PRINTED: 09/27/2006 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY
COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING 465143 09/21/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 411 WEST 1325 NORTH KOLOB REGIONAL CARE AND REHAB CEDAR CITY, UT 84720 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) **POC** F 249 POC STANDERS 483.15(f)(2) ACTIVITY DIRECTOR **QUALIFICATIONS** SS=B F Tag 249 11/1/06 Resident #16 had progress note in The activities program must be directed by a qualified professional who is a qualified computer dated 5/18/06 & 7/31/06. therapeutic recreation specialist or an activities The Therapeutic Recreation Assessprofessional who is licensed or registered, if ment for Resident #17 was comapplicable, by the State in which practicing; and is pleted on 9/23/06. The Therapeutic eligible for certification as a therapeutic recreation specialist or as an activities professional by a Recreation Assessment for Residen recognized accrediting body on or after October #5 will be completed by 10/13/06. 1, 1990; or has 2 years of experience in a social All activity progress notes on Res-2.53 or recreational program within the last 5 years, 1 idents' #2,3,5,8,9,10,12,15,16 & of which was full-time in a patient activities 17 will be co-signed by MRTS on program in a health care setting; or is a qualified occupational therapist or occupational therapy 10/13/06. An audit of all current assistant; or has completed a training course residents was conducted and any approved by the State. activity progress notes lacking co-Monday Con signatures by the MRTS will be This REQUIREMENT is not met as evidenced signed by 10/13/06. An Inservice by: will be provided by the Nursing Based on record review and interviews it was Home Administrator on 10/13/06 determined that the facility failed to involve the to Recreation Therapy Staff and activity director in the assessment, development, MRTS on system to insure quartimplementation and/or revision of an erly co-signature by qualified

Resident #2 (R#2) was admitted to the facility on 10/28/05 with diagnoses that included cerebral vascular accident and diabetes. Activity progress notes found in R#2's record show no co-signatures by the qualified professional supervisor.

individualized activity program for 10 of 21 sampled residents. Resident Identifiers: 2, 3, 5,

8, 9, 10, 12, 15, 16, 17

Resident #3 (R#3) was admitted to the facility on 07/22/05 with diagnoses that included hypertension, Alzheimer disease and senile

