DEPARTMENT OF HEALTH AND HUM.	SERVICES
JEALTH CARE FINANCING ADMINISTRA	ATION

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	I OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDII B. WING		ISTRUCTION	(X3) DATE SU COMPLET	ED
		465108					1/1	6/02
	ROVIDER OR SUPPLIER  VALLEY HEALTH CE  SUMMARY ST.	ATEMENT OF DEFICIENCIE	STREET ADD 3706 WES' WEST JOE	r 9000 SOU RDAN, UT	TH 84088	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S		(X5) COMPLETE
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR 1	MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	TION)	PREFIX TAG	C	CROSS-REFERENCED TO THE AIDEFICIENCY)	PPROPRIATE	DATE
F 176 SS=D	An individual resident the interdisciplinary s483.20(d)(2)(ii), has safe.  This REQUIREMENT Based on observation record review, it was assessed a resident a administering his own resident to administer monitoring. The fact safety for 1 of 26	or, staff interview, and a determined that the fast on the staff interview, and a determined that the fast on the being a safe cand on medications, then all or his own medications could do not monitor for many down the staff of the staff o	drugs if  ractice is  ractical cility idate for owed without or drug lent 25)  3/6/01. major ion of leg, nerve ractures, nd arthritis. ciplinary sident 25 to //01. The ration of reasons ic history of nagement	F 176	is in readmininclud found named plan or be in each of the found of the	ellowing is a plan of conference to F-176 483 istration of drugs. The corrective action for to have been affected as resident #25. The f correction has been effect on 2/6/02.  IDT meeting will eversidents' ability to a Resident will sign and forms to self-medical Lock box with keys medication record we provided to resident will go to charge number energency situation. Careplan will design audit-where charge revaluate and review as ordered.  Record on MAR and notes weekly regard with resident regard of self-administration. The nurses will district controlled substance. In-service regarding was discussed with 12/6/02.	is will reach resident and were following instituted to aluate self-medicate opropriate and rill be. Extra key rese for s. The following instituted to aluate opropriate and rill be and rill be attentions of nurses will medications of nurses will medications of nurses ing review ing capability on. The ribute all the sonly. The above POC	t.
	V DIDECTORS OF PROVIE	CO/CUIDDLIED DEPRESENTA	VIVE'S SIGNAT	URF		TIPLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide efficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after the findings are information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMA SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465108 1/16/02 STREET ADDRESS, CITY, STATE, ZIP CODE ME OF PROVIDER OR SUPPLIER 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Continued From Page 1 F 176 F 176 months of April, 2001 through December 2001. In June 2001, resident 25's MAR documented that resident 25 had Oxy IR, 5 mg, 1-2 tablets by mouth every 4 hours as needed for pain, ordered. There was "Self Med" written across the individual boxes, where the nurses would initial, as documentation, if the drug had been administered. The other drug name for Oxy IR, is percocet immediate relief. There was no documentation as to whether the drug had been given or not. Nurses notes dated 6/10/01 at 6:00 PM documented the following: "... maintenance man will be in, in the AM to unlock patient medication drawer that contains resident 25's self - meds, including percocet..". Nurses notes dated 6/16/01 at at 6:00 PM, documented the following: "...he went to get his pain pills, and there were no more, he had taken 60...". Further in the entry, "... I took another nurse with me and we told [resident 25] we would have to keep the narcotics in the med cart. He felt like we were blaming him and we explained that was not what we were doing, but that the doctor wanted them kept in the med cart...". A physician's order, dated 7/11/01 reads: "pt able to to continue to self administer medications except narcotics." This was the only physician's order found in resident 25's medical record to allow resident 25 to administer self medications. There was no documentation to show that an original order was received from the physician, to permit resident 25 to administer his own medications. On 01/2/02 at 10:15 AM, an interview with a nursing staff member, who provided care for resident 25, stated that resident 25 was self administering

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medications with no monitoring by nursing or by

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Facility ID:

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## DEPARTMENT OF HEALTH AND HUMAI, SERVICES

HEALTH CARE FINANCING ADMINISTRATION

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AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM 465108		(X2) MUL A. BUILDI B. WING	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED 1/16/02	
WE OF D	DOMINED OR STIPPITED		STREET ADD	DESC CITY (	STATE, ZIP CODE		1/.	10/02
SOUTH VALLEY HEALTH CENTED 3706 WE			1	T 9000 SOU	J <b>TH</b>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEEDED BY  SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLA (EACH CORRECTIV CROSS-REFERENCED DEFIC	E ACTION SHOU	ILD BE	(X5) COMPLETE DATE
F 176	how many of each me what time each medic	medications were being edication was being take cation was being taken. t 25 does not have a me	ken, or The staff	F 176				
	The facility must prommanner and in an envienhances each resident recognition of his or has recognitive manner.  Findings include:  1. On 12/31/01, at 12: of room 203 was obsernance assistant entered. There was 16 minutes observed to be on until the residents in room 2.  2. On 12/31/01, at 1:20.	mote care for residents ironment that maintains it's dignity and respect the individuality.  T is not met as evidence, individual interview at erview, the facility did dents in a manner and intained dignity and responding of the request for sthrough use of the call taff did not answer call extend to be on. At 1:04 the room to assist the between the time the lil staff entered the room 203.	in a sor in full ced by: and a not n an pect as r ll light lights in e the door PM, a residents. ight was n to assist	F 241	F-241The following is a reference to F-241 483.15 include corrective action fhave been affected. The fethas been instituted to be elementary in the property of the fethas been instituted to be elementary in the property of the fethas been instituted to be elementary in the property of the fethas been instituted to be elementary in the property of the fethas will be within the building is so the administrator of the fethas will compliance is accountable to the fethas will compliance is accountable fethas and property of the fethas will be monitary of the fethas will be within the property of the fethas will be within the	(a) Quality of a core each resident of lowing plan of fect on 2/6/02. Itee has determined in the min. Items at the core in the	Life. This wat found to of correction ined that ely manner of for all SVH illity to answater throughout directed by was initiated and the until 90% with resident residents ght issues.	ill IC er ut y
	of room 303 was obser nurse assistant entered	rved to be on. At 1:30	PM, a					

There was 10 minutes between the time the light was observed to be on until staff entered the room to assist

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#### DEPARTMENT OF HEALTH AND HUM. ... SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465108 1/16/02 ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 241 Continued From Page 3 F 241 the residents in room 303. 3. On 1/3/02, at 10:18 AM, the light above the door of room 205 was observed to be on. At 10:20 AM, a nurse aid passed room 205 but did not enter the room to assist the residents. At 10:21 AM, there were observed to be 6 staff members present at the nurses station. The call light above the door of room 205 remained on. At 10:33 AM, a staff member entered room 205 to assist the residents. There was 15 minutes between the time the light was observed to be on until staff entered the room to assist the residents. 4. On 12/31/01, at 8:19 AM, the light above the door of room 303 was observed to be on. At 8:21 AM, a facility nursing assistant was observed to walk past the room while turning her head, she had looked at the room with the light on but continued to walk down the hall. At 8:24 AM, a voice from room 303, stated, "Nurse, would you get in here". A facility nursing assistant was observed to enter room 303 at 8:28 AM. There was 9 minutes between the time the light was observed to be on until staff entered the room to assist the residents in room 303. 5. On 1/02/02, at 8:35 AM, the light above the door of room 313 was observed to be on. A facility nursing assistant was observed to enter room 313 at 8:45 AM. There was 10 minutes between the time the light was observed to be on until staff entered the room to assist the residents in room 313. 6. On 1/3/02, the call light for room 115 was observed to be on at 7:40 AM. The nursing staff answered the call light at 07:50 AM. There was 10 minutes between the time the light was observed to be on until staff entered the room and answered the call light. 7. On 1/3/02, the call light for room 115 was observed to be on at 8:40 AM. The nursing staff answered the call light at 8:50 AM. There was 10

Facility ID:

DEPARTMENT OF HEALTH AND HUMA SERVICES **HEALTH CARE FINANCING ADMINISTRATION** 

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02 ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION lD (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From Page 4 F 241 minutes between the time the light was observed to be on until staff entered the room and answered the call light. A confidential interview was held with a group of residents on 1/2/02 at 9:00 AM. Fourteen residents participated in the interview. Eight (8) of the 14 residents stated that they have had to wait too long for their call light to be answered. Two residents stated they've had to wait up to an hour before a staff member would respond to their call lights. F-252--The following is a plan of correction and is in 3/1/02 reference to F-252 483.15 (h) Environment. This will include corrective action for each resident found to have been affected. The following plan of correction: F 252 483.15(h)(1) ENVIRONMENT F 252 has been instituted to be effect on 2/6/02. SS=E The facility must provide a safe, clean, comfortable There has been new maintenance logs put at each nurse and homelike environment, allowing the resident to station the maintenance man will check these every use his or her personal belongings to the extent morning. There has been put together by plant op, a new preventative maintenance log which QA will look possible. over also plant ops will document every week through out building. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview Housekeeping supervisor is going to have an the facility did not provide a safe, clean, comfortable in-service on 2/20/02, cleaning of clean and homelike environment for the residents as covebase on a weekly basis so we no longer have stains and dirt build in the halls. Plant evidenced by: The facility was observed to be op manager will oversee or audit designated unclean, the building in ill repair, and a leak was areas and address weekly. present in the ceiling on 1/8/02 that resulted in an 2. Housekeeping supervisor hired a new floor employee fall. man. The floor man will steam clean and get red stains and brown stains out, clean carpet Findings include: through out the building. The buffet in the dining room will be recovered by 2/22/02. The table that was unstable is now fixed. Observation of the environment from 12/31/01 until Areas of frayed carpet will be repaired and 1/8/02 revealed the following problems: patched. Missing masonite will be replaced as budget allows. 1. The tile floor along the coving of the 100, 200, and Entry doors to resident room that draw wood 300 halls had grey and brown stains and dirt buildup. chips or cracks including the double doors to The special needs unit tile floor along the coving had the unit will be puttied and painted 2/22/02 some areas with grey and brown stains and dirt buildup.

1/16/02

#### DEPARTMENT OF HEALTH AND HUMAN JERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IE OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

B. WING\_ STREET ADDRESS, CITY, STATE, ZIP CODE

**3706 WEST 9000 SOUTH** WEST JORDAN, UT 84088

(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 (X5)  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X5)  COMPLETE  DATE
F 252	Continued From Page 5 2. The main dining room carpet had large brown and red stains. There were strips in the carpet under the tables and throughout the carpeted area that were worn and frayed. There was a strong odor of urine present. The buffet tables, that food was served on, had large areas where the masonite was missing and wood was exposed causing it to be unsanitizable. There was one resident table that had paper towels stacked under the legs to maintain stability.  3. All entry doors to the residents' rooms had wood chipped or cracked. The double doors to the units had wood chipped or cracked. The double doors to the units had wood chipped or cracked.  4. The window sills in the hallway from the lobby area had strips of formica missing which exposed the wood underneath, leaving them unsanitizable. There was a broken window that had white tape over the crack.  5. All the windows throughout the building were dirty and difficult to see through.  6. There were areas on all the hallways that had wallpaper on them, where the wallpaper was missing or coming off the wall.  7. The dining room carpet on the 100 hall had large stains that were brown in color. There was a strong odor of urine present. There was a broken window.  8. The brass ring around the door knob of the shower room in the 300 hall was not attached and could be turned easily.  9. There was a used disposable towel on the floor outside room 308 that smelled of urine.  10. There was a hole in the wall above the wardrobe in room 201 that allowed one to see through from the resident room to the outside of the building in the court yard.  11. There were ceiling tiles on the 100, 200, and 300 halls, and throughout the building, that had brown stains, round in shape, that appeared to be water damage. There were several ceiling tiles that were broken or had portions missing.	F 252	<ol> <li>Windowsills in the hallway from lobby area will have Formica replaced by 6/1/02 and broken window in hallway/lobby area will be replaced by 2/25/02.</li> <li>Housekeeping supervisor has assigned a housekeeper for 1 day a week to clean window throughout the building. Also in the in-service which will be informed to clean those windows.</li> <li>Housekeeping supervisor will go through the building and fix wallpaper. Expected date to be done is 2/25/02.</li> <li>Housekeeping supervisor hired a new floor person who will be cleaning carpets. It will be put on a schedule to do every week. Also housekeeping supervisor will do morning check and if there are stains they will be addressed. Broken window will be replaced by 2/25/02.</li> <li>Replace and fix the brass ring and doorknobs of shower. This will be replaced 2/25/02.</li> <li>Housekeeping supervisor is having in-service on 2/22/02 with housekeeping staff to spot check throughout the building for anything on floors.</li> <li>Hole in the wall of room 201 will be puttied and painted by 2/14/02.</li> <li>Maintenance man has replaced a lot of ceiling tiles. They will be all done by 2/25/02.</li> <li>Shower room water. Maintenance will replace and fix shower room across from unit to turn off water by 2/25/02.</li> <li>Light fixture in room 218 is now on.</li> <li>Room 315 hot water will be repaired 2/25/02.</li> <li>Housekeeping supervisor will have an inservice on 2/22/02 with housekeeping staff. They will be informed to check rooms throughout day for spills and how important it is to clean them up. A mop and bucket with clean water and sanitizer will provide</li> </ol>

Facility ID:

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM						URVEY TED
		465108		B. WING			1/3	16/02
ME OF P	ROVIDER OR SUPPLIER	107000	STREET ADD	RESS, CITY, S	STATE, ZIP	CODE	1	
SOUTH V	VALLEY HEALTH CE	NTER	t .	T 9000 SOU RDAN, UT				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
F 252	12. The water in the surress station, in the off. 13. There was no light. There were exposed of the transfer was no hot off. 14. There was no hot off. 15. There was standing bathroom of room 30. 16. There were three bathroom on the outstapproximately 1/2 incompared in the call high and present. 18. The dirty utility round in the wall behind stains on the floor in the transfer water heater, had a duroom from the outside for pest and rodent en 20. There were areas missing in the special station and outside of 21. The refrigerator in hall had broken areas prevented it from seal appropriate temperature the sink. There was a connected nor being utover. 22. There was a hole in machine in the 100 ha 23. The dirty utility round plastic light fixture had plastic light fixture.	shower room across from special needs unit, work above the mirror in revires instead of a light water in resident rooming water on the floor in 8.  Though the wall next to the floor in 18.  Though the wall of room 206 the floor in 18.  Though the wall of room 206 the floor in 18.  The wall of room 206 the floor in 18.  The floor in diameter and the toilet pedestal in the floor in front of the floor in the	oom 218. ing fixture. i 315. i the to the hat were r. in room own stains d a large e brown or. used a into the ould allow oken or the nurses on the 100 oor that i work in was not had no wending al supply own.	F 252	17. 18. 19. 20. 21. 22. 23. 24. 25. 26. Record re each station	for staff at each hall after hour housekeeping for unexpected so The maintenance man has covin room 206. Housekeeping staff cleaned to 310. Also maintenance man retoilet Maintenance has patched and behind the door. Housekeepin having in-service on 2/22/02 whousekeepers to be aware of st spot check throughout day. A log at each station will also preinformation regarding stain an addressed which plant ops mar addressed, weekly, a log will be with all information above for auditing. Utility room will have mainten replace duct screen and vent we equipment by 2/14/02. The maintenance will put cove replace broken cove in a timely 2/25/02. The water in the sink is now we Regarding the light fixture a nebeen ordered. The ice machine is going to look at it try to fix is removed by 2/25/02. Refriger medication room will be replaced the hole in the wall behind the machine is now fixed. Light fixture has been ordered a replaced in shower room by 2/2. This area of water running dow physical therapy room has been 2/1/02.  View: Reviewed with maintenance with his initial when completed.	spills. ered the holes illet in room c-caulked the fixed the hole g supervisor i vith ains and to maintenance ovide d spots to be nager will the maintained continue thance will ith new up and y manner orking. ew one has e maintenance t or it will be ator in ced by 2/25/02 evending and will be 25/02. vn wall outsid n repaired by request logs at	

25. There was water running down the wall outside the physical therapy room on the 100 hall that resulted

exposed light bulbs with no light cover.

