STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations it was determined the facility did not have an effective maintenance system to ensure the resident's environment was maintained in good repair in resident rooms. Findings include: Room 1, had a strip of Linoleum 12 inches long that was pulling away from the floor. The Linoleum pulling away was in front of the bathroom entry and one foot in front of the door, as you entered the residents room. Room 4, had no cover on the ceiling fan in the bathroom. The fan was coated with dirt and dust particles. Room 6's, bathroom shower had an exposed pipe that had no hose attached to the end of the shower pipe. Room 7's bathroom shower had an exposed pipe with no hose attached to the end of the shower pipe. Room 9's, bathroom shower had an exposed pipe with no hose attached to the end of the shower pipe. Room 11's bathroom shower had an exposed pipe with no hose attached to the end of the	F 253	6/12/06 POC acceptable completion date 6/30/06 Brandenburg RN Room 1 was scheduled for complete floor replacement in our QA program when the current resident was discharged. Resident #06-0605-01 discharged on 5/16/06. The entire floor is scheduled to be replaced in the main room as well as the bathroom. Room 4, the ceiling fan cover was replaced after the fan was cleaned. Rooms 6,7,9, and 11 had no shower hoses attached because there were no residents in those rooms at the time that could use the shower. However, shower hoses and nozzles were purchased and placed in those rooms. Room 11 the sink drain was cleaned out and correct operation resumed. Maintenance does a comprehensive walkthrough each Monday morning and looks for discrepancies and/or problems in each room as well as the common areas. For problems that arise during the course of the week, such as a slow drain, corrections are made timely and as necessary. Maintenance monitors weekly and records are examined quarterly at QA meeting. The work will be completed on or before 6/30/06.	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 6/1/06

/ deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 1 shower pipe. The sink would not adequately drain water. Room 15 Bed A's light fixture over the bed, had no cover and missing blinds on the window.	F 253	F-281 1. Through our medical software a note will be placed alongside each resident in the MAR that receives Digoxin reminding and requiring the administering nurse to take an apical pulse for one minute prior to giving the medication and then recording the results in the MAR. See attached for an example of the new MAR record. The DON will monitor the MAR sheets on a monthly basis and report her findings to the QA committte on a quarterly basis. 2. The medications refrigerator was placed on a weekly checklist for the night nurse to review the contents and ensure that all meds are labeled and current. The refrigerator and it's contents will also be placed on the monthly pharmacy consulting contract. The consulting pharmacist will include these findings on his report. Pharmacy reports are reviewed quarterly by the QA committee. Both corrections will be completed by 6/30/06.	
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based upon observation, it was determined that the services provided by the facility did not meet professional standards of quality. Specifically, medications were not administered or stored according to acceptable standards of practice. Findings include: 1. On May 9, 2006, at 7:30 A.M. RN 1 adminstered a dose of Digoxin .125 mg to a Supplemental Resident without first taking the Resident's pulse. Nursing 2006 Drug Handbook (2006), published by Lippincott, Williams & Wilkins, p. 232 states: "Before giving drug (Digoxin), take apical-radial pulse for one minute." 2. An inspection of the Medications Refrigerator on May 11, 2006 at 10:45 A.M. revealed the following problems: a. A vial of Regular Insulin was opened but not	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 281	Continued From page 2 labelled with a date. b. A vial of Lantus was opened but not labelled with a date. c. A bottle containing Biscodyl 10 mg suppositories had expired on February 1, 2005. d. A vial of Cyanocobalamin had expired on April 6, 2006. e. A box of Acetaminophen 650 mg suppositories had expired on January 4, 2006. f. A box of "Acephen" 650 mg suppositories had expired on January 27, 2006. g. A box of Acetaminophen 650 mg suppositories had expired on February 26, 2006.	F 281	F-325 As a result of the survey, we found a breakdown of communication between the dietician, the physician, our care planner, and medical records. After analyzing our information flow we have instituted several changes that will result in more timely and more accurate information passing between nursing, dietary, and the physicians and ulitmately to our care plan nurse.	