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

professsional supervisor and

assessments within 30-days of admission are obtained. The

report to the monthly Quality

Improvement meeting any out-

standing assessments not com-

gress notes not co-signed by a

qualified professional super-

pleted within 30-days after admission and/or any quarterly pro-

Recreation Therapy Director will

(X6) DATE

ADMINISTRATOR Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULT	PLE CONSTRUCTION	(X3) DATE SURVEY	
		is a second residence.	A. BUILDING		G	COMPLETED	
		465143	B. WING			09/21/2006	
NAME OF PROVIDER OR SUPPLIER				STA	REET ADDRESS, CITY, STATE, ZIP CODE		
KOLOBI	REGIONAL CARE AN	D REHAB		4	11 WEST 1325 NORTH		
	· · · · · · · · · · · · · · · · · · ·			C	EDAR CITY, UT 84720		
(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 SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 249	Continued From pa	ige 1	F	249	visor within 30-days follow	ing	
	psychotic dementia	. Activity progress notes found			the IDT meeting. The Medi	.cal	
	in R#3's record sho	w no co-signatures by the			Records Director (MRD) wi	111	3
	qualified profession	nal supervisor. The last activity			conduct an audit each week	on	
	progress notes are dated 05/03/06. Resident #5 (R#5) was admitted to the facility on				residents scheduled for the		
					weekly IDT meeting to veri	fv	414
					if necessary assessments are	-	
	11/15/US With diagr	1/15/05 with diagnoses that included diabetes ellitus type II, gout, major depressive disorder, eripheral neuropathy, hypertension, and ongestive heart failure. R #5 's record contained "Data Collection Therapeutic Recreation Tool" ompleted by S#2 on 11/20/05. No "Therapeutic			completed. The MRD will		700
	nemina type II, got				, –	-	
	condestive heart fa				at the monthly Quality Impr		:
	a "Data Collection				ment meeting any assessme		1.0407
	completed by S#2				quarterly notes not in comp		(34)
	Recreation Assess	ment" was found in the record		.s.	The initial audit will be rep	ort-	
	and no co-signature	es by the qualified professional	•		ed at the QI meeting on 10/	12/06,	
	supervisor were no	ted.		same	and any follow-up will be c		NAME OF BRIDE
					pleted by 11/01/06.		
	Resident #8 (R#8)	was admitted to the facility on			picted by Thombs.		1*
	7/3/06 with diagnos	ses that included atrial					
	fibrillation, urinary r	etention, hypertension,					
	congestive neart ra	illure, volume depletion and					
	dementia. An adm	ission activity assessment was by S#2 but no co-signature by	•				
	the qualified profes	sional supervisor was noted.			,		
	are decimed broics	sional supervisor was floted.					
	Resident #9 (R#9)	was admitted to the facility on					
	01/19/06 with diagr	noses that included atrial					
	fibulation and diabe	etes. Activity progress notes					j
	found in R#9's reco	ord show no co-signatures by					
	the qualified profes	sional supervisor.					
	Dooldonk #40 (D#4)	~					
	nesident #10 (K#1)	0) was admitted to the facility		:			
	unspecified hypothe	agnoses that included yroidism and essential			•		
	hypertension. Activ	vity progress notes found in				•	
	R#10's record show	d show no co-signatures by the					
	qualified professional supervisor.			٠		,	
		•					
	Resident #12 (R#1)	2) was admitted to the facility					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	465143		B. Wil	NG		09/21/2006		
NAME OF PROVIDER OR SUPPLIER KOLOB REGIONAL CARE AND REHAB				41	EET ADDRESS, CITY, STATE, ZIP CODE 11 WEST 1325 NORTH EDAR CITY, UT 84720			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 249	on 05/01/03 with didementia and seizunotes found in R#1 co-signatures by th supervisor. Resident #15 (R#1 on 10/25/05 with di hypothyroidism; Be bladder. Activity precord show no co-professional super Resident #16 (R#1 on 04/21/06 with diseizures, traumatic obstruction, and psinotes were documed Resident #17 (R#1 on 07/17/06 with dihypertension, asthractures. R#17's in Collection Therape completed by S#2 Recreation Assess	agnoses that included arthritis, are disorder. Activity progress 2's record show no e qualified professional 5) was admitted to the facility agnoses that included all's palsy and disorder of the ogress notes found in R#15's signatures by the qualified visor. 6) was admitted to the facility iagnoses that included brain, chronic airway sychosis. No activity progress ented in R#16's chart. 7) was admitted to the facility agnoses that included ma and bilateral ankle ecord contained a "Data autic Recreation Tool" on 07/17/06. No "Therapeutic ment" was found in the record es by the qualified professional	F	249				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	465143		B. WING				
NAME OF PROVIDER OR SUPPLIER KOLOB REGIONAL CARE AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 411 WEST 1325 NORTH CEDAR CITY, UT 84720				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 250 \$S=E	services to attain of practicable physical well-being of each. This REQUIREMED by: Based on record redetermined that the necessary and apprinterventions to attain highest practices ampled residents 6, 7, 8, 9, 10, 11, 11, 11/3/05 with diagnifibrillation, congest abnormality of the documentation of shortes were found. Resident #2 (R#2) 10/28/05 with diagnifibrillation accident, social service histodated or co-signed The last document	rovide medically-related social or maintain the highest al, mental, and psychosocial resident. INT is not met as evidenced eview and interview, it was a facility did not provide the propriate Social Service ain the residents psychosocial cal well-being in 11 of 21. Resident Identifiers: 1, 2, 5, 5, 16 was admitted to the facility on oses that included atrial tive heart failure, dementia, heart and psychosis. No social service assessment or was admitted to the facility on noses that included cerebral diabetes and hypertension. A pry was completed but was not by a qualified social worker, ted social services progress	F	250	F Tag 250 Residents' #1,2,5,6,7,8,9,10 15, & 16 will receive a soci services assessment by a lice Social Worker not later than 11/01/06. In addition, all carent residents' medical char will be audited and any four be deficient in social service assessments within the past days will receive an assessments within the past days will receive an assessment within the past days will receive addressing psycho-social wing and appropriate dischar planning, if necessary, with the last 90-days will receive documented social services covering such information become such information because of the social services assistant (non-licensed) will docume least quarterly, notes address the psycho-social well-bein charge planning, if appropri	al ensed in- ir- ts ind to es 90 nent r not rent in note ell-be- ge in a note by a later t int, at essing g, dis-	11/1/06
	continuing psycho- Resident #5 (#5) w	dressing discharge planning or social issues were found. vas admitted to the facility on noses that included diabetes		-	and perform admission assoments and update social ser assessments and any other in preparation for the quarte IDT meetings. Until a licer	ess- vice tems erly	