Interview

#### DEPARTMENT OF HEALTH AND HUMAI. JERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

AME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

1/16/02

465108

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH		706 WEST 9000 SOUTH VEST JORDAN, UT 840		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 252	Continued From Page 7 in an employee fall on 1/8/02.  Record review:  Review of the maintenance request logs at each station revealed that most of the requests for the hall from staff to repair problems in the facility documentation that they had been done since the of October 2001. Some of the request for the 3 and the special needs unit had no documentation the problems had been taken care of since the environment of the problems had been taken care of since the environment of the problems.  Interview:  An interview was conducted on 1/8/02, with the administrator and the new plant operations man.	e 100 had no e end 00 hall n that nd of		
	concerning the building environment. The administrator stated that they had had a mainten manager full time until October 2001; and he hat taken the routine maintenance logs with him. We the plant operations manager was asked to obtain information about preventive maintenance, she presented the nurse surveyor with a binder with documentation of maintenance performed and states that she had developed the binder to begin documentation.	ance d 'hen n		
SS=H	483.25(i)(1) QUALITY OF CARE  Based on a resident's comprehensive assessment facility must ensure that a resident maintains acceptable parameters of nutritional status, such body weight and protein levels, unless the reside clinical condition demonstrates that this is not possible.	as	·	

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Facility ID:

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If continuation sheet 8 of

# DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  (X3) DATE S  COMPLE  A. BUILDING	
465108 B. WING	6/02
AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
SOUTH VALLEY HEALTH CENTER  3706 WEST 9000 SOUTH WEST JORDAN, UT 84088	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
This REQUIREMENT is not met as evidenced by:  Based on clinical record review and staff interviews it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by 8 of 26 sampled residents experienced significant weight loss with no dietary interventions implemented to prevent further weight decline. Resident identifiers:  13.20,28,40,50,70,72,74. Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the previous weight and multiplying by 100.  Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months.  (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000).  Findings include:  1. Resident 13, a 79 year old female, was admitted to the facility on 10/11/01 with diagnoses of chronic obstructive pulmonary disease, hypothyroidism and bronchitis, urinary tract infection, helicobacter pylori gastritis (h.pylori), anxiety and chronic dizziness.  Resident 13 was admitted with physician orders for medications to treat the h. pylori.  Review of the physician's order and nursing care referral form, dated 10/11/01, from the discharging hospital to the mursing facility documented that resident 13, "eats well, but slowlyPt [patient] is very aware and careful when eating."  On 10/15/01 the RD [registered dietitian] completed a mutritional assessment that documented resident 13 was 61 inches tall, weighed 95 pounds, had a small frame and resident 13's ideal body weight range was from 106 to 118 pounds.	dates is at al mod by

Facility ID:

1/16/02

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## DEPARTMENT OF HEALTH AND HUMAN LERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

SOUTH	VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH VEST JORDAN, UT 840	<del>1</del> 988
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATIO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
F 325	During an interview with a facilty restorative rassistant on 1/11/02, she stated that the restorat aides are the only staff members that weigh the residents each month. She stated that the reside weighed at the end of each month to obtain the for the following month. For example, all residere weighed at the end of December 2001 for January 2002 weights.  Review of the weights for resident 13 revealed following: October 2001 – 95 pounds.  November 2001 – 84 pounds. This represents a weight loss of 11 pounds, (11.5%) between the of October and November 2001.  December 2001 – 75.5 pounds. This represents weight loss of 8.5 pounds, (10%) between the nof November and December 2001.  Resident 13 experienced a significant weight lost 19.5 pounds (20%) between the months of October and December 2001.  Review of an assessment written by the RD on 10/15/01 revealed the following: "Intake fair, she adequate for needs if intake > [greater than] average - otherwise need to consider snacks or supplements. Weight is < [less than] IBW [ideal weight] range and Pt/family stated she has lost sweight x [times] 1 yr [year] Talked with them at supplements. Said she doesn't like the taste. Me intake and weight. Encourage intake." The RD not address any nutritional management issues in regards to the h.pylori. No further RD assessme could be found in resident 13's clinical record. To RD did not address the November and December weight loss.  Review of an admission Minimum Data Set (MI	ents are weights dents  the  a months s a nonths ss of ober  hould 60% l body come cout onitor did n cents The cer 2001	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature.  13. Dietary in-service will be held weekly-Tuesday 3pm of discuss all survey issues, training, and any problems with the dietary services.  14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents.  15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record.  16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly.  17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding.  1) Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff.  18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out.  20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions.  21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely. The unit manager for out-dated food will check the Alzheimer's

1/16/02

#### DEPARTMENT OF HEALTH AND HUMA SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING \_ 465108

ME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

X4) ID REFIX 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) COMPLE DATE
F 325	Continued From Page 10 assessment, dated 10/15/01, for resident 13 revealed under section K. Oral/Nutritional status, 5. Nutritional Approaches c. Mechanically altered diet was marked and e. Therapeutic diet was marked.	F 325		
	Review of a "Malnutrition/Dehydration – Pressure Sore Risk Assessment", dated 10/11/01, completed by a facility nurse documented that resident 13 was not a nutritional risk.			
	A nutritional care plan dated 10/15/01, documented that resident 13 was at nutritional risk due to poor intake and appetite, chronic obstructive pulmonary disease and weight loss prior to admit, low body weight and that resident 13 would have no significant			
	weight loss through next review. The approaches were to identify and offer food preferences, monitor intake, weights, and labs as available, diet as ordered and recommend house supplement. The care plan did not address any intervention for the h.pylori.			
	The Brunner and Suddarth's Textbook of Medical-Surgical nursing, Eighth Edition, Chapter 36: Management of Patients With Gastric and Duodenal Disorders (h.pylori), Page 887, documents, "The major goals of the patient may be to reduce anxiety, avoid irritating foods and assure adequate intake of nutrients, maintain fluid balance, increase awareness of dietary management and relieve pain."			
	Review of the nurse's notes for October 2001 revealed no documentation to indicate that resident 13 had a decrease in appetite or complaints of pain or nausea.			
	Review of resident 13's meal intake for October 2001 revealed that the facility was documenting meal intake as good, fair and poor. Out of a possible 63 meals, 2 meals were documented as good intake, 13 meals were documented as fair intake, 11 meals were documented			

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Event I XP7W11

Facility ID:

UT0080

## DEPARTMENT OF HEALTH AND HUMAN ... ERVICES

HEALTH CARE FINANCING ADMINISTRATION

AND PLAN OF CORRECTION IDENTIFICATION I		(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM	ION NUMBER:  A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
_	ME OF PROVIDER OR SUPPLIER SOUTH VALLEY HEALTH CENTER		STREET ADD	DRESS, CITY, STA ST 9000 SOUTH RDAN, UT 840	н		1/16/02
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	7 FULL	ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCY	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 325	as poor intake and 37 documented.  Review of an IDT (in minutes dated 11/7/0 weighed 84 pounds, a facility would place resident 13 was to be meals for weight loss.  A physician order data resident 13 was to be meals for weight loss.  A nurse's note dated a supplement 60cc with pounds from admit.  Review of the Novem revealed that the houst times daily] with meastarted until 11/15/01 written.  Review of the Decem revealed that the houst on 12/2/01 because resupplement stating it a throat. No evidence of facility tried any other A physician order data weigh weekly and recomplete blood coun (laboratory tests used No evidence could be had been followed.  Review of a resident of the complete weigh weekly and recomplete blood coun (laboratory tests used No evidence could be had been followed.	7 meals had no intake nterdisciplinary team) no 1 revealed that resident a loss of 10 pounds, and resident 13 on supplemented 11/7/01 documented given 60 cc of supplemented 20	at 13 and the ments with sed that ment with sheet continued at the cate that the or snack.  The detect continued at the cate that the or snack.  The detect continued at the cate that the or snack.  The detect continued at the cate that the or snack.  The detect continued at the cate that the or snack.  The detect continued at the cate that the or snack.	F 325			

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Event I XP7W11

Facility ID:

UT0080

If continuation sheet 12 of

## DEPARTMENT OF HEALTH AND HUMAI. ERVICES

HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUM		A. BUILDIN	IG	COMPL	
		465108		B. WING _		1	/16/02
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F 325	the facility was to ass until stable, a nutrition be done weekly by the obtained, Fibersource resident to be monitor	ess resident 13's weight in/dehydration assessme team, laboratory value. HN 120cc TID, doubted and assessed in the ietary intake to be more seen note dated 11/19/0 ry] week weight and reburnin ordered for weight provide any document on 11/19/01 had been motes for November 20 graph and the ietary intake to be more seen of a possible 93 meals and as good intake, 36 meals and intake document to eat."  Is meal intake for November 20 graph and intake for November	ent was to les to be le portions, restorative nitored and lecord. ght loss." tation that  2001  id."  ember s, 10 neals were cumented nented leasing and mber ing meal 93	F 325			

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Event I XP7W11

Facility ID:

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If continuation sheet 13 of

2567

## DEPARTMENT OF HEALTH AND HUMA , ERVICES

**HEALTH CARE FINANCING ADMINISTRATION** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

ME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

1/16/02

465108

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING\_

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

	, <u></u>	RDAN, UT 84	1088	
(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)	(XS) COMPLETE DATE
F 325	Continued From Page 13	F 325		
	Review of the nurses noted for December 2001 revealed the following: 12/3/01- "Pt requested NAS [no added salt] to her food. Diet order written. House supplement given as ordered." 12/4/01- "Pt has been having wt loss. Encouraging eating." 12/5/01-" Pt. not eating well family bringing in special foods" 12/12/01- "Will continue to monitor and encourage to eat." 12/13/01- "Supplements offered- Family brought in food today pt ate 100%." 12/14/01- "Weight stable. Monthly 75. Dec wk 1 77 week 2 77." 12/15/01- "Encourage to eat."			
	12/16/01- "Snacks offered." 12/17/01- "Family brings in treats."			
	Resident 13 was weighed on 12/31/01 and weighed 79 pounds, a weight gain of 3.5 pounds from previous weight on the first of December.			_
	During an interview with resident 13 on 1/16/01 she stated that when she was admitted to the facility one of the first meals she received, had meat that had made her sick so she would not eat the meat any more. She stated that she would eat most of the vegetables and fruit. Resident 13 stated that she had not discussed this with any facility personnel and that no one had asked her about her meals. She stated that she liked peanut butter and jelly sandwiches and would eat them when the facility had them. Resident 13 also stated that approximately a month ago her family had started bringing snack packs in to her which she kept in her room and would eat them when she was hungry. She also stated that her family had brought her in some Ensure which she would drink when she wanted.			

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Event I XP7W11

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UT0080

If continuation sheet 14 of

#### DEPARTMENT OF HEALTH AND HUMA. ERVICES HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVE

		THEMINISTRATION	<del></del>	·   · · ·			<u> </u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDIN			E SURVEY PLETED
		465108		B. WING			1/16/02
MAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE	<del></del>	1/10/02
SOUTH	VALLEY HEALTH CE	NTER		ST 9000 SOUT RDAN, UT 8			
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F 325	Continued From Page 1	4		F 325			
	the facility on 8/10/01 cerebral vascular acci peripheral vascular di hypothyroidism and n  Resident 70 received	intervenous fluids and eived oral antibiotics unt of pneumonia notes from 8/10/01 throsident 70's medical cotation indicated that resum was improving. Resident Re	umonia, ibrillation, antibiotics until ough ndition sident 70				
	On 8/15/01 the RD conthat documented reside weighed 138 pounds, I resident 70's ideal bod 154 pounds.	ent 70 was 67 inches ta nad a medium frame an	ıll, ıd				
	Review of the weights following: On admission 8/10/01- September 2001- 127 pweight loss of 11 pound of August and September 2001- 115 pouloss of 12 pounds (9.4% September and October November 2001- 112 pweight loss of 3 pound October and November Resident 70 experience 26 pounds (18.8%) between the series of	138 pounds. bounds. This represent ds (7.9%) between the per 2001. ands. This represents a between the months a 2001. bounds. This represent s (2.6%) between the r 2001. d a significant weight	months weight of s a nonths of	-			

and November 2001.

### DEPARTMENT OF HEALTH AND HUMA. LERVICES

HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02 ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3706 WEST 9000 SOUTH** SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 325 Continued From Page 15 F 325 Review of an assessment completed by the RD on 8/15/01 revealed that resident 70 was on a puree no added salt, increased protein, increased fat and nectar thick liquids diet. The assessment documented, "Pt with considerable nutritional risk due to low body weight, low albumin, poor intake unable to feed self dependant on others and swallow deficit. Refer to care plan. Monitor weight, intake and labs." Review of the admission Minimum Data Set (MDS) dated 8/23/01, completed by facility staff, revealed the following: Under section K. Oral/Nutritional status 1. Oral Problems a. chewing problem was marked and b. swallowing problem was marked. 2. height and weight, resident weighed 130 pounds. Under K.4. Nutritional problems c. leaves 25% or more of food uneaten at most meals was marked. Under K.5. Nutritional Approaches nothing was marked, On 8/15/01 resident 70 was evaluated by a speech language pathologist for swallowing problems. The evaluation documented, "Pt. tolerated puree texture with nectar thick liquids without s/s [signs and symptoms] of aspiration while sitting near 90 degrees in bed." Review of a "Malnutrition /Dehydration - Pressure Sore Risk Assessment", dated 8/10/01, completed by a facility nurse documented resident 70 was a high nutrition risk. A nutritional care plan dated 8/15/01 documented that resident 70 was at nutritional risk and would have no

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Approaches to the problem on the care plan were to obtain food preferences, feed patient by staff, monitor intake, labs, and weight, diet as ordered puree/thick

significant weight loss through next review.

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Facility ID:

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ROVE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465108 1/16/02 ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 325 Continued From Page 16 F 325 liquids and notify the RD of significant changes. No documentation in the clinical record evidenced that resident 70's weight had been monitored by the RD or the nursing staff or that the RD had been notified of the weight loss. Review of resident 70's monthly recertification orders, signed by the physician on a monthly basis, documented that resident 70 was to receive a puree diet with thickened liquids and snacks three times daily. Review of resident 70's meal intake for August 2001 revealed that the facility was documenting intake as good, fair and poor. Out of a possible 66 meals, 32 meals were documented as good intake, 6 meals were documented as fair intake, 25 meals were documented as poor intake, and 2 meals were marked refused. Under the nourishments offered section, out of a possible 66 times for nourishments to be offered, 11 nourishments were documented as being offered. Review of resident 70's meal intake for September 2001 revealed that out of a possible 90 meals, 45 meals were documented as good intake, 24 meals were documented as fair intake, 4 meals were documented as poor intake, 4 meals were documented as refused and 13 meals had no intake documented. Under th nourishments offered section, out of a possible 90 times for nourishments to be offered, 9 nourishments were documented as being offered, 1 nourishment was documented as being refused. Review of resident 70's meal intake for October 2001 revealed that out of a possible 93 meals, 19 meals were documented as good intake, 51 meals were documented as fair intake, 1 meal refused and 22 meals had no intake documented. Under the nourishments offered section, out of a possible 93

#### DEPARTMENT OF HEALTH AND HUMA. ERVICES **HEALTH CARE FINANCING ADMINISTRATION**

2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02

ME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VALLEY HEALTH CENTER				
(EACH DEFICIENCY MUST BE PRECEEDED B	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
Continued From Page 17 times for nourishments to be offered, one is was documented as being offered on 10/9/ resident took 100% of that nourishment.	nourishment 01 and the	F 325		
2001 revealed that out of a possible 90 me meals were documented as good intake, 8 meals were documented as fair intake, 2 meals were do as poor intake, 1 meal refused and 18 meal intake documented. Under the nourishment section, out of a possible 90 times for nour be offered, 3 nourishments were documented taken, 9 nourishments were documented as intake, a total of 12 nourishments out of 90 documented as being offered.  On 11/26/01 an assessment by the RD documented as intake, a total of 12 nourishments out of 90 documented as being offered.	als, 61 meals were ocumented is had no ats offered ishments to ed as 100% good were			
supplements/snacks. Need to continue with plan - assist with meals, encourage intake."	The RD			
by facility staff, revealed the under Section and weight, resident 70 weighed 112 pound section K3 weight change a. weight loss wa indicating that resident 70 had not experience loss of 5% or more in last 30 days; or 10% clast 180 days. The MDS did not identify the	K2. height s. Under s marked 0, ced weight or more in e 26 pound			
resident 70 had not seen by a physician from to 11/30/01, during the period of time that re experienced a 26 pound weight loss. No documentation could be found in resident 70	n 8/21/01 esident 70 O's clinical			
	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEEDED BE REGULATORY OR LSC IDENTIFYING INFORM.  Continued From Page 17 times for nourishments to be offered, one awas documented as being offered on 10/9/resident took 100% of that nourishment.  Review of resident 70's meal intake for Not 2001 revealed that out of a possible 90 memeals were documented as good intake, 8 documented as fair intake, 2 meals were documented. Under the nourishment section, out of a possible 90 times for nour be offered, 3 nourishments were documented as intake, 9 nourishments were documented as intake, a total of 12 nourishments out of 90 documented as being offered.  On 11/26/01 an assessment by the RD documented as sintake, a total of 12 nourishments out of 90 documented as being offered.  On 11/26/01 an assessment by the RD documented as being offered.  Review of meet needs. Should continue supplements/snacks. Need to continue with plan - assist with meals, encourage intake." did not address the 26 pound weight loss from 2001 to November 2001.  Review of a quarterly MDS dated 11/7/01, by facility staff, revealed the under Section and weight, resident 70 weighed 112 pound section K3 weight change a. weight loss waindicating that resident 70 had not experienceloss of 5% or more in last 30 days; or 10% clast 180 days. The MDS did not identify the weight loss from August 2001 to November Further review of the clinical record revealeresident 70 had not seen by a physician from to 11/30/01, during the period of time that reexperienced a 26 pound weight loss. No documentation could be found in resident 70 documentation could be found in re	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  Continued From Page 17 times for nourishments to be offered, one nourishment was documented as being offered on 10/9/01 and the resident took 100% of that nourishment.  Review of resident 70's meal intake for November 2001 revealed that out of a possible 90 meals, 61 meals were documented as good intake, 8 meals were documented as fair intake, 2 meals were documented as poor intake, 1 meal refused and 18 meals had no intake documented. Under the nourishments offered section, out of a possible 90 times for nourishments to be offered, 3 nourishments were documented as 100% taken, 9 nourishments were documented as good intake, a total of 12 nourishments out of 90 were documented as being offered.  On 11/26/01 an assessment by the RD documented, "Pt remains at a significant nutritional risk. Intake may not meet needs. Should continue supplements/snacks. Need to continue with current plan - assist with meals, encourage intake." The RD did not address the 26 pound weight loss from August 2001 to November 2001.  Review of a quarterly MDS dated 11/7/01, completed by facility staff, revealed the under Section K2. height and weight, resident 70 weighed 112 pounds. Under section K3 weight change a. weight loss was marked 0, indicating that resident 70 had not experienced weight loss of 5% or more in last 30 days; or 10% or more in last 180 days. The MDS did not identify the 26 pound weight loss from August 2001 to November 2001.  Further review of the clinical record revealed that resident 70 had not seen by a physician from 8/21/01 to 11/30/01, during the period of time that resident 70	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From Page 17 times for nourishments to be offered, one nourishment was documented as being offered on 10/9/01 and the resident took 100% of that nourishment.  Review of resident 70's meal intake for November 2001 revealed that out of a possible 90 meals, 61 meals were documented as good intake, 8 meals were documented as fair intake, 2 meals were documented as poor intake, 1 meal refused and 18 meals had no intake documented. Under the nourishments offered section, out of a possible 90 times for nourishments to be offered, 3 nourishments were documented as good intake, 9 nourishments were documented as good intake, a total of 12 nourishments out of 90 were documented as being offered.  On 11/26/01 an assessment by the RD documented, "Pt remains at a significant nutritional risk. Intake may not meet needs. Should continue supplements/snacks. Need to continue with current plan - assist with meals, encourage intake." The RD did not address the 26 pound weight loss from August 2001 to November 2001.  Review of a quarterly MDS dated 11/7/01, completed by facility staff, revealed the under Section K2. height and weight, resident 70 weighed 112 pounds. Under section K3 weight change a. weight loss was marked 0, indicating that resident 70 had not experienced weight loss of 5% or more in last 30 days; or 10% or more in last 180 days. The MDS did not identify the 26 pound weight loss from August 2001 to November 2001.  Further review of the clinical record revealed that resident 70 had not seen by a physician from 8/21/01 to 11/30/01, during the period of time that resident 70 experienced a 26 pound weight loss. No documentation could be found in resident 70's clinical	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From Page 17 times for nourishments to be offered, one nourishment was documented as being offered on 10/9/01 and the resident took 100% of that nourishment.  Review of resident 70's meal intake for November 2001 revealed that out of a possible 90 meals, 61 meals were documented as good intake, 8 meals were documented as fair intake, 2 meals were documented as poor intake, 1 meal refused and 18 meals had no intake documented. Under the nourishments offered section, out of a possible 90 times for nourishments to be offered, 3 nourishments were documented as 100% taken, 9 nourishments were documented as good intake, a total of 12 nourishments out of 90 were documented as being offered.  On 11/26/01 an assessment by the RD documented, "Pt remains at a significant nutritional risk. Intake may not meet needs. Should continue supplements/snacks. Need to continue with current plan - assist with meals, encourage intake." The RD did not address the 26 pound weight loss from August 2001 to November 2001.  Review of a quarterly MDS dated 117//01, completed by facility staff, revealed the under Section K2. height and weight, resident 70 weighed 112 pounds. Under section K3 weight change a. weight loss was marked 0, indicating that resident 70 had not experienced weight loss of 5% or more in last 30 days; or 10% or more in last 180 days. The MDS did not identify the 26 pound weight loss from August 2001 to November 2001.  Further review of the clinical record revealed that resident 70 had not seen by a physician from 8/21/01 to 11/30/01, during the period of time that resident 70 experienced a 26 pound weight loss. No documentation could be found in resident 70's clinical

