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

PRINTED: 09/27/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465143	A. BUILDING _____ B. WING _____	09/21/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOLOB REGIONAL CARE AND REHAB	411 WEST 1325 NORTH CEDAR CITY, UT 84720

(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 249 SS=B	483.15(f)(2) ACTIVITY DIRECTOR QUALIFICATIONS The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that the facility failed to involve the activity director in the assessment, development, implementation and/or revision of an individualized activity program for 10 of 21 sampled residents. Resident Identifiers: 2, 3, 5, 8, 9, 10, 12, 15, 16, 17 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. Resident #3 (R#3) was admitted to the facility on 07/22/05 with diagnoses that included hypertension, Alzheimer disease and senile	F 249	POC F Tag 249 Resident #16 had progress note in computer dated 5/18/06 & 7/31/06. The Therapeutic Recreation Assessment for Resident #17 was completed on 9/23/06. The Therapeutic Recreation Assessment for Resident #5 will be completed by 10/13/06. All activity progress notes on Residents' #2,3,5,8,9,10,12,15,16 & 17 will be co-signed by MRTS on 10/13/06. An audit of all current residents was conducted and any activity progress notes lacking co-signatures by the MRTS will be signed by 10/13/06. An Inservice will be provided by the Nursing Home Administrator on 10/13/06 to Recreation Therapy Staff and MRTS on system to insure quarterly co-signature by qualified profesSsional supervisor and assessments within 30-days of admission are obtained. The Recreation Therapy Director will report to the monthly Quality Improvement meeting any outstanding assessments not completed within 30-days after admission and/or any quarterly progress notes not co-signed by a qualified professional super-	11/1/06

10/16/06 POC acceptable completion date 11/1/06 Inservice

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hadr C Hamilton — TITLE: ADMINISTRATOR — (X6) DATE: 10/6/06

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

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F 249	Continued From page 1 psychotic dementia. Activity progress notes found in R#3's record show no co-signatures by the qualified professional supervisor. The last activity progress notes are dated 05/03/06. Resident #5 (R#5) was admitted to the facility on 11/15/05 with diagnoses that included diabetes mellitus type II, gout, major depressive disorder, peripheral neuropathy, hypertension, and congestive heart failure. R #5 's record contained a "Data Collection Therapeutic Recreation Tool" completed by S#2 on 11/20/05. No "Therapeutic Recreation Assessment" was found in the record and no co-signatures by the qualified professional supervisor were noted. Resident #8 (R#8) was admitted to the facility on 7/3/06 with diagnoses that included atrial fibrillation, urinary retention, hypertension, congestive heart failure, volume depletion and dementia. An admission activity assessment was done on 07/08/06 by S#2 but no co-signature by the qualified professional supervisor was noted. Resident #9 (R#9) was admitted to the facility on 01/19/06 with diagnoses that included atrial fibulation and diabetes. Activity progress notes found in R#9's record show no co-signatures by the qualified professional supervisor. Resident #10 (R#10) was admitted to the facility on 12/24/05 with diagnoses that included unspecified hypothyroidism and essential hypertension. Activity progress notes found in R#10's record show no co-signatures by the qualified professional supervisor. Resident #12 (R#12) was admitted to the facility	F 249	visor within 30-days following the IDT meeting. The Medical Records Director (MRD) will conduct an audit each week on residents scheduled for the weekly IDT meeting to verify if necessary assessments are completed. The MRD will report at the monthly Quality Improvement meeting any assessments and quarterly notes not in compliance. The initial audit will be reported at the QI meeting on 10/12/06, and any follow-up will be completed by 11/01/06.	

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F 249	Continued From page 2 on 05/01/03 with diagnoses that included arthritis, dementia and seizure disorder. Activity progress notes found in R#12's record show no co-signatures by the qualified professional supervisor. Resident #15 (R#15) was admitted to the facility on 10/25/05 with diagnoses that included hypothyroidism; Bell's palsy and disorder of the bladder. Activity progress notes found in R#15's record show no co-signatures by the qualified professional supervisor. Resident #16 (R#16) was admitted to the facility on 04/21/06 with diagnoses that included seizures, traumatic brain, chronic airway obstruction, and psychosis. No activity progress notes were documented in R#16's chart. Resident #17 (R#17) was admitted to the facility on 07/17/06 with diagnoses that included hypertension, asthma and bilateral ankle fractures. R#17's record contained a "Data Collection Therapeutic Recreation Tool" completed by S#2 on 07/17/06. No "Therapeutic Recreation Assessment" was found in the record and no co-signatures by the qualified professional supervisor were noted..	F 249		

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F 250 SS=E	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not provide the necessary and appropriate Social Service interventions to attain the residents psychosocial and highest practical well-being in 11 of 21 sampled residents. Resident Identifiers: 1, 2, 5, 6, 7, 8, 9, 10, 11, 15, 16 Findings Include: Resident #1 (R#1) was admitted to the facility on 11/3/05 with diagnoses that included atrial fibrillation, congestive heart failure, dementia, abnormality of the heart and psychosis. No documentation of social service assessment or notes were found. Resident #2 (R#2) was admitted to the facility on 10/28/05 with diagnoses that included cerebral vascular accident, diabetes and hypertension. A social service history was completed but was not dated or co-signed by a qualified social worker. The last documented social services progress note was dated 04/18/06. No further documentation addressing discharge planning or continuing psycho-social issues were found. Resident #5 (#5) was admitted to the facility on 11/15/05 with diagnoses that included diabetes	F 250	F Tag 250 Residents' #1,2,5,6,7,8,9,10,11, 15, & 16 will receive a social services assessment by a licensed Social Worker not later than 11/01/06. In addition, all current residents' medical charts will be audited and any found to be deficient in social services assessments within the past 90 days will receive an assessment by a licensed Social Worker not later than 11/01/06. All current residents who are identified in not having a social services note addressing psycho-social well-being and appropriate discharge planning, if necessary, within the last 90-days will receive a documented social services note covering such information by a licensed Social Worker not later than 11/01/06. The social services assistant (non-licensed) will document, at least quarterly, notes addressing the psycho-social well-being, discharge planning, if appropriate, and perform admission assessments and update social service assessments and any other items in preparation for the quarterly IDT meetings. Until a licensed	11/1/06