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CLIVIE	13 LOV MEDICAKE	& MEDICAID SERVICES				<u>OMB NO.</u>	<u> 09</u> 38-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465143		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING			09/21/2006		
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	· -	
KOLOBI	REGIONAL CARE AN	D REHAR		4	11 WEST 1325 NORTH		
				0	EDAR CITY, UT 84720		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG CF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 250	Continued From pa	ige 4	ĺ F:	250	Social Worker is permanen	tly em-	
	· •				ployed, the consultants will		
	nemus type II, got	t, major depressive disorder,			view and sign the assessme		
	concestive beart for	thy, hypertension, and illure. R#5's social history was	1,1		· -		
	electronically signe	d as having been completed			quarterly notes documented		
	by the Recreation 1	Therapy Assistant Director.	1		social services assistant du		
	No date was found	indicating when the			their regular monthly visits	. The	1 12 C B X 1
	assessment was co	ompleted, and no co-signature			Medical Records Director (1
	by a qualified socia	worker. No social services	3		will conduct an audit each	week	(tr/3)
	notes were found d	ated after 04/19/06,		1.7.22	on residents scheduled for	the	
	D 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				weekly IDT meeting to ver	ifv if	
	Resident #6 (R#6) was admitted to the facility on 02/21/06 with diagnoses that included chronic				-necessary assessments are		11000 fg
	02/21/06 With diagr	loses that included chronic		**	pleted. The MRD will repo	>O111-	
	organic brain synor	ome, constipation, chronic ulsions and traumatic	1	. 4			
	amputation of the k	uisions and traumatic egs. R#6 had a social services	1		the monthly Quality Improv		
	note completed on	05/25/06 delineating an	~	· 57 1	meeting any assessments ar		or on the community
	incident between th	ne resident and a facility aide	, ·	Υ.	quarterly notes not in comp	oliance.	ાતબ્રીક
	that required APS	adult protective services)			The initial audit will be rep	orted	ke Su
	notification. No so	cial services notes were found			at the QI meeting on 10/12/	/06	to a season
	dated after 05/25/0	6.			and any follow-up will be o		
			1		pleted by 11/01/06.	~111	
	Resident #7 (R#7)	was admitted to the facility with			protou by 11/01/00.		
	diagnoses that incli	uded: atrial fibrillation.					
	congestive heart fa	ilure and 2nd degree burn. No	i '			•	
	social service note:	s were found after 5/23/06.	Ì		*		
	Pasidant #0 (D#0)				\$		
	7/3/06 with diagram	was admitted to the facility on ses that included: atrial			La de Alba		*
	fibrillation urinary	etention, hypertension,	1		15/		
	concestive heart fa	ilure, volume depletion and					
	dementia. No reco	rd of a social services					
	assessment was fo	und. R#8's medical record]	•			ļ · · · · ·
	contained a social	service note dated 8/1/06		**	Later.		
!	delineating visitation	on rights between the		;			
	daughter, Wendy a	nd the wife. Ruth. The note				1	
	was signed by Staf	#4. No other Social Service	v. u				÷
	documentation was	found on the chart.			}		
j			l		1 .		1

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but was not dated or co-signed by a qualified social worker. The last documented social services progress note was dated 03/29/06. No documentation addressing discharge planning or continuing psycho-social issues were found.

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1. The ceiling vents in resident restrooms in rooms 105, 103, 108, 115, 119, and 302 did not

provide adequate air movement to cause a piece of toilet tissue to adhere to the vents. The

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will be reviewed on a monthly basis at the Quality Improvement

Committee meeting.

10/13/2006 FRI 9:07 FAX 4355860363 KOLOB REGIONAL

2009/009

PRINTED: 09/27/2006 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 465143 09/21/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 411 WEST 1325 NORTH KOLOB REGIONAL CARE AND REHAB CEDAR CITY, UT 84720 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY Continued From page 7 F 467 restrooms in rooms 103 and 115 were noted to be very malodorous, with the smell of urine at the time of the observation. 2. The ceiling vent on the 300 hall resident on bathroom did not provide adequate air movement to cause a piece of toilet tissue to adhere to the 2.53 Control of the Contro vent. The restroom was noted to be very malodorous, with the smell of chlorine at the time FUDIN of observation. CMD 3. There were no ceiling vents in the public INTERESTANCE restroom, located in the lobby, or facility staff alition in restroom on the 100 hallway. ELIAN (An interview with Staff #3 (S#3) took place on -1.0χ 0 Administra 09/20/06 at 3:15 PM. S#3 stated the vents in the 100 resident rooms run off specific ventilation systems. S#3 further stated that the system is usually not checked unless a complaint is received that the bathrooms have an odor. S#3 stated that they were aware that the public restroom and the staff restroom did not have any outside ventilation. 5 Sept 1

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