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Event I XP7W11

Facility ID:

UT0080

If continuation sheet 18 of

#### DEPARTMENT OF HEALTH AND HUM. **SERVICES**

A CARE FINANCING	<u>J ADMINISTRATION</u>	<u> </u>			FOR	m approve _ 2567
T OF DEFICIENCIES OF CORRECTION			A. BUILDING		(X3) DATE COMPL	SURVEY
	465108		B. WING			
PROVIDER OR SUPPLIER		STREET ADD	RESS CITY STA	ATE ZID CODE		/16/02
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(EACH DEFICIENCY	Y MUST BE PRECEEDED BY I	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETE DATE
Continued From Page 1 weight loss.	.8		F 325		, <u></u>	
facility on 7/9/01 with	h diagnoses of Alzheim	ner's				
completed an initial made documented resident 2 weighed 217 pounds a was documented as 15	nutritional assessment th 20 was 6'0" (72 inches) and his ideal body weig 57 to 170 pounds. The	hat ) tall, ght range diet				
documented in the initial weighted 217 pounds of 20's monthly weights, nurses aides and obtain	tial nurses note, reveale on 7/9/01. A review of , completed by the restoned from the dietary su	f resident orative opervisor,			~	
September, 2001: 217 October, 2001: 214 po November, 2001: 201 significant weight loss of the months of October of December, 2001: 201 January, 2002: 195 por request of the survey ter weighed. Resident 20's represents a significant 5% between the months January, 2002 and a 10.	7 pounds. ounds. pounds. This represent of 13 pounds, or 6%, be and November 2001. pounds. On 1/11/02, at the am, resident 20 was rest weight was 191 pounds to weight loss of 10 pounds of December 2001 and 0.7% significant weight	he ds. This nds, or nd				
	ROVIDER OR SUPPLIER  VALLEY HEALTH CE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From Page 1 weight loss.  3. Resident 20 was a facility on 7/9/01 with disease, depression, culcer disease.  On 8/14/01, 36 days a completed an initial m documented resident 2 weighed 217 pounds a was documented was regul portions.  A review of resident 2 documented in the init weighted 217 pounds of 20's monthly weights, nurses aides and obtain documented the follow  August, 2001: 212 pour September, 2001: 217 October, 2001: 214 pour September, 2001: 217 October, 2001: 217 October, 2001: 201 significant weight loss the months of October December, 2001: 201 January, 2002: 195 por request of the survey te weighed. Resident 20's represents a significant 5% between the months January, 2002 and a 10.	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER SUPPLIER IDENTIFICATION NUMBER SUPPLIER  ROVIDER OR SUPPLIER  VALLEY HEALTH CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF DESCRIPTION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF DESCRIPTION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF DESCRIPTION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF DEFICIENCIES (EACH DEFICIES (EACH DEFICIES (EACH DEFICIES (EACH DEFICIES (E	Ad5108  ROVIDER OR SUPPLIER  VALLEY HEALTH CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From Page 18  weight loss.  3. Resident 20 was a 61 year old male admitted to the facility on 7/9/01 with diagnoses of Alzheimer's disease, depression, cerebral degeneration and peptic ulcer disease.  On 8/14/01, 36 days after his admission, the RD completed an initial nutritional assessment that documented resident 20 was 6'0" (72 inches) tall, weighed 217 pounds and his ideal body weight range was documented as 157 to 170 pounds. The diet documented was regular with finger foods, double portions.  A review of resident 20's admission weight, documented in the initial murses note, revealed that he weighted 217 pounds on 7/9/01. A review of resident 20's monthly weights, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 20:  August, 2001: 212 pounds.  September, 2001: 217 pounds.  October, 2001: 214 pounds.  November, 2001: 201 pounds. This represents a significant weight loss of 13 pounds, or 6%, between the months of October and November 2001.	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465108  ROVIDER OR SUPPLIER  VALLEY HEALTH CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  Continued From Page 18 weight loss.  3. Resident 20 was a 61 year old male admitted to the facility on 7/9/01 with diagnoses of Alzheimer's disease, depression, cerebral degeneration and peptic ulcer disease.  On 8/14/01, 36 days after his admission, the RD completed an initial nutritional assessment that documented resident 20 was 60" (72 inches) tall, weighed 217 pounds and his ideal body weight range was documented as 157 to 170 pounds. The diet documented was regular with finger foods, double portions.  A review of resident 20's admission weight, documented in the initial nurses note, revealed that he weighted 217 pounds on 7/9/01. A review of resident 20's monthly weights, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 20:  August, 2001: 212 pounds.  November, 2001: 214 pounds.  November, 2001: 214 pounds.  November, 2001: 201 pounds.  November, 2001: 201 pounds.  November, 2001: 219 pounds.  November, 2001: 210 pounds.  November, 2001: 210 pounds.  November, 2001: 210 pounds.  November, 2001: 201 pounds.  November, 200	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDERSUPPLIER LOSTRUCTION NUMBER:  465108  ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3706 WEST 9000 SOUTH  WEST JORDAN, UT \$4088  STREET ADDRESS, CITY, STATE, ZIP CODE  3706 WEST 9000 SOUTH  WEST JORDAN, UT \$4088  STREET ADDRESS, CITY, STATE, ZIP CODE  3706 WEST 9000 SOUTH  WEST JORDAN, UT \$4088  FROVIDERS PLAN OF  (EACH DEPICIENCY MIXTS EP PRECEDED BY FULL  REGULATORY OR I.SC IDENTIFYING INFORMATION)  FROM 1 TAG  CROSS-REFERENCED TO DEFICIENCE  STREET ADDRESS, CITY, STATE, ZIP CODE  3706 WEST 9000 SOUTH  WEST JORDAN, UT \$4088  FROVIDERS PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO THE PRINT OF TH	TO SEPTICENCES OF CORRECTION  (X1) PROVIDER SUPPLIER  (X2) MULTIPLE CONSTRUCTION  (X3) DATE OF CORRECTION  (X1) PROVIDER SUPPLIER  (X2) MULTIPLE CONSTRUCTION  (X3) DATE OF CORRECTION  (X3) DATE OF CORRECTION  (X3) DATE OF CORRECTION  (X3) DATE OF COMPI  A BULDING  B WING  SUMMARY STATEMENT OF DEPICENCES (EACH DEPICENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEPICENCES (EACH DEPICENCY MUST BE PRECEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION)  Continued From Page 18  weight loss.  3. Resident 20 was a 61 year old male admitted to the facility on 7/9/01 with diagnoses of Alzheimer's disease, depression, cerebral degeneration and peptic ulcer disease.  On 8/14/01, 36 days after his admission, the RD completed an initial mutritional assessment that documented resident 20 was 60° (72 inches) tall, weighed 217 pounds and his ideal body weight range was documented was regular with finger foods, double portions.  A review of resident 20's admission weight, documented was regular with finger foods, double portions.  A review of resident 20's admission weight, documented in the initial nurses note, revealed that he weighted 217 pounds on 7/9/01. A review of resident 20's monthly weights, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 20:  August, 2001: 212 pounds. November, 2001: 217 pounds. November, 2001: 219 pounds. November, 2001: 219 pounds. On 1/11/02, at the request of the survey team, resident 20 was reweighed. Resident 20's weight was 191 pounds. This represents a significant weight loss of 10 pounds, or 5% between the months of December 2001 and January, 2002 and a 10.7% significant weight loss

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2002(using the December weight of 201 pounds and

the January re-weight of 191 pounds).

Event I XP7W11

Facility ID:

UT0080

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1/16/02

## DEPARTMENT OF HEALTH AND HUMAN JERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

465108

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING\_

SOUTH	VALLEY HEALTH CENTER		F 9000 SOUTH EDAN, UT 840		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From Page 19 An initial dietary assessment completed by registered dietitian on 8/14/01 documented, adequate for needs, current weight 126 % If body weight] [and] considered obese, [questor double portions, will need to monitor we [patient] [at] nutritional risk [secondary to] swallow deficit chokes, needs assist [with most that the resident would choke and that he required assistance with for the RD's documented nutrition plan for resident was to, "monitor intake, weight (for loss), In 1/2/02 a quarterly nutrition assessment was by the RD. The nutritional stress factors dowere obesity and depression with potential follows. The weights documented on this assessmer November 2001, 201 pounds, December 201 pounds and January 2002, 195 pounds. In 1/2/02 dietary assessment did not identify resignificant weight loss of 13 pounds between months of October 2001 and November 2002 significant weight loss of 19 pounds between months of October 2001 and January 2002. January re-weight of 191 pounds had not ye obtained. A review of resident 20's medical showed the only dietary evaluations of this recurred on 8/14/01 and 1/2/02. No further documented dietary notes were found in resimedical record.  A review of the "Nursing Monthly Summary assessment for November 2001 documented 20's current weight was 201 pounds this was by a question mark, his diet was documented 20's current weight was 201 pounds this was by a question mark, his diet was documented 20's previous month's weight for O 2001 was 214 pounds. This would indicate pound, or 6%, significant weight loss over 3	"Intake BW [ideal tion] need bight. Pt obesity, neals]". O had a at times eeding. Ident 20 abs". On completed cumented for weight sment fer 2001, The esident 20's in the 11 or his in the The trecord resident dent 20's in the state of the s	F 325		
	review of the nursing summary notes revealed				

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Facility ID:

UT0080

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1/16/02

## DEPARTMENT OF HEALTH AND HUMAI - ERVICES

HEALTH CARE FINANCING ADMINISTRATION <u>25</u>67 STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

465108

SOUTH V	ALLEY HEALTH CENTER		T 9000 SOU RDAN, UT		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY F REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From Page 20 documented evidence that resident 20's significant weight loss was identified as a concern and n interventions were documented as being implemented resident 20 to document a current with documented resident 20 was receiving a regulant his appetite was good. A review of the misummary notes revealed no documented evidence identified as a concern and no interventions with documented as being implemented. The care section of this monthly nursing summary documented as being implemented. The care section of this monthly nursing summary documented as being implemented. The care section of this monthly nursing summary documented as being implemented. The care section of this monthly nursing summary documented wide as a concern and no interventions with the section of the "Nursing Monthly Summary" January 2002 documented resident 20's current was 195 pounds, his diet was regular and his a was good. A review of the nursing summary revealed no documented evidence that resident significant weight loss of 19 pounds between months of October 2001 and January 2002 was identified as a concern and no interventions with documented as being implemented. The January reveight of 191 pounds had not yet been obtained as the properties of this summary documented as being implemented. The January revealed no documented that resident 20 had an appetite. On 11/7/01, the nurse documented that resident 20 had a good appetite. On 11/20/01 nurse documented that resident 20 needed con encouragement and re-direction but would use 75-100% of meals. On 12/2/01, the nurse documented con encouragement and re-direction but would use 75-100% of meals. On 12/2/01, the nurse documented con the nurse documented that resident 20 needed con encouragement and re-direction but would use 75-100% of meals. On 12/2/01, the nurse documented con the nurse documented that resident 20 needed con encouragement and re-direction but would use 75-100% of meals. On 12/2/01, the nurse documented that resident 20 needed con encouragement and re-di	demented.  ' for veight but lar diet ursing ence that between 001 was vere plan umented weight  ' for nt weight appetite notes at 20's the as vere ary ained. ented  02 in 0/19/01, excellent hat the utinual aally eat	F 325	DEFICIENCY)	
	that resident 20 had a good appetite. On 12/15				

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Facility ID:

UT0080

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#### DEPARTMENT OF HEALTH AND HUMA. SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

465108 B. WING	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>
SOUTH VALLEY HEALTH CENTER  3706 WEST 9000 SOUTH WEST JORDAN, UT 84088	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) OMPLETE DATE
F 325  Continued From Page 21 murse documented that resident 20, "Eats 100% of meals, d/t (due to) shaking-needs to be fed. Frequently looks for more to eat".  A review of resident 20's "Malnutrition/Dehydration-Pressure Sore Risk Assessment", completed by the nursing staff, was done. Resident 20 was assessed on 7/9/01 as having a total score of 9. Resident 20 was assessed on 10/28/01 as having a total score of 11. Per this form, a total score of 10 or higher placed the resident at high nutritional risk.  A "-view of all documented physician assessments or inpleted from resident 20's admission on 7/9/01 through 1/15/02 was done. Resident 20's significant weight loss was not addressed on these assessments.  A nutritional care plan, initiated by the RD and dated 8/13/01, documented that resident 20 was at nutritional risk related to obesity, a slight swallowing deficit (as reported by the family) needing assistance with meals and not communicating well and would have no significant weight fluctuations through next review. Approaches to the problem on the care plan included, dietary was to obtain food preferences, weights, meal intakes and labs were to be monitored, resident 20 was to be assisted with meals as needed and his diet was finger foods/double portions. The care plan was not updated to address resident 20's significant weight loss, which occurred between the months of October 2001 and November 2001 and between the months of October 2001 and January 2002.  A review of resident 20's meal intakes, documented on the "ADL Flow Sheet Record" for October 2001 revealed the nurse arides were documenting meal intake as good, fair or poor. Out of a possible 93 meals for	

## DEPARTMENT OF HEALTH AND HUMA. LERVICES

HEALTI	H CARE FINANCING	J ADMINISTRATION	1	<del></del>		ruk	CM APPROVE 2567
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIP A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE COMPI	
		465108	77			1	1/16/02
NAME OF P	PROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
SOUTH	VALLEY HEALTH CE	ENTER		ST 9000 SOUT] DRDAN, UT 84			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY LSC IDENTIFYING INFORMA	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	documented as fair, 1 were documented as a documented.  A review of resident 2 record for November were documenting me a possible 30 breakfast documented at 100%, were documented at 0 documented. Out of month, 26 were documented documented at 90% and documented at 90%, 1 documented at 50% and A review of resident 2 record for December 2 were documented at 100%, was documented as red documented. Out of a month, 28 were documented at 0% and Out of 31 possible suppossible	22 12 were documented as refused and 19 were not 20's "Daily Dietary Intar 2001 revealed the nursulation in the meals for the month, 6, 1 was documented at 60% and 2 had no meal if a possible 30 lunch meamented at 100%, 1 was and 3 had no meal intake a possible 30 supper meals for the month, 7 was documented at 75 and 13 had no meal documented at 75 and 13 had no meal documented at 75 and 13 had no meal documented at 100%, 2 were documented at 100%, 2 were documented at 100%, 2 were down and 17 had no meal documented at 100%, 2 were down and 17 had no meal documented at 100%, 1 were down and 17 had no meal documented at 100%, 2 were down and 17 had no meal documented at 100% and 17 had no meal 00% and 18 had no meal 00% and 1	take" rse aides rse. Out of r, 8 were rse 60%, 19 intake reals for the rse reals for rwas rse, 1 was rumented. rse aides rse. Out of a rwere rse at 0%, 1 rse ali intake rse aides for the rse aides	F 325			
	January 2002 from 1/1/	20's meal intake record, ADL Flow Sheet Record 1/02 through 1/9/02 reve ng meal intake in percer	d" for vealed the		·		