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F 250	Continued From page 4 mellitus type II, gout, major depressive disorder, peripheral neuropathy, hypertension, and congestive heart failure. R#5's social history was electronically signed as having been completed by the Recreation Therapy Assistant Director. No date was found indicating when the assessment was completed, and no co-signature by a qualified social worker. No social services notes were found dated after 04/19/06. Resident #6 (R#6) was admitted to the facility on 02/21/06 with diagnoses that included chronic organic brain syndrome, constipation, chronic osteomyelitis, convulsions and traumatic amputation of the legs. R#6 had a social services note completed on 05/25/06 delineating an incident between the resident and a facility aide that required APS (adult protective services) notification. No social services notes were found dated after 05/25/06. Resident #7 (R#7) was admitted to the facility with diagnoses that included: atrial fibrillation, congestive heart failure and 2nd degree burn. No social service notes were found after 5/23/06. Resident #8 (R#8) was admitted to the facility on 7/3/06 with diagnoses that included: atrial fibrillation, urinary retention, hypertension, congestive heart failure, volume depletion and dementia. No record of a social services assessment was found. R#8's medical record contained a social service note dated 8/1/06 delineating visitation rights between the daughter, Wendy and the wife, Ruth. The note was signed by Staff #4. No other Social Service documentation was found on the chart.	F 250	Social Worker is permanently employed, the consultants will review and sign the assessments and quarterly notes documented by the social services assistant during their regular monthly visits. The Medical Records Director (MRD) will conduct an audit each week on residents scheduled for the weekly IDT meeting to verify if necessary assessments are completed. The MRD will report at the monthly Quality Improvement meeting any assessments and quarterly notes not in compliance. The initial audit will be reported at the QI meeting on 10/12/06, and any follow-up will be completed by 11/01/06.	

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F 250	Continued From page 5 Resident #9 (R#9) was admitted to the facility on 01/19/06 with diagnoses that included atrial fibulation, diabetes, and hyperlipidemia. A social service history was completed but was not dated or co-signed by a qualified social worker. The last documented social services progress note was dated 05/03/06. No further documentation addressing discharge planning or continuing psycho-social issues were found. Resident #10 (#R10) was admitted to the facility on 12/24/05 with diagnoses that included unspecificied hypothyroidism; and essential hypertension. A social service history was completed on 01/16/06 but was not co-signed by a qualified social worker. The last documented social services progress note was dated 03/28/06. No further documentation addressing discharge planning or continuing psycho-social issues were found. Resident #11 (#R11) was admitted to the facility on 09/08/06 with diagnoses that included diabetes mellitus type II, dehydration, anxiety state, hemiplegia, chronic airway obstruction and unspecified cerebral artery occlusion with cerebral infarct. No record of a social services assessment was found. Resident #15 (R#15) was admitted to the facility on 10/25/05 with diagnoses that included hypothyroidism, Bell's palsy and disorder of the bladder. A social service history was completed 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.	F 250		

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F 250	Continued From page 6 Resident #16 (R#16) was admitted to the facility on 04/21/06 with diagnoses that included seizures, traumatic brain injury, chronic airway obstruction and psychosis. No psychosocial assessment was documented in the medical record. A social service history was completed but was not dated or co-signed by a qualified social worker. The last documented social services progress note was dated 05/30/06. No documentation addressing discharge planning or continuing psycho-social issues were found.	F 250	F Tag 467 The heat diffuser is used to vent to the outside in the public rest-room located in the lobby, and the facility staff restroom on 100 hall. However, the ventil-ation motor was not working. The motor was repaired and re-installed on 9/21/06 and is pro-viding the necessary ventilation. Staff #3 was unaware of the ventilation problem in the public and staff restrooms located in the lobby and 100 hall. The fan capacity for resident restroom on 300 hall, and rooms 105, 103, 108, 115, 119, & 302 will be increased by replacing a 12" fan with a 14" fan by 11/17/06, which will double the ventilation capacity. The safety coordinator will con-tinue to conduct his monthly safe-ty inspection checklist of clean-ing and operability of fan motors and the results of that inspection will be reviewed on a monthly basis at the Quality Improvemcnt Committee meeting.	11/17/06
F 467 SS=B	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not provide adequate ventilation by means of windows, or mechanical ventilation. Findings Include: Observations of the facilities environment occurred from 09/19/06 to 09/21/06. 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	F 467		

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F 467	Continued From page 7 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 bathroom did not provide adequate air movement to cause a piece of toilet tissue to adhere to the vent. The restroom was noted to be very malodorous, with the smell of chlorine at the time of observation. 3. There were no ceiling vents in the public restroom, located in the lobby, or facility staff restroom on the 100 hallway. An interview with Staff #3 (S#3) took place on 09/20/06 at 3:15 PM. S#3 stated the vents in the 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.	F 467		