F 325 SS=G	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident medical records, it was determined that for 4 of 10 sampled residents, the facility did not ensure that the residents maintained acceptable parameters of nutritional status. Specifically, there were five residents with abnormal (low) albumin levels, some of which indicated severe visceral protein depletion. The facility's consultant dietitian had not addressed any of the low albumin levels. Resident identifiers 5, 2, 7 and 8.	F 325	1. Each resident will be weighed on a weekly basis. 2. Any resident that has a weight variance of >than 2% will be referred to the weekly NAR (Nutritionally At Risk) meeting. Other indications that will trigger a referral include, but are not limited to; dehydration, dialysis, abnormal labs, fecal impaction, TF/TPN treatment, pressure ulcer, and general decline. (see attached NAR Review form). 3. Once referred to the weekly NAR meeting, a Nutritional Risk Review(see attached) will be performed. Recommendations to the resident's physician will be made based on the results of this review. (continued on p. 4)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 325	Continued From page 3 Findings included: An albumin level of less than 2.4 g/dl is considered a severe visceral protein deficit, an albumin level of 2.4 g/dl- 2.9 g/dl is considered a moderate visceral protein deficit and an albumin level of 3.0 g/dl-3.5 g/dl is considered a mild visceral protein deficit. . (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000, page 22). 1. Resident 5 was a 58 year old female who was admitted to the facility on 5/4/01 with diagnoses which included cerebellar atrophy , seizures, idiopathic neuro degeneration, contractures and dysphasia. On 1/27/2005, the facility's registered dietitian (RD) completed a nutritional assessment for resident 5 which included calculations of her calorie and protein needs. These calculations were based on the resident's weight of 160 pounds or 72 kilograms (kg). The dietitian documented in her note "needs assessed as 1240 kcal (kilocalories) with 47 - 59 gms (grams) of protein. Current receiving 1080 kcals with 45 grams of prot. (protein) from 2cal HN et (and then) 110 kcals from cranberry jc. (juice). total caloric intake 1190 kcals...If possible would like to see albumin/ T. (total) protein level for resident to see if meeting needs." (It should be noted that as of 5/11/06, the protein and caloris needs of resident 5 had not been recalculated.) The average person needs from 0.8 to 1.0 grams of protein per kilogram per day to maintain good nutritional status (Manual of Clinical Dietetics).	F 325	4. A telephone order will be made to reflect the changes, if any, made by the physician. If nutritional change is ordered, the kitchen will receive a copy of the T.O. to implement the change. If a lab is ordered, it will be scheduled. Any other changes ordered will be complied with. A copy of the T.O. is also made available to the care planning nurse to include in the resident's care plan. These care plan changes will be made each Tuesday and reviewed by IDT on Thursday. 5. If a lab was ordered, the lab results will be reviewed by the DON on a daily basis and forwarded to each physician. If a nutritional value is not WNL the DON will notify the Registered Dietician for recommendations to make to the physician. Any changes made by the physician will follow (4) above. 6. NAR meetings will be held at IDT each Thursday. Recommendations made and care plan changes made on the following Tuesday. Any change of physician orders will be implemented the same day (continued on p.5)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 325	Continued From page 4 The facility's dietitian figured the protein needs of resident 5 to be approximately 35% less than what the normal person would need to maintain a good nutritional status. Based on standard calculations to determine needed calories, taking into account height, weight, age and activity factors, resident 5 should have been receiving approximately 1472 kcal, not 1190. On 1/31/2006, one year after the RD had suggested obtaining labs to see if the diet was meeting the needs of resident 5, the facility obtained an albumin and total protein level for this resident. The albumin measured 1.4g/dL (laboratory reference range 3.5 - 5.0) and the total protein measured 4.6g/dL (6.3 - 8.2). These results would indicate a severe visceral protein deficit. As of the survey date of 5/11/06, these results had not been addressed by the facility nor by the RD. On 4/6/06, another albumin and total protein level were obtained which showed an albumin of 2.5 g/dL and a total protein level of 5.5 g/dL. Again, as of 5/11/06, these results had not been addressed by the facility nor by its RD. The physician recertification