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Out of a possible 9 breakfast meals reviewed, 1 was documented at 100%, 6 were documented at 0%, 1 was documented as refused and 1 had no meal documented. Out of a possible 9 lunch meals

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#### DEPARTMENT OF HEALTH AND HUMAL ERVICES HEALTH CARE FINANCING ADMINISTRATION

2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 465108 1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH V	ALLEY HEALTH CENTER		T 9000 SOUT RDAN, UT 84		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PROPERTY OF THE PROPE	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE
F 325	Continued From Page 23 reviewed, 8 were documented at 100% and meal documented. Out of a possible 9 supper reviewed, 1 was documented at 75% and 8 h meal documented.  A review of the facility's Dietary Managemer minutes revealed that resident 20 was not idente team as at nutritional risk related to his sweight loss of 13 pounds, or 6% which occur between the months of October 2001 and No. 2001 and 19 pounds, or 8.8% which occurre the months of October 2001 and January 2001/2/02. A review of the Dietary Management 1/2/02 minutes documented resident 20 was for review, however, there were no team mer comments, recommendations or intervention documented on the monitoring form.  Observations on 1/2/02, 1/3/02 and 1/8/02 in Facility Alzheimer's unit dining room revealer resident 20 was sent a breakfast tray on the mon these days, however, resident 20 did not represent to be in bed sleeping during the breakfast med 1/2/02, 1/3/02 and 1/8/02.  Interviews with the certified nurses' aides wo the facility Alzheimer's Unit, who were family resident 20's care, were done on 1/2/02 and 1/8/02.  Interviews with the certified nurses' aides wo the facility Alzheimer's Unit, who were family resident 20's care, were done on 1/2/02 and 1/8/02.  Interviews with the certified nurses' aides wo the facility Alzheimer's Unit, who were family resident 20's care, were done on 1/2/02 and 1/8/02.  Interviews with the certified nurses' aides wo the facility Alzheimer's Unit, who were family resident 20's care, were done on 1/2/02 and 1/8/02.  Interviews with the certified nurses' aides wo the facility Alzheimer's Unit, who were family resident 20's care, were done on 1/2/02 and 1/8/02.  Interviews with the certified nurses' aide wo with the certified nurses' aide was not to wake resident 20 to offer his breakfast tray 1/3/02, the same certified nurses' aide who with the certified nurses' aide was not to wake resident 20 to offer his breakfast tray 1/3/02, the same certified nurses' aide who with the certified nurses' aide was not to wake res	er meals and no ent Team entified by ignificant rred ovember d between 02 until at Team's on the list mber s ed that neal cart eceive his realed him eals on erking on iar with 1/3/02 1/2/02, the ad not days ald not observed of the observe	F 325		

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Facility ID:

UT0080

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1/16/02

#### DEPARTMENT OF HEALTH AND HUMAN LERVICES HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVE 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

465108

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

#### SOUTH VALLEY HEALTH CENTER

**3706 WEST 9000 SOUTH** WEST JORDAN, UT 84088

	WEST JO	RDAN, UT 8	4088	
(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) COMPLETE DATE
F 325	Continued From Page 24 offer his tray.	F 325		
	Observation on 1/2/02, 1/3/02, and 1/8/02, and 1/11/02, of the meal portion sizes of resident 20's breakfast trays revealed he received regular portions for breakfast on these days. Review of resident 20's diet card documented he was to get large portions.  On 1/11/02, an interview with the food service supervisor was done. She was asked to confirm what diet the kitchen was to send resident 20. She checked and stated that he was to receive a mechanical soft diet with double portions.  On 1/11/02, an interview with a certified nurses aide who was familiar with resident 20's care was done. She was asked if resident 20 received large portions at meals. She stated no, that she was unable to "pinpoint exactly" but resident 20 had been receiving regular meal portions for a least a month. She further stated than when he ate meals he needed increased portions because he would eat "a lot".  Observation on 1/16/01 revealed that at 8:12 AM, resident 20's tray was taken to his room by a nurses aide. Resident 20 was encouraged to wake up and the aide assisted him with his breakfast meal. He consumed 100%. In a later interview with the nurses aide who assisted resident 20, at 8:30 AM, she confirmed that resident 20 had eaten 100% of his breakfast tray and then consumed 100% of a second tray.  4. Resident 72 was a 78 year old female admitted to this facility on 11/10/00 with diagnoses of congestive heart failure, cerebrovascular accident, deep vein thrombosis, atrial fibrillation, angina, hypothyroidism and gastro-esophageal reflux disorder (GERD). Resident 72 had physician's orders for Prilosec to treat			

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Event I XP7W11

Facility ID:

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

B. WING\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH

SOUTH V		ST 9000 SOUT ORDAN, UT 8		
(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)	(XS) COMPLETE DATE
F 325	Continued From Page 25 GERD on 3/26/01. Resident 72 had physician's orders written on 6/11/01 for Risperdal 1milligram every night, Oxycontin 20 milligrams three times a day for pain, and Percocet 5-325 milligrams every four hours as necessary for pain. Risperdal and Percocet may produce side effects including nausea, vomiting, anorexia and over sedation. The reference for side effects to medications was obtained from the Mosby's Nursing Drug Book, 2000.  The registered dietician's nutritional assessment on 11/14/00 documented resident 72's height as 63.5 inches and her weight was 230 pounds. The ideal body weight recommendation was 121-135 pounds.  Resident 72's weight history was obtained from the quarterly nutritional reassessment, dated 8/20/01, and was as follows:	F 325		
	January 2001-214 pounds February 2001-198 pounds. This represents a weight loss of 16 pounds, (7.5%) between January and February 2001. March 2001-203 pounds April 2001-187 pounds. This represents a weight loss of 16 pounds, (7.9%) between March and April 2001. June 2001-182 pounds July 2001-167 pounds. This represents a weight loss of 15 pounds, (8.3%) between June and July 2001. Resident 72 lost 23.7% of her body weight during a six month period.  Review of resident 72's advanced directives revealed that she desired artificial nutrition and hydration, minor surgery, antibiotic treatment orally and intravenously, simple diagnostic tests, and pain medication for comfort.			
	Review of resident 72's MDS (minimum data set),			

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Event I XP7W11

Facility ID:

UT0080

If continuation sheet 26 of

## DEPARTMENT OF HEALTH AND HUMA. JERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

465108

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH VALLEY HEALTH CENTER		3706 WEST 9000 SOUTH						
		WEST JORDAN		8				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA)	FULL PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
	Continued From Page 26 dated 5/7/01, 8/4/01, and 11/1/01, revealed to Section K5, there was no indication that resist was on a planned weight change program. In K1, the MDS identified that resident 72 had problems.  Review of resident 72's care plan revealed the resident 72 was admitted to this facility them care plan, dated 11/00, identified her at nutrical with potential for weight loss related to a swed deficit and inability to feed herself without as One goal to this care plan problem was that mould not have a significant weight loss through next review. A second goal stated that if she weight, the weight loss would be gradual with five pounds a month. The approaches to that problem were to assist resident 72 with her monitor weights and intake.  Review of resident 72's assessments on admit quarterly, revealed that there was a malnutrite form present in the chart with no documentate present.  Review of resident 72's physician's telephone dated 7/30/01, signed by the physician, revealed.	hat in dent 72 in section a chewing lat when autritional tional risk allowing sistance, resident 72 lugh the did lose in less that it care plan heals and lossion and lon risk ion lossion and lon risk lon long long long long long long long	AG	CROSS-REFERENCED TO THE APPROPRIATE				
order for house formula 60cc for each meal we than 50% eaten. This order was initiated after continuous January to July 2001 weight loss be occurred.  Review of resident 72's monthly nursing assess for the month of May 2001, revealed document by nursing, that resident 72 had a good appeting fed herself. The monthly nursing assessment month of June 2001, revealed documentation nursing that resident 72's appetite was fair and and drinks by herself." The monthly nursing assessment for the month of July 2001, for resident 72's appetite was fair and and drinks by herself."		r the had ssment						
		ntation ite and for the by i "eats						

HCFA-2567L

ATG112000

Event I XP7W11

Facility ID:

UT0080

## DEPARTMENT OF HEALTH AND HUMAN JERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED

465108

A. BUILDING B. WING

1/16/02

NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

**3706 WEST 9000 SOUTH** WEST JORDAN, UT 84088

	WEST JO	RDAN, UT 8		
(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) COMPLETE DATE
F 325	Continued From Page 27 documented by nursing did not have any documentation in the "appetite" area but documented that she "eats and takes fluid by herself. "  Review of resident 72's activity of daily living flow sheet record, documented by the nurse aids, for the month of May, 2001, revealed that of the 90 meals documented in this month, resident 72's intake showed 40 were good, 42 were fair, 5 were poor, 2 were Y (an unknown measurement), and 1 was refused.  The activity of daily living flow sheet record for the month of June 2001, revealed that of the 90 meals	F 325		
	documented in this month, 25 were good, 21 were fair, 13 were poor, 20 were not documented, and 5 had zero as the amount taken.  The activity of daily living flow sheet record for the month of July 2001, revealed that of the 93 meals documented in this month, 52 were good, 26 were fair, 8 were poor, 2 were refused.			
	Review of the nurses notes for June 2001 revealed the following: 6/1/01- "Pt spit up when I gave her noon meds." 6/2/01- "Pt c/o stomach pain, gave tylenol, had small mucousy emesis. IM phenergan with good results." 6/2/01- "Pt has tried to spit up pills all day." 6/3/01- "She only drank part of her nubasic." 6/4/01- "Did not wake up for breakfast." 6/5/01- "MD in to see pt. today. Swallow eval." 6/6/01- "Addendum-watch pts. food intake-if 0 intake over next 2 days, notify MD for feeding tube order."			
	6/8/01- "Therapy informed me that swallow evaluation was done, but they did not know the results."  The results of the swallow study for resident 72 were not in the medical record. There was no indication that the nurses had informed the physician that resident 72's food intake had been zero for breakfast on 6/6/01,			

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Event I XP7W11

Facility ID:

UT0080

If continuation sheet 28 of

1/16/02

#### DEPARTMENT OF HEALTH AND HUMA: SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING

AND PLAN OF CORRECTION

465108

B. WING\_ STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH

CONTROL STATE DAY TED AT THE CHEMPEN		3706 WEST 9000 WEST JORDAN,			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI	(	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 325	Continued From Page 28 poor on 6/7/01 and 6/8/01, or that there was n documentation of dinner on 6/7/01 and 6/8/01  During a family interview on 1/2/02, the fami member was questioned concerning the care of resident 72. The family member stated that wh resident 72 was placed on hospice, August 20 began to receive the assistance she had needed her activities of daily living and assistance with The family member also stated that resident 7 assisted with her noon meal by a family memb throughout the week.  5. Resident 74, a 60 year old male, was admit the facility on 10/3/01 with diagnoses of hypo	ly of nen 01, she 1 with th eating. 2 was ner		DEFICIENCY)	
	protein calorie malnutrition, dehydration, cerebrovascular accident and depression.  Resident 74 was admitted with a gastrostomy (g-tube) with orders to administer two cans of three times daily via the g-tube. Resident 74 a physician order to receive a puree diet by me	tube Ensure also had			
	On 10/15/01 the registered dietician (RD) commutational assessment that documented that re 74 was 70 inches tall, weighed 150 pounds, has frame and resident 74's ideal body weight rang from 158 to 180 pounds.	sident d a large			
	Review of resident 74's monthly weights reveated following: On admission, 10/10/01, 150 pounds. November 2001- 147.5 pounds. This represent weight loss of 2.5 pounds, (1:6%) between the of October and November 2001. December 2001-142.5 pounds. This represents weight loss of 5 pounds, (3.4%) between the november and December 2001. January 2001- 140 pounds. This represents a very series of the	ts a e months s a nonths of			

HCFA-2567L

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Event I XP7W11

Facility ID:

UT0080

If continuation sheet 29 of

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DEPARTMENT OF HEALTH AND HUMA ERVICES HEALTH CARE FINANCING ADMINISTRATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	MBER:	(X2) MULTIP A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE COMPI	LETED
NAME OF P	PROVIDER OR SUPPLIER	703100	T	DDRESS, CITY, STA	ATE 7ID CODE	1	/16/02
	SOUTH VALLEY HEALTH CENTED		3706 WES	ST 9000 SOUT DRDAN, UT 84	'H		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
	loss of 2.5 pounds, (1) December and Januar At the request of the sweighed on 1/11/02. pounds. This represer (2.5%) between 1/1/02 Resident 74 experienc 13.5 pounds, (9%) bet 2001 and January 200.	.75%) between the mory 2002. survey team, resident 7. Resident 74 weighed 1 Ints a weight loss of 3.5 2 and 1/11/02. The a significant weight tween the months of Octo.  The completed by the Family in the complete in the complet	74 was 136.5 5 pounds, at lossof betober  RD on y and pt po [by e 2.0 TID provide ald use keand could be ent 74 had e RD.  ted tion G. s, h. that son  was problems. ves 25%  red a Enteral	F 325			

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ATG112000

would have no significant weight fluctuations through next review. Approaches to the problem on the care

