7/6/05, 9/6/05, 11/6/05 and 1/6/05		387	Documentation was found in re 4's chart to support a MD visit of 02/08/06. A physician's visits schedule wideveloped by medical records of designee by 06/26/06. Primary Physicians will be provided with residents to be seen each monresident has not been seen by primary physician in a timely marrangements will be made for be seen by the Medical Directo. An audit tool will be developed medical records or designee by 06/26/06 to ensure continued compliance with physician visits. Audits will be conducted by me records or designee bi-monthly monthly x 2, and randomly ther 6 months. Audits will be presented in the 6 meeting and changes will be mineded to ensure continued compliance. The first QA meeting be held by 07/05/06.	on ill be or n a list of th. If a his/her anner, them to r. by dical x 2, eafter x QA ade as	07/14/06	

FORM CMS-2567(02-99) Provious Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0098

If continuation sheet Page 25 of 29

PRINTED: 06/12/2006 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465101 05/25/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 416 NORTH STATE **HURRICANE REHABILITATION CENTER** HURRICANE, UT 84737 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID **ID** (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 387 Continued From page 25 F 387 11/6/05 or 2/6/06. Resident 3 was originally admitted to the facility in August of 1987, then readmitted in April of 2006 with diagnoses that included multiple sclerosis, urinary tract infection, methicillin resistant staph aureus and hypertension. A complete review of resident 3's active and discharge charts occurred on 05/23/06. Resident 3's charts had physician progress notes indicating physician visits for 5/19/05, 6/30/05, 9/15/05, 12/15/05, and 3/23/06. Between 6/30/05 and 9/15/05 resident 3 went 77 days without a physician visit. Between 12/15/05 and 3/23/06 resident 3 went 98 days without a physician visit. Resident 3 should have had physician visits on or about 8/29/05 and 2/13/06.

FORM CMS-2567(02-99) Previous Versions Obsolete

on 5/22/06.

8/29/05 or 12/13/06.

and hypothyroidism.

No documentation was found on the chart indicating physician visits occurred on or about

Resident 6 was admitted to the facility in June of 2005 with diagnoses that included osteoporosis

A complete review of resident 6's chart occurred

Resident 6 had physician progress notes indicating physician visits for 06/30/05, 08/26/05, 09/16/05, 9/16/05, 12/15/05, 1/19/06 and 3/23/06.

Event ID: 6LDN11

Facility ID: UT0096

If continuation sheet Page 26 of 29

PRINTED: 06/12/2006 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465101		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WII	NG		05/25/2006			
NAME OF PROVIDER OR SUPPLIER HURRICANE REHABILITATION CENTER				416	ET ADDRESS, CITY, STATE, ZIP CODE 8 NORTH STATE JRRICANE, UT 84737			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
F 387	Continued From p	age 26	F	387				
	have had physicia days. The reside physician visit on one of the physician visit on one of the physician visit on one of the physician visits for	was found on the chart itan visit occurred on or about the Director of Nursing (DON) of at 1:45 PM. The DON stated other documentation of						
	depression, conge hypertension, pep	estive heart failure, tic ulcer disease, Alzheimer's ascular accident and						
		nt 4's medical record revealed been seen by a physician on 11/06.						
	Resident 4 was se on or around Augu	n there was no evidence that en by her attending physician ist of 2005, October of 2005, i, February of 2006 and April of						
	stated that the only	ON was interviewed. The DON y time that the resident had orimary physician in the past 05 and on 5/11/06.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5LDN11

Facility ID: UT0096

If continuation sheet Page 27 of 29

PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIP LDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465101	B. WING			05/25/2 006		
NAME OF PROVIDER OR SUPPLIER HURRICANE REHABILITATION CENTER				41	EET ADDRESS, CITY, STATE, ZIP CODE 16 NORTH STATE URRICANE, UT 84737	····		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE	
F 463 \$\$=E	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation of resident rooms, it was determined that 10 out of 42 bedside call lights the facility staff did not ensure the nurses's station was equipped to receive resident calls through a communication system from resident rooms and toilet facilities. Findings included: On 5/23/06 at 2:00 PM a tour was made of all resident rooms, 10 out of 42 bedside call bells tested were either inoperative or had to be held in the down position by the resident to work properly and register on the call board at the nurse's station. It was observed in rooms 14 A, 18 B and 18 C the call bells did not function. In rooms 15 B, 17 A, 19 B, 21 A, 21 C and 24 A the call bell only worked if the button was held in the down position. On 5/23/06 at 2:15 PM, in an interview with the Administrator, he stated that monthly checks were done on the system and that the system had passed all checks in April. During the interview with the Administrator, he stated that the call system would be worked on that evening		PREFIX TAG				07/14/06	
	system would be w (5/23/06).	orked on that evening						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5L0N11

Facility ID: UT0096

If continuation sheet Page 28 of 29

DEPART	PRINTED: 06/12/2006 FORM APPROVED OMB NO. 0938-039									
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/25/2006					
465101			B. WIN	IG						
NAME OF PROVIDER OR SUPPLIER HURRICANE REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 416 NORTH STATE HURRICANE, UT 84737						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
•				`						
;										
						·				
•										
	:					·	3			
				!						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: SLDN11

Facility ID: UT0096

If continuation sheet Page 29 of 29