orders, dated 4/27/06 through 5/31/06, ordered resident 5 to receive the following diet: - Novasource @ 45 cc/hr (cubic centimeters per hour) to run for 12 hours - 720 cc liquid at mealtimes three times a day (560cc of water, 120cc of cranberry juice) - 600 cc of water at night with the feeding	F 325	with care plan changes made the following Tuesday and reviewed by IDT on Thursday. Find attached a copy of the nutritional care planning guide. We believe that with the above policy and procedure change, no lab values will be overlooked. Nutritional status changes will be flagged and physicians notified timely. Recommendations and order changes will be complied with in a timely manner. Our IDT will monitor the process each Thursday with their findings reported to the QA committee quarterly. Completion date for re-writing policies and procedures with full implementation will be complete by 6/30/06. For the residents specified in the deficiency, lab values were already reviewed, recommendations to physicians made, and changes implemented to reduce their nutritional risk. Follow-up will occur as indicated and will be monitored weekly by our IDT and quarterly by the QA committee. Overall, the administrator will monitor the program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 325	Continued From page 5 The total calories provided by this diet order would equal 1233. The total grams of protein provided by this diet order would equal 48.1. (Each 8 ounce box of Novasource provided 475 calories and 21.3 grams of protein.) The floor nurse at the facility was interviewed twice, once on 5/10/06 and again on 5/11/06. She was asked to describe what resident 5 received through her feeding tube, what diet was being provided. During both interviews, the floor nurse stated that resident 5 received two boxes of the Novasource in a 24 hour period. The nurse also stated that resident 5 received 720 cc of fluid (120 cc of the cranberry juice and the water) three times a day as well as the water bolus with her feeding. Based on the diet as described by the nurse, resident 5 would receive 1115 kcals and 42.6 grams of protein. Based on the 1/27/05 weight of 160 pounds, resident 5 should have been receiving at least 72 grams of protein per day and 1472 kcals. The diet recommended by the RD and administered by the facility was significantly different that these calculations and provided only a portion of what was needed by resident 5. In addition, during the last month from April to May 2006, resident 5 went from 151 pounds to 144 pounds, a 4.6% weight loss in one month. This had not been addressed by the facility nor by the RD. Neither the severe visceral protein deficit	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 325	Continued From page 6 (albumin of 1.4g/dL), nor the 4.6% weight loss of resident 5 had been care planned. A skin check of resident 5 was performed with two registered nurse surveyors and the director of nurses on 5/10/06 at 3:08 PM. Resident 5 was found to have a 0.5cm by 0.5 cm area of reddness with a .25 by .25 blistered area in the center. This would be considered a stage 2 pressure sore. This pressure sore was located on left inner malleolus. Staff was not aware of this breakdown. The facility's consultant dietitian was interviewed by two survey nurses on 5/11/06 at approximately 10:30 AM. She was asked why, in January 2005, she had calculated the calorie and protein needs of resident 5 to be so low. After reviewing her notes and the information presented in this deficiency, the dietitian stated, "I screwed up." The dietitian also stated that she had never seen the laboratory results for this resident or the other residents with low albumin levels which were discussed with her during this interview. 2. Resident 2 was a 75 year old female who was admitted to the facility on 8/28/04 with diagnoses which included debility, joint pain, trans-cerebral ischemia, confusion, depression and constipation. On 9/9/04, shortly after being admitted, the facility's consultant dietitian completed a nutritional assessment of resident 2 which included her protein and calorie needs. The RD documented that resident 2 needed 1477 - 2068 kcals and 59 - 70 grams of protein. (It should be noted that as of 5/11/06, the calorie and protein needs of resident 2 had not been recalculated.)	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 325	Continued From page 7 On 8/30/05, the facility obtained an albumin level for resident 2. The albumin level measured 2.9g/dL. This would be considered a moderate visceral protein deficit. From the time this low albumin result was available (8/31/05), to the end of survey on 5/11/06, the RD had written two notes in the medical record of resident 2 which included the following: 11/10/05 - "...Resident at fair nutritional status..." 