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 30 of

### DEPARTMENT OF HEALTH AND HUMA: SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATUMENT OF DEFICIENCES ADDITION OF CORRECTION  NAME OF PROVIDER OR SUPPLIER SOUTH VALLEY HEALTH CENTER  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PAL TAG  CONTINUED From Page 30 plan indicated that resident 74 was to receive the hube feedings as ordered, weekly weights and to notify the RD of significant changes.  On 10/25/01, the (RD) was asked by the nursing staff to evaluate resident 74 sg. tube feeding. The RD recommended, "Fiber Source HN to run at 70/cc an hour to provide 2016 K.cal and 89 grams protein. This should be adequate to maintain weight and replete residual proteins [Albumin] This TF [Imber feeding] regimen would provide 1600 cc H20 (water], Recommended of the Normal Continued From Page 30 (every) 8 hours. Vill monitor tol [tolerance] to TF and weights." A physicians' order was obtained on 10/25/01 following the RD? street orders and the resident of the residence of the stated she only wants pt. to have 1 can @ [all qlas [every night at bedtime] - H20 [water] to run rest of day - Drcontacted - orders H20 @ 83cc X [times] 24 hours - 1 can of HN Fibersource @ glas added to water - weight q 2 wks [weeks] - wife informed of possible wt [weight] loss if not cating well - will continue to monitor."  On 10/29/001 the RD documented, "Nursing stated family concerned about TF may cause kidney failure? This TF does not provide excess protein and is adequate for needs. I do not have any concerns in regard to this." There was no evidence that this was discussed with the family by the RD of when the residence is a state of the residence of t	HEALI	CARL LIMATEING	7 IDMINIBILITION			·		2301
AME OF PROVIDER OR SUPPLIER  SOUTH VALLEY HEALTH CENTER  SIMMARY STATEMENT OF DEFICIENCES  (CACIL DEFICIENCY MUST BE PRECEEDED BY VILL  TAG  CONTINUED FOR THE APPROPRIATE  CONFIDENCY MUST BE PRECEEDED BY VILL  F 3.25  Continued From Page 30 plan indicated that resident 74 was to receive the tube feedings as ordered, weekly weights and to notify the RD of significant changes.  On 10/25/01, the (RD) was asked by the mursing staff to evaluate resident 74's g-tube feeding. The RD recommended, "Fiber Source HN to run at 70/cc an hour to provide 2016 Keal and 89 grams protein. This should be adequate to maintain weight and replete residual proteins [Albumin] This TF [tube feeding] regimen would provide 1600 ce H20 [water]. Recommend 600c additional free H20 as 200cc q [every] 8 hours. Will monitor toll (tolerance) to 17 and weights." A physicians' order was obtained on 10/25/01 following the RD's recommendation.  A nurses note on 10/25/01 documented the following: "Pt. wife informed of new enteral feeding order - she stated she only wants pt. to have 1 can @ [at] dps [every night at bedding] + H20 [water] to run rest of day - Drcontacted - orders H20 @ 83c x { [times] 24 hours - 1 can of HNF Fibersource @ sha added to water - weight q 2 wks [weeks] - wife informed of possible wt [weight] loss if not eating well - will continue to monitor."  On 10/25/001 the RD documented, "Nursing stated family concerned about Tr may cause kidney failure? This TF does not provide excess protein and is adequate for needs. I do not have any concerns in regard to this." There was no evidence that this was discussed with the family by the RD or the nursing					A. BUILDING		` '	
STREET ADDRESS, CITY, STATE, ZIP CODE  3706 WEST 9000 SOUTH VALLEY HEALTH CENTER  (PAPEN CHARLEY HEALTH CENTER)  SUMMARY STATEMENT OF DEFICIENCES PROVIDERS PLAN OF CORRECTION (REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR THE REGULATORY OR LSC IDENTIFYING INFORMATION)  F 325  Continued From Page 30 plan indicated that resident 74 was to receive the tube feedings as ordered, weekly weights and to notify the RD of significant changes.  On 10/25/01, the (RD) was asked by the mursing staff to evaluate resident 74 sg-tube feeding. The RD recommended, "Fiber Soutce HN to run at 70/cc an hour to provide 2016 Kcal and 89 grams protein. This should be adequate to maintain weight and replete residual proteins, [Albumin] This TF [tube feeding] regimen would provide 1600 cc H20 [water]. Recommend 600cc additional fee H20 as 200cc q [levery] 8 hours. Will monitor tol [tolerance] to TF and weights." A physicians' order was obtained on 10/25/01 following the RD's recommendation.  A nurses note on 10/25/01 documented the following: "Pt. wife informed of new enteral feeding order - she stated she only wants pt. to have 1 can @ [at] qhs [levery night at bedtime] - H20 [water] to run rest of day - Drcontacted - orders H20 @ 32cc X [times] 24 hours - 1 can of HN Fibersource @ qhs added to water - weight q 2 wks [weeks] - wife informed of possible wt [weight] loss if not eating well - will continue to monitor."  On 10/29/001 the RD documented, "Nursing stated family concerned about TF may cause kichney failure? This TF does not provide excess protein and is adequate for needs. I do not have any concerns in regard to this." There was no evidence that this was discussed with the family by the RD or the nursing			465108		B. WING	1/16/02		
SOUTH VALLEY HEALTH CENTER   3706 WEST JORDAN, UT \$44088     CAPID   PREFIX   CEACI DEFICIENCY MUST BE PRECEEDED BY PULL (EACH DEFICIENCY MIST BE PRECEEDED BY PULL TAG     F 325   Continued From Page 30   plan indicated that resident 74 was to receive the tube feedings as ordered, weekly weights and to notify the RD of significant changes.   F 325     On 10/25/01, the (RD) was asked by the nursing staff to evaluate resident 74's g-tube feeding. The RD recommended, "Fiber Source HN to run at 70/cc an hour to provide 2016 Kcal and 89 grams protein. This should be adequate to maintain weight and replete residual proteins [Albumin] This FI flube feeding] regimen would provide 1600 cc H20 [water]. Recommend 600cc additional free H20 as 200cc q [every] 8 hours. Will monitor tol [tolerance] to TF and weights." A physicians' order was obtained on 10/25/01 following the RD's recommendation.	NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
FREEIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F325  Continued From Page 30 plan indicated that resident 74 was to receive the tube feedings as ordered, weekly weights and to notify the RD of significant changes.  On 10/25/01, the (RD) was asked by the mursing staff to evaluate resident 74's g-tube feeding. The RD recommended, "Fiber Source HN to run at 70/cc an hour to provide 2016 Kcal and 89 grams protein.  This should be adequate to maintain weight and replete residual proteins [Albumin] This Tf [fube feeding] regimen would provide 1600 cc H20 [water]. Recommend 600cc additional free H20 as 200cc q [every] 8 hours. Will monitor to [tolerance] to TF and weights." A physicians' order was obtained on 10/25/01 following the RD's recommendation.  A murses note on 10/25/01 documented the following: "Pt. wife informed of new enteral feeding order - she stated she only wants pt. to have 1 can @ [at] qhs [every night at bedtime] - H20 [water] to run rest of day - Drcontacted - orders H20 @ 38cc X [times] 24 hours - 1 can of HIN Fibersource @ qhs added to water - weight q 2 wks [weeks] - wife informed of possible wt [weight] loss if not eating well - will continue to monitor."  On 10/29/001 the RD documented, "Nursing stated family concerned about TF may cause kidney failure? This TF does not provide excess protein and is adequate for needs. I do not have any concerns in regard to this," There was no evidence that this was discussed with the family by the RD or the nursing			ENTER					
plan indicated that resident 74 was to receive the tube feedings as ordered, weekly weights and to notify the RD of significant changes.  On 10/25/01, the (RD) was asked by the nursing staff to evaluate resident 74's g-tube feeding. The RD recommended, "Fiber Source HN to run at 70/cc an hour to provide 2016 Kcal and 89 grams protein.  This should be adequate to maintain weight and replete residual proteins [Albumin] This TF [tube feeding] regimen would provide 1600 cc H20 [water]. Recommend 600cc additional free H20 as 200cc q [every] 8 hours. Will monitor tol [tolerance] to TF and weights." A physicians' order was obtained on 10/25/01 following the RD's recommendation.  A nurses note on 10/25/01 documented the following: "Pt. wife informed of new enteral feeding order - she stated she only wants pt. to have 1 can @ [at] qhs [every night at bedtime] - H20 [water] to run rest of day - Drcontacted - orders H20 @ 83cc X [times] 24 hours - 1 can of HN Fibersource @ phs added to water - weight q 2 wks [weeks] - wife informed of possible wt [weight] loss if not eating well - will continue to monitor."  On 10/29/001 the RD documented, "Nursing stated family concerned about TF may cause kidney failure? This TF does not provide excess protein and is adequate for needs. 1 do not have any concerns in regard to this." There was no evidence that this was discussed with the family by the RD or the nursing	PREFIX	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL			PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETE
During a meeting with facility administrative staff and the RD on 1/8/02, the RD stated that he had not done any other assessments on resident 74 since 10/29/01.	F 325	plan indicated that refeedings as ordered, RD of significant chat On 10/25/01, the (RD to evaluate resident 7 recommended, "Fibe hour to provide 2016. This should be adequate replete residual prote feeding] regimen wou Recommend 600cc act [every] 8 hours. Will weights." A physician 10/25/01 following the A nurses note on 10/2. "Pt. wife informed of stated she only wants [every night at bedtim day - Drcontacted 24 hours - 1 can of Hi water - weight q 2 wk possible wt [weight] I continue to monitor."  On 10/29/001 the RD family concerned about This TF does not provadequate for needs. I regard to this." There discussed with the family staff. There was no further RD on 1/8/02, the	sident 74 was to receive weekly weights and to larges.  D) was asked by the must's g-tube feeding. The resource HN to run at 6 Kcal and 89 grams projected to maintain weight ins[Albumin] This TF ald provide 1600 cc Hodditional free H20 as 2 monitor tol [tolerance inst order was obtained the RD's recommendation of the received experience of the received experience (a) Robert H20	notify the  arsing staff the RD  70/cc an rotein. and [tube 20 [water]. 00cc q ] to TF and on on.  following: rder - she t] qhs in rest of t X [times] added to med of will  g stated ty failure? d is terns in this was nursing y the RD.  e staff and not done	F 325			

ATG112000

A review of resident 74's meal intake for October 2001

Event I XP7W11

Facility ID:

UT0080

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PRINTED: 1/25/ FORM APPROVE <u>2</u>567

## DEPARTMENT OF HEALTH AND HUM. SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		465108		B. WING		1	/16/02	
SOUTH VALLEY HEAT TH CENTED 3706 V		3706 WES	ET ADDRESS, CITY, STATE, ZIP CODE  WEST 9000 SOUTH  ST JORDAN, UT 84088					
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
F 325	as good, fair and poor meals were documented as fair in documented.  A review of resident 2001 revealed that the intake in percent of it meals, 46 meals were meals had no intake of the meals had no intake of th	ality was documenting report. Out of a possible 63 ated as good intake, 20 antake and 25 meals had 74's meal intake for Note facility was documentake. Out of a possible documented in percendocumented.  74's meal intake for Deat of 93 meals, 15 meals and 78 meals had note of 93 meals had note of 93 meals had note of 93 meals had note of 10/24/01, resident 74 ansure TID at 8:00 AM, ocumentation resident ansure at 8:00 AM on 10 16/01, 10/18/01 10/20/04 did not receive two of 10/10/01, 10/12/01 the old 10/25/01 documented our end of 10/25/01 documented our and water to run 24 documentation record in 10/25/01 through 10/31/01 in the receive per documented on 10/25/01, 10/26/01 in 10/25/01, 10/26/01	s meals 18 meals were no intake  ovember ting meal e 93 at and 47  cember s were intake  evealed was to 3:00 PM 74 did not 0/10/01, 01, and cans of rough  ed to give ght added hours a  for revealed tation one 1,	F 325				

ATG112000

Event I XP7W11

Facility ID:

UT0080

#### DEPARTMENT OF HEALTH AND HUM. SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 325 Continued From Page 32 F 325 wife was done. She stated that she had not been informed by the facility the resident 74 had lost 13.5 pounds. She stated that she goes to the facility almost every evening around supper time to assist her husband with his meal. She stated that more than once a week she had observed resident 74's lunch tray still on the bedside table in his room and it had not been touched. 6. Resident 40 was a 97 year old female admitted to this facility on 10/9/01 with diagnoses of fractured humerus, dementia, hypertension, hypothyroidism and constipation. Review of resident 40's dietary assessment on 10/6/01 revealed that the dietician had assessed her at the height of 60 inches and a weight of 121 pounds with an ideal body weight recommendation of 113-126 pounds. The registered dietician had identified ill-fitting dentures, the need for resident 40 to be fed, encouragement, and that she had poor intake. The dietary assessment stated that resident 40's intake was poor and might not be adquate for her needs, the facility should consider offering supplements, and recommended Novasource supplements. There was no physician's order found for Novasource and no intervention for resident 40's ill-fitting dentures. Review of resident 40's care plan, initiated by the facility, revealed a nursing care plan problem identifying resident 40 at risk for malnutrion with a score of 21. There were two goals addressed in this care plan problem. One goal was that resident 40 would have no unexpected or unplanned weight loss and the second goal was that resident 40 would have an average intake of 75% with every meal. The approaches for the problem included documentation of percentage that resident 40 ate at each meal, monitor for less that 50% average per meal, and monitor for

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Facility ID:

UT0080

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#### DEPARTMENT OF HEALTH AND HUMAIN SERVICES HEALTH CARE FINANCING ADMINISTRATION

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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	
465108			B. WING		,	/1 / /02		
NAME OF P	ROVIDER OR SUPPLIER	L	STREET ADDRI	ESS, CITY.	STATE, ZIP CODE		/16/02	
SOUTH	ALLEY HEALTH CE	ENTER	3706 WEST WEST JORI	9000 SO1	U <b>TH</b>			
(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)			
	Continued From Page 3 significant unplanned plan problem initiated identified her at signif poor intake and need goal for this care plan would have no significant approaches for this prand weight and to assi recommended nutrents.  Review of resident 40' 10/10/01 revealed the  October 2001- 120 por December 31, 2001- 1 weight loss of 10.5 por months of October 20 January 11, 2002- 107 weight loss of 14 poun 2001 and January 11, 2001 are sident desired a scommunication in reside a "select" diet.  Continued review of refood preference form, of that Ensure would be gand would be brought if documentation in residereceived Ensure at any	weight loss. The dietal on admission for resident nutritional risk refor assist with her mean problem was that resident weight fluctuation oblem were to monitor ist with meals. The diesupplements  's IDT meeting commend following information unds 10.5 pounds. This repunds, (8.7%) between 101 and December 31, in pounds. This represents, (11.6%) between (2002.  Interdisciplinary team recalled a comment that short diet. The only diet dient 40's medical reconsistent 40's dietary hist dated 10/17/01, documiven after meals and at an by the family. There ent 40's chart that she is activities of daily living the day in the nurse aids, first day in the	ary care dent 40 elated to ls. The dent 40 is. The intake entitian ents on :  aresents a the 2001. ints a Detober  meeting etated that ary int was for  ory and ented is bedtime is was no had ing flow com	F 325				
10/9/01 until 10/31/01, revealed that of the 69 meals			meals					

8 were fair, 36 were poor, and 21 were left blank with

offered 4 were documented as good,

## DEPARTMENT OF HEALTH AND HUMAIN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE

STATEMENT OF DEFICIENCIES (X1) PROVIDERA

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

B. WING\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF FI	KOVIDER OR SUPPLIER	SINCE I AD	DRESS, C11 1, 3	STATE, ZIP CODE
SOUTH V		ST 9000 SOU PRDAN, UT		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY I REGULATORY OR LSC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
F 325		offered, mented ere zero, n. ing flow 1, fair, 52 if as mentation. as good, mented as ith a line in no ing flow 7, re air, 78 ed as entation. mented as it 46 were itted to hageal		CROSS-REFERENCED TO THE APPROPRIATE DATE
	hiatal hernia, hypothyroidism, status post cerebrovascular accident and edema.  On 8/14/01, the RD completed an initial nutrit assessment that documented resident 28 was 5 inches) tall per the resident, the admit weight s	ional '0" (60		
ICEA-2567I	ATG112000 Event I VI		Facility ID:	LITOORO

### DEPARTMENT OF HEALTH AND HUMAN JERVICES

(using the July 2001 weight and the January re-weight

An initial dietary assessment completed by the registered dietitian on 8/14/01 documented, "Intake appears to be adequate for nutritional needs, current diet appropriate for needs, pt [patient] would be considered at a nutritional risk [secondary to] GERD [gastroesophageal reflux disease], diarrhea [with] a

of 100 pounds).

HEALTI	H CARE FINANCING	ADMINISTRATION	<u> </u>				2567
· · · · · · · · · · · · · · · · · · ·		(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA MBER:	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPL	ETED
		465108				1	/16/02
NAME OF P	PROVIDER OR SUPPLIER		i	DRESS, CITY, STA	·		
SOUTH '	VALLEY HEALTH CE	INTER		ST 9000 SOUTE RDAN, UT 840			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEEDED B			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 325	was blank, the resider recorded as 108-115 prange was documented small frame size. The mechanical soft.  A review of resident 2 documented on the "Recollection Form" come admission, revealed the was 5'2" (62 inches) to the restorative nursed dietary supervisor, does for resident 28:  July 2001: 114 pound August 2001: 114 pound August 2001: 114 pound September 2001: 110 poechos 2001: 111 December 2001: 107 January 2002: 103 poof the survey team, research 28's weight was significant weight to between the months of 2002, and a 14 pound,	ent's usual body weight pounds and her ideal bed as 104-115 pounds bed as 104-115 pounds bed as 104-115 pounds bed diet documented was 28's admission weight a Resident Assessment-Dompleted by the nursing that she weighted 114 ptall.  28's monthly weights, coses aides and obtained occumented the following dds.  By pounds.  3 pounds.  5 pounds.  5 pounds.	and height, Data staff upon pounds and completed I from the ng weights the request ghed. s represents 0%, I January weight loss	F 325			

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FORM APPROVE 2567

	OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUI	VCLIA MBER:	A. BUILD		(X3) DATE COMPI	
		465108		B. WING		1	/16/02
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE	<del> ^</del>	710,02
SOUTH	VALLEY HEALTH CE	NTER	3706 WES WEST JOI	T 9000 SOU RDAN, UT	JTH 84088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	Continued From Page 36 potential for [decrease initial assessment iden appetite (75%) and wa documented nutrition monitor weight, intak quarterly nutrition assed dietary supervisor and no nutritional stress far documented dietary no medical record.  A review of the "Nursia assessment for August current weight was 114 appetite. The nurse do no edema and no abdord There were no "Nursing assessments in the medical September, October or A review of the "Nursia assessment for Decemb 28's current weight was good appetite. The nursia assessment for Decemb 28's current weight was good appetite. The nursia had no edema and no condistress.  A review of nursing not resident 28's medical record documented evidence of On 9/14/01, the nurse do not like the nutritional subhad been ordered on 8/1 There was a physician ted discontinue the supplement documented that resident supplement". On 1/12/0 resident 28 had a good as possible to the supplement.	ed] intake, advanced as attified resident 28 had as able to feed herself. plan for resident 28 ware, labs". On 11/1/01, essment was complete signed by the RD. The ctors documented. Notes were found in resident and she had a cumented that resident minal distress.  In Monthly Summary and Monthly Summary ical record for the month in the month is a documented that resident in the month is a document in the month in the month in the month is a document in the month in the month in the month in the month is a document in the month i	a good The RD's as to, a d by the here were further dent 28's dent 28's dent 28 had hths of esident ad a sident 28 d for the	F 325			

HCFA-2567L

ATG112000

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 37 of

### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

	OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION N	UMBER:	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMP	LETED
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F 325	documented evidence supplements or that it calories in resident 2  A review of all documents of through 1/15/02 was weight loss was not a	the that other types of reinterventions to increase. It is diet were attempted to the series of the pounds, or 10001 and January 20021 the original January steady, gradual weight	essments of 7/31/01 gradual sessments.  D and dated nutritional of diarrhea through the on the care preferences, monitored of changes. The sesident 28's 19%, between the cusing the weight of on those	F 325			
	A review of resident 2 record for November days the aides docum of her breakfast and 1 of lunch and 1 day the supper. Two days doc breakfast and 1 lunch documented. There we for resident 28 for the	2001 was done. On lented that resident 28 18 days that resident 2 at resident 28 ate 100 cumented that resident meal which had no newere no other meal into month of November 28's "Daily Dietary In	16 of the 3 ate 100% 28 ate 100% % of at 28 ate no neal intake take records 2001.				
	record for December days the nurse aides d						

ATG112000

100% of her breakfast and lunch and 15 days which

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Facility ID:

UT0080

If continuation sheet 38 of

# DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE \_\_\_\_\_ 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

B. WING\_\_

\_\_\_1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### SOUTH VALLEY HEALTH CENTER

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(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)	(XS) COMPLETE DATE
F 325	Continued From Page 38 had no meal intake documented. There were no other meal intake records for resident 28 for the month of December 2001.  A review of the facility's Dietary Management Team minutes revealed that resident 28 was identified as	F 325		
i	needing nutritional intervention/monitoring during the 1/2/02 meeting. Resident 28 was on the Dietary Management Team list for review 1/2/02, however, there were no team member comments, recommendations or interventions documented on the monitoring form.			
	8. Resident 50 was an 83 year old female admitted to the facility on 4/4/01 with diagnoses of dementia with depressive features, non insulin dependent diabetes mellitus, osteoarthritis, agitation and generalized pain.			
	The registered dietitian completed an undated initial nutritional assessment that documented resident 50 weighted 145 pounds, was 5'2" (62 inches) tall and her ideal body weight range was 108-121 pounds upon admission. The diet documented was mechanical soft.			
	A review of resident 50's admission weight, documented in the physician's admit note, revealed that she weighted 145 pounds on 4/4/01. A review of resident 50's monthly weights from June 2001 through January 2002, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 50:			
	June 2001: 140 pounds. July 2001: 142 pounds. August 2001: 142 pounds. September 2001: 139 pounds. October 2001: 137 pounds. November 2001:134 pounds. December 2001: 128.5 pounds.			