2/9/06 - "...Resident at fair to good nutritional status..." Neither of these notes addressed the low albumin level. The low albumin had not been care planned. The dietitian had not re-evaluated the needs of resident 2 to ensure that the current diet would address the low albumin. Resident 7 is a was admitted on February 24, 2006 with diagnosis of Cellulitis, Atrial Fibrillation, Hypertension and Dermatitis. A record review of resident 7 medical records reflected that she had been initially evaluated on March 9, 2006 by the Registered Dietician (RD). At that time, the RD completed an Annual Nurtitional History which contained guidance to provide a protein supplement in the morning and evening. She assessed the Residents' needs at that time as 1425-1995 kilocalories with 46-57 grams of protein per day. She further noted,	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 325	Continued From page 8 "Watch as continued adjustment and additional needs. Follow next visit." No further documentation after this date by the RD was found in the Medical record. Abnormal Laboratory results on March 21, 2006 indicated Resident had an Albumin level of 2.20 and Protein level of 5.20. Abnormal Laboratory results on April 12, 2006 indicated Resident had an Albumin level of 2.40 and Protein level of 5.60. No documentation addressing these abnormal laboratory values was found in the medical record. During an interview with the Registered Dietician on May 11, 2006, she stated that she does not always review Laboratory results, and was unaware of low Laboratory values.	F 325	F-371 An inservice was held on 5/12/06 with all kitchen employees. Every employee was informed that ANY item placed in ANY walk-in, refrigerator, or freezer was to be labeled with content and date. Every employee was also informed that when an expiration date is reached, that food is to be discarded. All labels will be checked prior to each meal for suitability. The Food Service Supervisor will monitor all refrigerators and freezers daily for a three month period, reporting the results to the QA committee. If compliance is continuous, she will continue to monitor weekly. Completion date: 6/30/06	
F 371 SS=B	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not prepare, distribute and serve food under sanitary conditions. Findings include:	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 371	Continued From page 9 During the initial inspection of the kitchen on 5/8/06 and 5/9/06 the following was observed. Freezer 1, located on the right side of the wall next to freezer 2: Pink bowl with brown and white food present, not labeled, dated or covered. A small white package not label or dated. A package of what appears to be a type of meat, no label. Freeze 2, located between freezer 1 and the walk-in refrigerator: Large blue plastic bag with a large amount of broccoli present, not labeled or dated. Walk-in refrigerator: One gallon of non-fat milk with an expiration date of 5/8/06 was observed, the reformatory was rechecked on 5/9/06 and the non-fat milk had been moved from the walk-in refrigerator to the smaller refrigerator, located to the left of the stove. In an interview with the food service supervisor, on 5/9/06 at 8:00 AM, she said that the milk was used for resident's that morning, she did not think one day would make a difference with the expiration date.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 SS=B	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: Findings include: On 05/09/06 at 2:30 PM, an interview was conducted with a facility registered nurse (RN) 1. The RN did not clearly know what should be done if a fire was discovered in a residents room. The RN 1 stated..."try to put out fire with a blanket, get patient out of room, call a code." During the same interview, RN 1 was unable to give clear directions on the use of the fire extinguisher..."pull the pin, aim at the base of the fire." On 05/10/06 at 1:30 PM, in an interview was conducted with a facility RN 2. RN 2 did not clearly know what should be done if a fire was discovered in a residents room. RN 2 stated..."we have split hallways, so you direct people to each hallway,...check each resident room, alarms notify the police dept & the fire department." On 05/10/06 at 2:00 PM, an interview was conducted with a facility certified nursing assistant (CNA) 3. CNA 3 did not clearly know what should be done if a fire was discovered in a residents room. She stated..."split up into hallways, evacuate to outside of building, get residents out of room, shut the door, call for help."	F 518	F-518 Our policy and procedures will be re-written to reflect changes made to the building and to address the installation of a new fire alarm panel and how it operates. Clarifications will be made in the policy to identify specific duties for each person on any given shift. Clarifications will be included to address the difference in actions taken during a drill and actions taken when an actual fire is found, as they are obviously not the same. The local fire department has been contacted and an actual demonstration of how to use a fire extinguisher will be provided by them. Each employee will be given a written exam upon completion indicating whether or not the instructions were completely understood. This material will be made available in the orientation packet so that every new employee gets a copy on their first day of employment. They will also be required to pass the written exam. The administrator will monitor with results reviewd by the QA committee and completed by 6/30/06.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 On 05/10/06 at 1:40 PM, an interview was conducted with a facility nursing assistant (NA) 4. The NA 4 did not clearly know what should be done if a fire was discovered in a residents room. The NA 4 stated..."try to get everyone out of the building, contact the nurse, have someone call 911." The NA 4 was unable to tell the surveyor where the fire alarms and fire extinguishers are located in the building..."can't remember." The surveyor asked to review the staff member's personal record for training on emergency procedures. There was no record which indicated that NA 4 had completed any training on fire. The director on nursing (DON) stated the NA 4 was a "new hire" to the facility. On 05/10/06 at 9:30 AM, the surveyor asked to review the facility's "Fire Safety and Disaster Preparedness-Operational Procedures." The following is the communication procedure for sounding a fire alarm: 1. Contact the fire department (dial 911 or 477-3383).... 2. Provide the Fire Department with the following information: a. type of fire b. exact location of fire; c. extent of fire; d. if evacuation is in process; and e. other information.... 3. Keep communication lines open... 4. Relay instructions... 5. Remain calm... The policy states what should be done when discovering a "major fire or minor fire that is now out of control, immediately activate the nearest	F 518		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 12 fire pull station. Then...close all doors and windows to rooms as they are evacuated..."The policy states instruction for evacuation..."do not evacuate until the order has been given unless emergency conditions warrant other actions be taken.... " The policy further states how to use "ABC Extinguishers": ...."hold extinguisher upright, pull the ring pin to snap the safety seal, start back ten feet from the fire, aim at the base of the fire, do not start at the top of the fire, squeeze the lever, sweep the hose from side to side.." Based upon observation, interviews, and record review, it was determined that the facility did not sufficiently train all employees in emergency procedures. Specifically, during interviews with staff members regarding the facility's "Fire Safety and Disaster Preparedness - Operational Procedures", employees did not know expected actions during fire emergencies. Further, during observation of a fire drill, staff actions taken did not coincide with the facility's policy. Findings include: a. During an unannounced fire drill, RN 2 was standing in the hallway outside of Room one. The RN went into room one and checked for fire. She then proceeded to room two and then each of the other rooms in the south hallway. She did not close the doors to the rooms. The facility's "Fire Safety and Disaster	F 518		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465153	A. BUILDING _____ B. WING _____	05/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IRON COUNTY NURSING HOME	69 EAST 100 SOUTH PAROWAN, UT 84761

(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 13 Preparedness - Operational Procedures" states that in event of a fire, "close all doors and windows to rooms as they are evacuated".	F 518		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 465153	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 5/11/2006
NAME OF PROVIDER OR SUPPLIER **IRON COUNTY NURSING HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **69 EAST 100 SOUTH PAROWAN, UT**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 323	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility did not have an environment that was free from hazards that can endanger a resident's safety, specifically one room had a water temperature that was over 120 degrees Fahrenheit. Finding include: On 05/09/06 at 2:00 PM in room 6, the sink water temperature was tested in the residents room. The temperature of the water was 130 degrees Fahrenheit.

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

The above isolated deficiencies pose no actual harm to the residents