# DEPARTMENT OF HEALTH AND HUMAN JERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION
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(X3) DATE SURVEY COMPLETED

465108

B. WING\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### SOUTH VALLEY HEALTH CENTER

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

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(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) COMPLETE DATE
F 325	January 2002: 131.5 pounds. On 1/11/02, at the request of the survey team, resident 50 was reweighed. Resident 50's weight was 128 pounds. This represents a significant weight loss of 14 pounds, or 10% between the months of July 2001 and January 2002 (using the July weight of 142 pounds and the January re-weight of 128 pounds). There was steady weight decrease noted from September 2001 to January 2002.  An undated "initial dietary assessment" completed by the registered dietitian documented, "Intake/fluids good. Should meet needsPt [patient] at nutritional risk m/b [manifested by] senile dementia [with] potential for weight loss". This initial assessment identified resident 50 had a fair appetite (50-75%), good swallowing ability, dentures which fit properly and she could feed herself. The RD's documented nutrition plan for resident 50 was to, "monitor intake, weights, labs". An undated "quarterly nutrition note" not co-signed by the registered dietitian, was completed by the food service supervisor. Resident 50's gradual weight decrease was not identified in this note. A review of resident 50's medical record showed these were the only completed dietary assessments of this resident. The quarterly note for January 2002 had not yet been fully completed but had been partially completed by the food service supervisor. In a telephone interview with her on 1/17/02, she stated that she began to fill out the January 2002 quarterly assessment in November 2001 but had not yet completed it for January. This quarterly note had not yet been reviewed and signed by the dietitian.  A review of the "Nursing Monthly Summary" assessment for November 2001 documented resident 50's current weight was 134 pounds. The nurse completing the form documented that resident 50's weight was stable and next to that documented a	F 325		

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Event I XP7W11

Facility ID:

#### DEPARTMENT OF HEALTH AND HUMA. JERVICES HEALTH CARE FINANCING ADMINISTRATION

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				!	DEFICIENCY)		<u> </u>
F 325	1			F 325			
	gradual loss of 3 pow	inds and her appetite wa		Ī			
				1			
		sing Monthly Summary		ļ			
		mber 2001 documented		!			
		as 134 pounds. The nu		1			
		documented no weight	changes	†			
ı	and that resident 50 ha	ad a fair appetite.		J			
		1 37 d.1 0		ļ			
		sing Monthly Summary			ĺ		
		ry 2002 documented res 29 pounds, which was a			I		
	nounds The purse co	ompleting the form doci	C 10 8801		İ		
	that resident 50 had gr				I		
	appetite was good.	aduat weight toss and .	ner		l		
	арренее нас доси.						
	A review of resident 50	50's					
	1	ation-Pressure Sore Ris	.sk				
	Assessment", complete	ted by the nursing staff,	, was				
	done. Resident 50 was	is assessed on 4/4/01 as	s having a	1			
	total score of 8. Reside	ent 50 was assessed on	a 7/5/01,				
	10/1/01, and 1/4/02 as	s having a total score of	f 12. Per				į
	this form, a total score		I the				
	resident at high nutrition	onal risk.				1	
	· · · · · · · · · · · · · · · · · · ·	. 11				1	
	A review of all docume			!		!	
	completed from resider through 1/15/02 was do	At our admission on 4/	4/01			!	
	weight loss was not add					'	
	Meight has was not age	Tiessen on these assess	ments.			ļ	
	A nutritional care plan,	initiated by the RD at	nd dated			ļ	
	4/12/01, documented th	hat resident 50 was at 1	nutritional			J	
	risk related to advanced	d age and adjustment t	o the			ļ.	
	nursing home, senile de	ementia with potential	for			J	
] -	weight loss and diabetes	es and would have no s	significant			ļ	1
	weight loss through the	next review. Approac	ches to			ļ	1
	the problem on the care	e plan included, dietary	y was to	1		1	l
	obtain food preferences	s, meal intakes, weights	s and			ļ	j l
	labs were to be monitore					Ì	,

notified of significant changes. The care plan was not

1/16/02

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT	OF DEFICIENCIES
AND PLAN OF	F CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION	
A. BUILDING	

(X3) DATE SURVEY COMPLETED

465108

B. WING \_\_\_\_\_STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH VALLEY HEALTH CENTER

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

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(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) COMPLETE DATE
F 325	Continued From Page 41 updated to address resident 50's steady, gradual weight loss between the months of September 2001 and January 2002.  A malnutrition/dehydration risk care plan, initiated by nursing, dated 4/10/01 and updated 9/23/01, documented that resident 50 was at nutritional risk related to a total score of 8 on the malnutrition/dehydration assessment, poor ability to take fluids independently or feed self and osteoarthritis. Also documented was that resident 50's average dietary intake was 50-75% and she had good swallowing ability. Documented goals included the following: no unexpected or unplanned weight loss every month, average meal intakes of 75% and evaluate every monthly summary and in the interdisciplinary team meeting. Approaches to the problem of the care plan included document percentage eaten on ADL form every meal, monitor if less than 50% meal average every day, monitor significant unplanned weight loss.  A review of resident 50's meal intake record, documented on the "ADL Flow Sheet Record" for November 2001 revealed that the nurses' aides were documenting meal intakes in percentages. Out of a possible 90 meals for the month 10 had no meal percentage documented.  A review of resident 50's meal intake record, documented on the "ADL Flow Sheet Record" for December 2001 revealed that the nurses' aides were documenting meal intakes in percentages. Out of a possible 93 meals for the month 26 had no meal percentage documented.  A review of resident 50's meal intake record, documented on the "ADL Flow Sheet Record" for December 2001 revealed that the nurses' aides were documenting meal intakes in percentages. Out of a possible 93 meals for the month 26 had no meal percentage documented.  A review of resident 50's meal intake record, documented on the "ADL Flow Sheet Record" for January 2002 from 1/1/02 through1/9/02 revealed that	F 325		
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Event I XP7W11

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

to eat her breakfast by the certified nurses aide in the dining room or to be offered assistance with eating.

HEALTH CARE FINANCING ADMINISTRATION

2567

+	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUN		(X2) MULT A. BUILDIN B. WING		(X3) DATE COMP	
NAME OF D	ROVIDER OR SUPPLIER	1 100200	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
	VALLEY HEALTH CE	NTER	3706 WES	Γ 9000 SOU RDAN, UT &	тн		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PROVIDER'S PLAN OF CORP PREFIX (EACH CORRECTIVE ACTION) TAG CROSS-REFERENCED TO THE A DEFICIENCY)		TON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 325	the nurses' aides were percentages. Out of a percentage document. A review of the facili minutes revealed that needing nutritional in 12/17/01 meeting. R Management Team lithere were no team more recommendations or monitoring form.  On 1/3/02, from 7:45 Alzheimer's dining rowith her breakfast trat to be eating her food the foods around on a dining room stated, hers, she builds thing offer to help resident food. At 7:56 AM, rehalf of her glass of juresident 50 continued her plate and not eat, was having fun and to to eat. Resident 50 co food items around on her plate was remove offered a replacement.	e documenting meal interpretation in a possible 27 meals 8 had been at the company of the compan	ent Team fied as during the Dietary however, ted on the e Facility beserved served not on to move de in the lay with bserved to to eat her d to pour 3:01 AM, d around her if she supposed move the M when he was not juice on	F 325			
		observed to be offered Resident 50 was not re					

Event I XP7W11 Facility ID: UT0080 If continuation sheet 43 of ATG112000

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### DEPARTMENT OF HEALTH AND HUMAN \_\_RVICES HEALTH CARE FINANCING ADMINISTRATION

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
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NIA ME OF D	DOVIDED OF CURRING	403100	CTREET ADE	DECC CITY C	TATE, ZIP CODE		6/02
NAME OF F	ROVIDER OR SUPPLIER						
SOUTH Y	VALLEY HEALTH CE	NTER		T 9000 SOU RDAN, UT			
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	FCORRECTION	(X5)
PREFIX TAG		MUST BE PRECEEDED BY SC IDENTIFYING INFORMA		PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
F 326 SS=E	Based on a resident's facility must ensure the therapeutic diet when This REQUIREMEN Based on observation review, it was determined the residents, the facility received a therapeutic problem as evidenced her protein power as considered who does not protein rich meat alter 1/3/02. Resident iden not follow therapeutic these diets per physicial these diets per physicial findings include:  1. Resident 35 was a sediagnoses including he accident, congestive he also noted to have a him on 1/3/02, resident 35 A review of the Januar signed by the physicial with 1 scoop of Promopowder) was ordered condered Promod.	comprehensive assessmat a resident receives a there is a nutritional p. T. is not met as evident, interview and medical ined that for 2 of 26 said did not ensure that each diet, when there was a by: one resident did nordered by the physicial like meat was not service during the lunch tifiers: 35, 42. The farm diets for any resident pan orders.  94 year old female with emorrhagic cerebrovase eart failure and anemial story of pressure ulcerny, 2002 re-certification, documented that a product of the control of the	roblem.  ced by: I record mpled n resident nutritional of receive n and one ed a n meal on cility did orescribed  cular . She was s. reviewed. n orders, aree diet ein meal on ce the	F 326	The following is a plan of correction 483.25 (i) Quality of Care. This will 483.25 (i) (2) Quality of Care, F-360 483.35 1-2, F-363 483.35 (c) Dietar & (2),F-371 483.35 (h) (2). Action for been affected and were identified as a consistent done by the progress notes, the dieta current weights, and dia warranted.  2. NIT committee will add h-pylori on the residents residents' physician for interventions.  3. Dietary intake record has percentage of what residence accurately recorded rath 4. C.N.A. scheduler will at weekly to ensure accurate.  5. 4 way drug check will be QA to ensure that all ord will be on residents' MA percentage documentatic diagnosis's to medication and/or side effects.  6. Licensed staff has been in committee of any dietary interventions can be importance of any dietary interventions can be importance of any dietary interventions are incommittee of any dietary interventions are implementaged.  8. C.N.AN.A will be in-seregarding interventions feating, swallowing, and a limportance of communic interventions are implementaged.  9. Speech consultant will reconcerned by the RD what and what foods residents receive.  11. Extended menus for the recurrently being followed serviced by the RD what and what foods residents receive.	and is in reference to: F-325 I include corrective F-326 I 483.35 Dietary Services, F-366 y Services, F-364 483.35 (d) (1) or each resident found to have 13, 20, 28, 40, 50, 70, 72, 74. Inserviced on how to complete ation-pressure sore risk RD, the MDS, the dietary ary intake records, and the gnosis and medications as tress any medical conditions i.e. or careplan and consult with medical and nutritional as been changed so that lent ate is now what is tent and completion. The done monthly by ADON and ters regarding house supplementally is as warranted and to ensure to. The As well as to address on and any drug interactions instructed to inform NIT or problems so that other elemented as warranted. The problems are appropriate and any drug interactions to be placed MAR tummaries can address current therviced February 20, 2002 for residents' experiencing thewing difficulties. The problems are appropriate undations to the NIT committee. The problems are appropriate on the appropriate on the rapeutic diets are to the portion of the provide to the provide of the provide to the provide of the provide the provision, through assessment, the provide of the provide the provision, through assessment,	2/20/02
	A dietary aide was inte She stated that the diet on her tray in a small p	ary staff usually put the	Promod		loss. The RD will	is to prevent significant weight	

ATG112000

Event I XP7W11

Facility ID:

### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

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B. WING

1/16/02

NAME OF PROVIDER OR SUPPLIER

#### SOUTH VALLEY HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH

SOUTH	VALLEY HEALTH CENTER WES	ST JORDAN, UT 8	4088
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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)  COMPLE  DATE
F 326	Continued From Page 44 would add the Promod to her food. She stated that kitchen had been out of Promod for 3 or 4 days but that the nurses in the facility should have some and that they'd place a scoop in her food if it was not so from dietary.  An interview with the dietary manager on 1/3/02 at 1:32 PM was done. She stated that they were out of Promod in the kitchen but that it should be availabe the nurse's stations.  Interviews with nursing staff members on the differ halls on 1/3/02 revealed that no Promod was availabe at the nurse's stations or anywhere else in the facility.  An interview with the dietary manager on 1/3/02 at 2:00 PM was done. She stated that she'd been told they were out of Promod facility wide and had been for at least 3 days.  2. Resident 42 was a 68 year old female with diagnoses including senile dementia, depression and hypertension.  On 1/3/02, resident 42's medical record was review. A review of the dietary section of the chart revealed "Change of Diet" slip, which documented the following, "Regular diet [with] low salt (NAS)[no added salt] (She likes to eat fruits [and] fish) (She doesn't like meat. She also likes lemonade)".  Observation of tray line during the lunch meal on 1/3/02 was done. Resident 42's diet card stated as a only food preference, does not like meat. The following was to be served on the menu for lunch the day, meatballs in sweet & sour sauce, fried rice, oriental blend vegetables, bread/margarine and mandarin oranges. Resident 42 received the follow food items on her meal tray, mashed potatoes and	t d d d d d d d d d d d d d d d d d d d	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following  Therapeutic diets as written and serving foods at the proper temperature.  31. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services.  14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents.  15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at random resident's trays for proper food temps and record.  16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly.  17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding. Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff.  18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out.  20. The dietary staff will be in-serviced February 19, 200 on how to store, prepare, distribute, and serve food under sanitary conditions.  21. The grease trap was cleaned by a local plumbing company, and was scheduled to come our routinely.  22. The unit manager for out-dated food will check the Alzheimer'

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

The facility must ensure that residents receive proper

HCFA-2567L

HEALTH CARE FINANCING ADMINISTRATION

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 1/16/02 465108 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3706 WEST 9000 SOUTH** SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION מו (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 326 Continued From Page 45 F 326 gravy, white rice, a bowl of tomato soup, oriental blend vegetables, a slice of bread, mandarin oranges, an 8 ounce carton of fat free milk, and 4 ounces of juice. No high protein meat alternative was served to replace the meat not provided on resident 42's meal tray. 3. On 12/31/01 at 8:48 AM, the food service supervisor was interviewed. She was asked to provide the survey team with the extended menu for the week which would document the appropriate serving sizes to be provided for residents on all diets and document what diet modifications, if any, would need to be made for resident's receiving therapeutic or texture modified diets. She stated she was not sure what I was referring to and stated that since she'd taken over as dietary manager in August, 2001 the facility had not had the extended menus. She stated that all residents are served the same diet. She stated that foods are not cooked with salt and that if a resident is on a renal diet that they don't serve them potatoes. On 12/31/01 at 10:50 AM, the consultant dietitian was interviewed. He was asked whether he knew if the facility had extended menus for the menu cycle currently being followed. He stated he was unaware of any extended menus being used. He stated that the menu being served was low in salt and concentrated sweets. When asked how the staff knew what servings sizes were appropriate or what foods residents on therapeutic diets were to receive if they had no extended menu to specify this, he was unable to provide an answer. F 328 483.25(k) QUALITY OF CARE F 328 SS=E

> If continuation sheet 46 of Facility ID: UT0080 ATG112000 Event I XP7W11

### DEPARTMENT OF HEALTH AND HUMAN JERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

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B. WING\_

1/16/02

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STREET ADDRESS, CITY, STATE, ZIP CODE

#### SOUTH VALLEY HEALTH CENTER

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 328	Continued From Page 46 treatment and care for the following special services:	F 328	The following is a plan of correction and is in reference to F328 483.25 (k) Quality of Care. This will include	e
i			corrective action for each resident found to have been affected and were identified as is:	
	Injections			2/1/0
	Parenteral and enteral fluids;		A Podiatrist was hired November 2001 to provide podiatry care for all the residents in the facility-prior to hiring the new podiatrist	
	Colostomy, ureterostomy, or ileostomy care;		it was noted that podiatry care was lacking.  2. Medical records will maintain current	
	Tracheostomy care;		podiatry list so that all residents are seen every 60 days.	
	Tracheal suctioning;		Licensed staff will inform the podiatrist of any immediate problems.	
	Respiratory care;		Wound team nurse will assist the podiatrist during rounds.	
	Foot care;			
	Prostheses.			
	This REQUIREMENT is not met as evidenced by:			
	Based on observation, resident interview, and record review, it was determined that for 1 of 26 sampled residents, the facility did not ensure that proper diabetic foot care and treatment was provided.			
	(resident 15)			
	Findings include:			
	Resident 15 was admitted to the facility on 5/7/01. The resident's diagnoses included, multi infarct dementia, weight loss, diabetes mellitus-II requiring insulin, hypertension, hyperlipidemia, onychomycosis, bilateral pedal edema, and proteinuria.			
	Observation of resident 15 was made on 1/8/02 at 9:45 AM. Resident 15's feet had thick yellow, long, jagged toenails. Resident 15's toenail on her left foot great toe was growing upward at approximately an 80 degree angle to the nailbed. Resident 15 made the			٠

### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

HEALTH CAICE 1 1111 11 10 12 10			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED
	465108	B. WING	1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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SOUTH VALLEY HEALTH CENTER	WEST JORD.

(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) COMPLETE DATE
F 328	Continued From Page 47 comment, "I've been wanting someone to look at my feet.", while surveyor was observing resident 15's feet. Resident 15's feet were noted to be odorous.  A review of resident 15's medical record was done on 1/8/02. There was no documentation available to evidence that a podiatrist had evaluated and treated resident 15.  Resident 15's care plan, dated 5/7/01, under the activities of daily living care plan, identified a nursing approach to keep nails clean and trimmed.	F 328		
F 329 SS=E		F 329		
	This REQUIREMENT is not met as evidenced by: Based on medical record review, it was determined that for 4 of 26 sampled residents, the facility did not ensure that resident's insulin regime was monitored. Resident 4 had physician's orders to check blood glucose levels four times a day. Between the months of October and December 2001, blood glucose levels were obtained three times a day or less for 55 of 92			

If continuation sheet 48 of

HCFA-2567L

### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLI IDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
		465108		B. WING_			1/1	6/02
	NAME OF PROVIDER OR SUPPLIER SOUTH VALLEY HEALTH CENTER		3706 WES	PRESS, CITY, S T 9000 SOU RDAN, UT	ТН	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	1	PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	Л <b>.D BE</b>	(XS) COMPLETE DATE
F 329	blood glucose level to of October and Nove obtained two times a Resident 24 had phys glucose level two time October, and Novem obtained two times a Resident 76 had phys glucose level four tim dialysis every Tuesda 10:00 AM to 2:00 Ph levels before lunch orecorded in the MAR record). Resident 76 administered to him copportunities, from 1 1/07/02. (Resident Findings include:  Resident 4 was administered to him copportunities, from 1 1/07/02. (Resident Findings include:  Resident 4 was administered to him copportunities, from 1 1/07/02. (Resident Findings include:  Resident 4 was administered to him copportunities, hyperclobstruction, and diabeted fracture, congestive hosteoarthritis, hyperclobstruction, and diabeted fracture, and at hour of sliding scale regular in results of blood glucose I meals, and at hour of sliding scale regular in results of blood glucoregular insulin is an argiven, based on the relevels). Resident 4's selected for the relevels. Resident 4's selected for the relevels. Resident 4's selected for the relevels.	and physician's orders to three times a day. For the mber, blood glucose led day or less for 12 of 6 sician's orders to check the aday. For the month ber, blood glucose leved day or less for 9 of 61 sician's orders to check the aday. Resident 76 sician's orders to check the aday. Resident 76 the aday. Resident 76 the aday and Sature M, therefore, the blood on those days would not a (medication administrated incorrect insuling 55 out of 299 possible 0/16/01 (day after admits 4, 15, 24, and 76) the include the following: is ease, senile dementia, the art failure, hypothyrotholesterolemia, small between the characteristics of the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the senile dementia, the art failure, hypothyrotholesterolemia, small between the senile dementia, the art failure hypothyrotholesterolemia, small between the senile dementia, the art failure hypothyrotholesterolemia, small between the senile dementia, the art failure hypothyrotholesterolemia, small between the senile dementia, the art failure hypothyrotholesterolemia, small between the senileman the se	he months vels were 1 days . blood hs of ls were days. blood attends day from glucose t be ation  6/23/97  right hip idism, owel  wed on hat 0/01, to before to receive based on g scale is to be d glucose ders were:	F 329	to F-329 (a)Pharm action fo	owing is a plan of correction and 483.25 (I) (1) Quality of Care, I hacy Services. This will include or each resident found to have be identified as 4, 15, 24, 76.  The house physician ordered siscale for the diabetic.  Residents-who are the house pipatients 150-200= 2 units region 201-250= 4 units region 301-350= 8 units region 351-400= 10 uni	F-426 483.60 c corrective cen affected standard sliding shysicians' gular gular gular cegular or >450 regarding ard sliding on 2/6/02. Diabetic	2/1/02

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 1/25/ FORM APPROVE

2567

HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

B. WING \_

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING

3706 WEST 9000 SOUTH

	,	ST JORDAN, UT 840	088	
(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) COMPLE DATE
F 329	Continued From Page 49 Blood glucose 301-350 give 6 units of regular ins Blood glucose of 351-400 give 8 units of regular insulin.  Review of resident 4's MAR (medication administration record), the patient diabetic record flowsheet, and the diabetic monitoring flowsheet identified that resident 4's blood glucose levels we			
	not documented as being done on the following dand times.  10/02/01: before breakfast, before lunch 10/03/01: before lunch 10/04/01: before lunch, before dinner 10/05/01: before lunch, before dinner 10/06/01: before lunch, before dinner 10/07/01: before lunch, hour of sleep 10/09/01: before dinner 10/10/01: before lunch, before dinner	ates		
	10/11/01: before lunch 10/13/01: before lunch before dinner, hour of slee 10/14/01: before lunch, hour of sleep 10/15/01: before lunch,before dinner, hour of slee 10/16/01: before breakfast, before lunch, before dinner 10/17/01: hour of sleep 10/18/01: before lunch, before dinner 10/21/01: hour of sleep	p		
	10/22/01: before lunch, before dinner, hour of slee 10/15/01: before lunch, before dinner, hour of slee 10/29/01: before breakfast, before lunch, hour of sl 10/30/01: hour of sleep 10/31/01: before lunch, hour of sleep 11/01/01: before breakfast 11/03/01: before lunch 11/02/01: before dinner 11/04/01: before lunch, before dinner, hour of slee 11/05/01: before lunch	eep		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

A. BUILDING B. WING\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

F 329	REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From Page 50	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 329	Continued From Page 50	<del></del>	DETICIENCY)	
		F 329		
	11/07/01: before lunch			
1	11/10/01: before lunch, before dinner, hour of sleep			
	11/12/01: before dinner			İ
i	11/14/01: before lunch			
	11/17/01: before lunch			
[	11/18/01: before lunch			
	11/20/01: before dinner			
	11/22/01: before lunch, before dinner			
1	11/24/01: before lunch, before dinner, hour of sleep			
	11/27/01: before lunch, before dinner			
	12/01/01: before lunch			
	12/02/01: before lunch, before dinner			
	12/03/01: before lunch, hour of sleep			
	12/04/01: before lunch			1
	12/05/01: before lunch			
	12/06/01: before dinner			
1	12/07/01: before lunch, before dinner			
	12/08/01: before lunch, before dinner			
	12/09/01: before lunch, before dinner	[.		
	12/15/01: before lunch, before dinner			
	12/16/01: before lunch, before dinner			
	12/17/01: before lunch			
	12/18/01: before lunch			
i 1	12/19/01: hour of sleep			
t i	12/23/01: before lunch			
	12/24/01: before lunch, before dinner			
I	12/29/01: before lunch			
	12/31/01: before lunch, before dinner, hour of sleep			
	Resident 15 was admitted to this facility on 5/7/01			
	with the diagnoses which include the following: multi			
	infarct dementia, weight loss, diabetes mellitus (insulin			
	required), hypertension, hyperlipidemia,			•
	onychomycosis, bilateral pedal edema, and			
	proteinuria.			
	The medical record for resident 15 was reviewed on			
1	1/8/02. During this review, it was noted that resident			

#### PRINTED: 1/25/ FORM APPROVE

### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED

465108

A. BUILDING B. WING

1/16/02

SOUTH VAL	LEY	HEAL	TH	CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH

(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) COMPLETE DATE
F 329	Continued From Page 51 15 had physicians orders dated 5/7/01 to check blood glucose levels every AM, and every PM, and at hour of sleep. Resident 15 was to receive sliding scale regular insulin three times a day based on the results of blood glucose monitoring. Resident 15's sliding scale insulin orders were:  Blood glucose 200-250, give 2 units regular insulin. Blood glucose 251-300, give 4 units regular insulin. Blood glucose 301-350, give 6 units regular insulin. Blood glucose 351-400, give 8 units regular insulin. Blood glucose 401-450, give 10 units regular insulin. Review of resident 15's MAR, patient diabetic record flowsheet, and the diabetic monitoring flowsheet identified that resident 15's blood glucose levels were not documented as being done on the following dates and times.	F 329	DETERMINE TY	
	10/27/01: hour of sleep 10/28/01: hour of sleep 10/29/01: hour of sleep 10/31/01: hour of sleep 11/04/01: before dinner 11/05/01: hour of sleep 11/10/11: hour of sleep 11/13/01: before dinner 11/22/01: before dinner 11/22/01: before dinner 11/24/01: hour of sleep 11/25/01: before breakfast 11/29/01: before dinner Resident 24 was admitted to the facility on 4/5/01 with diagnoses which include the following: pyelonephritis, insulin dependent diabetes mellitus, pulmonary embolism, infarction, deep vein thrombosis, atrial fibrillation, femur fracture, hypertension, depression, insomnia, anxiety, and anemia.			

1/16/02

### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER .

SOUTH VALLEY HEALTH CENTER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

B. WING\_ STREET ADDRESS, CITY, STATE, ZIP CODE

#### **3706 WEST 9000 SOUTH** WEST JORDAN, UT 84088

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(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) COMPLETE DATE
F 329	Continued From Page 52	F 329		
	The medical record for resident 24 was reviewed on 1/8/02. During this review it was noted that resident 24 had physicians orders dated 4/6/01 to check blood sugar two times a day. Resident 24 was to receive sliding scale regular insulin two times a day based on results of blood glucose monitoring. Resident 24's sliding scale insulin orders were:  Blood glucose 151-200, give 2 units of regular insulin. Blood glucose 201-250, give 4 units of regular insulin. Blood glucose 301-350, give 6 units of regular insulin. Blood glucose 351-400, give 10 units.  If blood glucose is greater than 400, give 12 units of regular insulin and check glucose every 2 hours until glucose is less than 150.			
	Review of resident 24's MAR (medication administration record), patient diabetic record flowsheet, and the diabetic monitoring flowsheet identified that resident 24's blood glucose levels were not documented as being done on the following dates and times.			
	10/12/01: before dinner 10/14/01: before dinner 10/15/01: before dinner 10/16/01: before breakfast 11/02/01: before dinner 11/05/01: before dinner 11/10/01: before dinner 11/10/01: before dinner 11/29/01: before dinner 11/30/01: before dinner 11/30/01: before breakfast 1. Resident 76 was a 53 year old male who was admitted to the facility on 10/15/01 with the diagnoses of gastric ulcers, respiratory distress syndrome, IDDM (insulin dependant diabetes mellitus), aspiration pneumonia, CAD (cardiac artery disease), acute renal failure, respiratory failure, gangrenous cholecystitis,			

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Facility ID:

	rment of health I Care financing						11ED: 17257 4 APPROVE 2567
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		465108	¥714 444 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	B. WING _		1/	16/02
NAME OF P	ROVIDER OR SUPPLIER		STREEŢ ADI	DRESS, CITY, ST	FATE, ZIP CODE		
SOUTH	VALLEY HEALTH CE	NTER		T 9000 SOUT RDAN, UT 8	<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
F 329	Continued From Page 5 acute MI (myocardial vascular accident).		(cerebral	F 329			
	A physician's order de "sliding scale AC [be. The sliding scale was	fore meals] and HS [at					
	Blood glucose level 1 insulin. Blood glucose level 2 insulin.	_	_				
	Blood glucose level 3	51 to 450 give 10 unit	s regular				

10/21/01: before breakfast, before lunch, before

10/22/01: before breakfast, before lunch, hour of

Blood glucose level greater than 450 call the

On 1/08/02 at 9:30 AM, an interview with a facility license practical nurse (LPN) was conducted about how to document the sliding scale insulin and glucose monitoring. The facility's LPN stated that the blood sugars should be documented on the "Diabetic

Monitoring Flowsheet" with the amount of insulin given. Resident 76's MAR and diabetic monitoring flowsheet was reviewed. The following were a list of

December, 2001, and January 1, 2002 through January 7, 2002, that resident 76 did not have a blood glucose

days and times during October, November,

level documented as being done as ordered.

10/16/01: before breakfast, before dinner 10/17/01: before lunch, hour of sleep

10/19/01: before lunch, before bedtime

10/18/01: hour of sleep

10/20/01: hour of sleep

dinner, hour of sleep

10/23/01: hour of sleep

sleep

5

insulin.

physician.

2567

# DEPARTMENT OF HEALTH AND HUMAI ERVICES

HEALTH CARE FINANCING ADMINISTRATION

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TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DAT
	465100	B. WING	

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1/16/02

465108

STREET ADDRESS, CITY, STATE, ZIP CODE

#### SOUTH VALLEY HEALTH CENTER

NAME OF PROVIDER OR SUPPLIER

3706 WEST 9000 SOUTH

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FURE REGULATORY OR LSC IDENTIFYING INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATION OF LIFE INFORMATI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETE
1740	ACCOUNT ON THE IDENTIFY THE INFORMATION	ON) TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F 329		F 329	-	
	10/24/01: before lunch, hour of sleep			
	10/25/01: hour of sleep			
	10/26/01: before lunch, hour of sleep			ļ
	10/27/01: hour of sleep			İ
	10/29/01: before lunch, before dinner, hour o	f sleep		
	10/30/01: hour of sleep			1
	10/31/01: before lunch, hour of sleep			1
	11/01/01: before breakfast, before dinner, hou	ır of		
	sleep			
	11/02/01: before lunch, before dinner, hour of	fsleep		
	11/03/01: before dinner, hour of sleep			İ
	11/04/01: before lunch, before dinner, hour of	sleep		
	11/05/01: before lunch, hour of sleep			
	11/07/01: before lunch, before dinner, hour of	sleep		
	11/08/01: before dinner		•	
	11/09/01: before lunch, hour of sleep			
	11/10/01: before breakfast, hour of sleep			
	11/11/01: before lunch			}
	11/12/01: before lunch, before dinner			
	11/13/01: before dinner			
	11/14/01: before lunch, hour of sleep			
	11/16/01: before lunch, hour of sleep			
	11/18/01: before lunch, hour of sleep			
	11/19/01: before dinner			
	11/20/01: before dinner			ĺ
	11/23/01: before lunch, before dinner, hour of 11/28/01: before dinner	sleep		
İ	11/29/01: before dinner			İ
	11/30/01: before lunch			
	12/01/01: before dinner, hour of sleep			
	12/03/01: before dinner			
	12/04/01: before dinner			
İ	12/05/01: before dinner			
	12/07/01: before drimer 12/07/01: before breakfast, before lunch, hour	-c	i	
	sleep	OY		
	12/09/01: before lunch			
	12/10/01: before lunch, before dinner, hour of s	1		
	12/12/01: before lunch	пеер		
1	12/14/01: before funch 12/14/01: hour of sleep			
	12/17/01. Hour of steep			

### DEPARTMENT OF HEALTH AND HUMAN JERVICES HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVE 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

B. WING

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH VALLEY HEALTH CENTER		3706 WEST 9000 SOUTH WEST JORDAN, UT 84088			
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F 329	Continued From Page 55 12/21/01: before lunch 12/23/01: before lunch 12/24/01: before lunch 12/27/01: hour of sleep 12/28/01: before lunch 12/30/01: before lunch 12/31/01: before lunch 01/02/01: before lunch 01/04/01: before breakfast, before lunch 01/04/01: before lunch, before dinner 01/06/01: before lunch 01/07/02: before lunch	F 329			
F 360 SS=H	The facility must provide each resident with a nourishing, palatable, well-balanced diet that met the daily nutritional and special dietary needs of resident.  This REQUIREMENT is not met as evidenced to Based on an annual survey with subsequent extensurvey, conducted December 31, 2001 through January 16, 2002, it was determined that the facilifailed to ensure residents were provided a diet that their special dietary needs. The consultant dietitic did not provide services, supports and supervision through assessment, monitoring and recommendate to meet each resident's nutritional needs to prever significant weight loss. There was not inadequate supervision and oversight provided by the consult dietitian to ensure that the dietary manager and distaff had proper training and systems in place to appropriately monitor the sanitation of the kitcher ensuring proper storage, preparation and the distribution and serving of foods, following the therapeutic diets as written and serving foods at the proper temperature.	each  by:  aded  ity  at met  an  n,  tions,  it  chant etary			

#### DEPARTMENT OF HEALTH AND HUMAN .... AVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

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NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID	SUMMARY STATEMENT OF DEFICIENCES	ID	PROVIDER'S PLAN OF CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE DEFICIENCY)  COMPLETE DATE
	This had the potential to affect all residents in the facility.  Findings include:  1. The facility did not have a system in place that would ensure that residents of the facility did not have avoidable weight loss. There was a lack of sufficient oversight, supervision and monitoring by the registered dietitian in identification, correction and prevention of weight loss, which resulted in the needs of the residents not being met. Eight residents were identified as having experienced avoidable and significant weight loss due to the breakdown in dietary services. (Refer to Tag F-325)  2. The facility did not have a system in place to monitor that the kitchen was following the approved, written therapeutic menus, including providing consistent food portions, which would allow for variances in the calories, protein and other nutrients provided to each resident. There was lack of sufficient oversight and supervision by the registered dietitian in identifying and correcting the serving of incorrect menus and portions sizes, which would result in the needs of the residents not being met. (Refer to tag F-363)  3. The facility did not have a system in place to ensure that each resident received a therapeutic diet when there was a nutritional problem. This resulted in residents not receiving extra protein as ordered by their physician and all residents receiving the same diet with no modifications made for those residents who had specific therapeutic diet orders. There was a lack of sufficient oversight and supervision by the registered dietitian in identifying and correcting the	F 360	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services, F-364 483.35 (d) (l) & (2), F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74.  1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted.  2. NIT committee will address any medical conditions in the residents' careplan and consult with residents' physician for medical and nutritional interventions.  3. Dietary intake record has been changed so that percentage of what resident at is now what is accurately recorded rather than good-fair-or poor.  4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion.  5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects.  6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted.  7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights.  8. C.N.AN.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted.  9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee.  10. NIT committee wi

1/16/02

#### DEPARTMENT OF HEALTH AND HUMAN JURVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

AND PLAN OF CORRECTION

465108

STREET ADDRESS, CITY, STATE, ZIP CODE

**3706 WEST 9000 SOUTH WEST JORDAN, UT 84088** 

B. WING\_

SOUTH	VALLEY	HEALTH	CENTER

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(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) COMPLETE DATE
F 361 SS=F	Continued From Page 57 improper serving of therapeutic diets, which resulted in the dietary needs of the residents no being met. (Refer to tag F-326)  4. The facility did not have a system in place to monitor food temperatures of foods sent out on resident trays or foods kept under refrigeration. Foods, which are not kept at the proper temperature, pose a possible health risk to residents and can affect the palatability and consumption of foods. There was a lack of sufficient oversight and supervision by the registered dietitian in identifying and correcting improper food temperatures. (Refer to tag F-364)  5. The facility did not have a system in place which would ensure that the sanitation of the kitchen was monitored, which includes, at a minimum, checking the kitchen for general cleanliness, monitoring the labeling and dating of foods and routinely monitoring that temperatures in the walk-in refrigerator were appropriate, on a regular basis. There was a lack of sufficient oversight and supervision by the registered dietitian in identifying and correcting sanitation concerns in the kitchen that would result in the needs of the residents not being met. (Refer to tag F-371)  483.35(a)(1)-(2) DIETARY SERVICES  The facility must employ a qualified dietitian either	F 361	ensure that the dictary manager and dictary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature.  13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dictary services.  14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dictary needs of the residents.  15. Temperatures are monitored by the dictary cooks daily and recorded. The dictary manager will monitor at random resident's trays for proper food temps and record.  16. The dictary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dictary manager will audit the above concerns weekly.  17. The RD will be employed by SVHC as a dictary consultant, who will provide adequate supervision to both the dictary manager and dictary staff regarding: Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dictary staff.  18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees.  19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dictary staff instructed to keep refrigerator door closed going in or out.  20. The dictary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions.  21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out rou
	full-time, part-time, or on a consultant basis.  If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.		

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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

465108

B. WING

1/16/02

# NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

	WEST JORDAN, UT	04000
SUMMARY STATEMENT OF DEFICIENC REFIX (EACH DEFICIENCY MUST BE PRECEEDED I FRAG REGULATORY OR LSC IDENTIFYING INFORM	BY FULL PREFIX	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (X5)  COMPLET  DATE
A qualified dietitian is one who is qualified upon either registration by the Commissi Dietetic Registration of the American Die Association, or on the basis of education, experience in identification of dietary needs	on on etetic training, or eds,	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services, F-364 483.35 (d) (1) &(2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74.  1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk
planning, and implementation of dietary p This REQUIREMENT is not met as evid Based on staff interview and observations determined that the facility did not utilize part-time consultant dietitian in a manner provided adequate supervision to the dieta or dietary staff regarding: 1. accurately m and assessing residents at risk for weight 1 monitoring the sanitation of the kitchen, e proper storage, preparation, distribution at foods, developing and implementing educa in-services for the dietary staff.  Findings include:  1. Based on clinical record review it was of that the facility did not ensure that each res maintained an acceptable parameter of nut status as evidenced by10 of 26 sampled res experienced significant weight loss with no interventions implemented to prevent furth decline. Further, the dietitian did not prov and supports, through assessment, monitor recommendations, to meet each resident's r needs.  The facility failed to provide dietetic suppor services which maintained the body weight resident as evidenced by:  a. Resident 13, a 79 year old female, was a	enced by: it was their which ary manager conitoring coss and 2. ensuring and serving of ational  determined sident ritional sidents o dietary er weight ide services ing and nutritional  orts and es for each	assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted.  2. NIT committee will address any medical conditions i.e.: h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional interventions.  3. Dietary intake record has been changed so that percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor.  4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion.  5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects.  6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted.  7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights.  8. C.N.AN.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted.  9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee.  10. NIT committee will calculate weight loss percentages weekly.  11. Extended menus for the menu cycle is available and currently being followed Dietary staff will be inserviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to receive.  12. Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide services, support, and supervision, through assessment, monitoring and recommendations, to meet each residents' nutriti

1/16/02

2567

# DEPARTMENT OF HEALTH AND HUMAN SLRVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

STREET ADDRESS, CITY, STATE, ZIP CODE

**3706 WEST 9000 SOUTH** WEST JORDAN, UT 84088

B. WING

(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 (X (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DA DEFICIENCY)	LETE
F 361	the facility on 10/11/01 with diagnoses of chronic obstructive pulmonary disease, hypothyroidism and bronchitis, urinary tract infection, helicobacter pylori gastritis (h.pylori), anxiety and chronic dizziness. Resident 13 was admitted with physician orders for medications to treat the h. pylori.  Review of the weights for resident 13 revealed the following:  October 2001 – 95 pounds.  November 2001 – 84 pounds. This represents a weight loss of 11 pounds, (11.5%) between the months of October and November 2001.  December 2001 – 75.5. pounds. This represents a weight loss of 8.5 pounds, (10%) between the months of November and December 2001.  Resident 13 experienced a significant weight loss of 19.5 pounds (20%) between the months of October and December 2001.  A physician order dated 11/7/01 documented that resident 13 was to be given 60 cc of supplement with meals for weight loss. Review of the December 2001 medication sheet revealed that the house supplement was discontinued on 12/2/01 because resident 13 was refusing the supplement stating it made her have mucous in her throat.  A review of dietary notes completed since resident 13's admission did not evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss. There was no documented evidence that alternative dietary interventions were attempted to increase calories in resident 13's diet after she refused the house supplement. Resident 13's weight had been on a downward trend since October 2001.  b. Resident 70, an 83 year old male, was admitted to	F 361	ensure that the dictary manager and dictary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following Therapeutic diets as written and serving foods at the proper temperature.  13. Dictary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dictary services.  14. RD will ensure that each resident will receive a therapeutic diet when there is a nutritional problem. The RD will assess in identifying and correct impropeserving of therapeutic diets to ensure the dictary needs of the residents.  15. Temperatures are monitored by the dictary cooks daily and recorded. The dictary manager will monitor at random resident's trays for proper food temps and record.  16. The dictary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dictary manager will audit the above concerns weekly.  17. The RD will be employed by SVHC as a dictary consultant, who will provide adequate supervision to both the dictary manager and dictary staff regarding:  Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dictary staff.  18. A new steam table with 4 wells is being purchased so foods will stay at the appropriate temperature above 140 degrees.  19. The dictary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions.  21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely.  22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator door local plumbing company, and was scheduled to come out routinely.	

ATG112000

Event I XP7W11

Facility ID:

# DEPARTMENT OF HEALTH AND HUMA! SERVICES

HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE COMPL	
		465108		B. WING_		1	/16/02
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F 361	the facility on 8/10/0 cerebrovascular accid peripheral vascular di hypothyroidism and review of the weight the following: On admission 8/10/01 September 2001- 127 weight loss of 11 pour of August and Septem October 2001- 115 polloss of 12 pounds (9.4 September and Octob November 2001- 112 loss of 3 pounds (2.6% October and November 2001- 12 loss of 3 pounds (18.8%) be and November 2001.  A review of dietary not 70's admission did not re-assessed his nutritic significant weight loss evidence that any dietation increase calories in weight had been on a calorie.  c. Resident 20 was a facility on 7/9/01 with disease, depression, ce ulcer disease.  A review of resident 2 documented in the init weighted 217 pounds of the service of the	I with diagnosis of pne- dent, dementia, atrial fil isease, hypertension, mild mental retardation is for resident 70 weight I-138 pounds. pounds. This represented in the resident for the resident for the resident for the month of the resident for the months of the resident for the months of the resident for the months of the resident for the months of the resident for the months of the resident for the months of the resident for the months of the resident for t	ts revealed  Ints a  Interpretation  Ints a  Interpretation  Ints a  Interpretation  Ints a  Interpretation  I	F 361			

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Event I XP7W11

Facility ID:

# DEPARTMENT OF HEALTH AND HUMAIN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE COMPL	
NAME OF P	ROVIDER OR SUPPLIER	.1	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	<u></u>	/10/02
	AME OF PROVIDER OR SUPPLIER OUTH VALLEY HEALTH CENTER		3706 WES	T 9000 SOUT RDAN, UT 84	H		
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F 361	August, 2001: 212 p September, 2001: 214 November, 2001: 214 November, 2001: 215 significant weight lot the months of Octob December, 2001: 20 January, 2002: 195 request of the survey weighed. Resident 2 represents a significate significate significate significate significate significate significate significate significate significate significate significate significant weight lot evidence that any dieto increase calories in weight had been on a 2001.  d. Resident 72 was a this facility on 11/10 heart failure, cerebro thrombosis, atrial fib and gastro-esophages Resident 72 had phys 3/26/01.  Resident 72's weight	tained from the dietary sowing weights for residence ounds.  17 pounds. pounds. 01 pounds. This represests of 13 pounds, or 6%, or and November 2001. 01 pounds pounds. On 1/11/02, at the team, resident 20 was at team, resident 20 was at team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team, resident 20 was at the team of the te	ents a between the re- unds. This unds, or and ht loss anuary, unds and esident itian s nented attempted sident 20's October  mitted to ongestive vein ayroidism D). ERD on	F 361			

ATG112000

Event I XP7W11

Facility ID:

### DEPARTMENT OF HEALTH AND HUMAIN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIP  A. BUILDING  B. WING	LE CONSTRUCTION	(X3) DATE COMPI	
	ROVIDER OR SUPPLIER VALLEY HEALTH CE	ENTER	3706 WES	DRESS, CITY, STA T 9000 SOUT RDAN, UT 84	H		,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE  MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 361	loss of 16 pounds, (7 February 2001. March 2001-203 pour April 2001-187 pound of 16 pounds, (7.9%) June 2001-182 pound of 15 pounds, (8.3%)  A review of dietary in 72's admission did not re-assessed her nutritisignificant weight lose evidence that any diet to increase calories in weight had been on a 2001.  e. Resident 74, a 60 the facility on 10/3/01 protien calorie malnut cerebralvascular accidence that any diet to increase diet in weight had been on a 2001.  e. Resident 74 was admit (g-tube) with orders to three times daily via the physician order to refer the facility on 10/3/01 protien calorie malnut cerebralvascular accidence that any diet is a physician order to refer the facility on 10/3/01 protien calorie malnut cerebralvascular accidence that any diet is a physician order to refer the facility of 10/10/10/10/10/10/10/10/10/10/10/10/10/1	unds ounds. This represents .5%) between January ands ds. This represents a way between March and A ls s. This represents a way between June and July otes completed since rate evidence that the diet ional needs based on has. There was no docur tary interventions were are resident 72's diet. Re downward trend since wear old male, was adm with diagnoses of hyperition, dehydration, dent and depression.  tted with a gastrostom of administer two cans of the g-tube. Resident 7 deceive a puree diet by re control of the control of the grant	weight loss pril 2001. eight loss y 2001. eight loss y 2001. esident titian er nented attempted sident 72's March  witted to potension, by tube of Ensure 4 also had mouth. ealed the sents a the months	F 361			

	IMENT OF HEALTH H CARE FINANCING						NTED: 1/25/ M APPROVE 2567
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		VCLIA (X2) MULTIPLE CO A. BUILDING B. WING		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465108				1/5	16/02
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	ORESS, CITY, ST	ATE, ZIP CODE		
SOUTH	VALLEY HEALTH CE	NTER		T 9000 SOUT RDAN, UT 84			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(XS) COMPLETE DATE	
F 361	Continued From Page 6. weight loss of 5 pound. November and Decem January 2001- 140 poloss of 2.5 pounds, (1. December and January At the request of the sweighed on 1/11/02. I pounds. This represent (2.5%) between 1/1/02	ds, (3.4%) between the other 2001. unds. This represents a .75%) between the most y 2001. urvey team, resident 74 weighed 1 ots a weight loss of 3.5	weight of 4 was 36.5	F 361			

On 10/25/01, the (RD) was asked by the nursing staff to evaluate resident 74's g-tube feeding. The RD recommeded, "Fiber Source HN to run at 70/cc an hour to provide 2016 Kcal and 89 grams protein. This should be adequate to maintain weight and replete residual proteins {Albumin} This TF [tube feeding] regimen would provide 1600 cc H20. Recommend 600cc additional free H20 as 200cc q [every] 8 hours. Will monitor tol [tolerance] to TF and weights." A physicians' order was obtained on 10/25/01 following the RD's recommendation.

Resident 74 experienced a significant weight loss of 13.5 pounds, (9%) between the months of October

The facility was not aware of the weight loss until

2001 and January 2002.

1/11/01.

A nurses note on 10/25/01 documented the following: "Pt. wife informed of new enteral feeding order - she stated she only wants pt. to have 1 can @ [at] qhs [every night at bedtime] - H20 [water] to run rest of day - Dr.....contacted - orders H20 @ 83cc X [times] 24 hours - 1 can of HN Fibersource @ qhs added to water - weight q 2 wks [weeks] - wife informed of possible wt [weight] loss if not eating well - will continue to monitor."

On 10/29/001 the RD documented, "Nursing stated family concerned about TF may cause kidney failure?

HCFA-2567L

ATG112000

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 64 of

#### PRINTED: 1/25/ FORM APPROVE

#### DEPARTMENT OF HEALTH AND HUMAIN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

1/16/02

465108

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

**3706 WEST 9000 SOUTH** WEST JORDAN, UT 84088

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(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) COMPLETE DATE
F 361	Continued From Page 64 This TF does not provide excess protein and is adequate for needs. I do not have any concerns in regard to this." There was no evidence that this was discussed with the family by the RD or the mursing staff. There was no further documentation by the RD.  A review of dietary notes completed since resident 74's admission did not evidence that the dietitian re-assessed his nutritional needs based on his significant weight loss. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 74's diet via his g-tube or by mouth after the 10/25/01 RD recommendations. Resident 74's weight had been on a downward trend since October 2001.  f. Resident 40 was a 97 year old female admitted to this facility on 10/9/01 with diagnoses of fractured humerus, dementia, hypertension, hypothyroidism and constipation.  Review of resident 40's IDT meeting comments on 10/10/01revealed the following information:  October 2001- 120 pounds December 31.2001- 110.5 pounds. This represents a weight loss of 10.5 pounds, (8.7%) between the months of October 2001 and December 31, 2001. January 11, 2002- 107 pounds. This represents a weight loss of 14 pounds, (11.6%) between October	F 361		
	A review of dietary notes completed since resident 40's admission did not evidence that the dietitian re-assessed her nutritional needs based on her significant weight loss. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 40's diet. Resident 40's			

# PRINTED: 1/25/

DEPARTMENT OF HEALTH AND HUMAN JERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 1/16/02 465108 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER **WEST JORDAN, UT 84088** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 361 Continued From Page 65 F 361 weight had been on a downward trend since October 2001. g. Resident 28 was a 88 year old female admitted to the facility on 7/31/01 with diagnoses of esophageal varices, bleeding ulcers, gastroesophageal reflux, hiatal hernia, hypothyroidism, status post cerebrovascular accident and edema. A review of resident 28's monthly weights, completed by the restorative nurses aides and obtained from the dietary supervisor, documented the following weights for resident 28: July 2001: 114 pounds. August 2001: 114 pounds. September 2001: 113 pounds. October 2001: 110 pounds. November 2001: 111 pounds. December 2001: 107 pounds. January 2002: 103 pounds. On 1/11/02, at the request of the survey team, resident 28 was re-weighed. Resident 28's weight was 100 pounds. This represents a significant weight loss of 11 pounds, or 10%, between the months of July 2001 and January 2002 (using the July 2001 weight and the original January weight of 103 pounds) and a 14 pound, or 12%, significant weight loss between the months of July 2001 and January 2002 (using the July 2001 weight and the January re-weight of 100 pounds). A review of dietary notes completed since resident 28's admission did not evidence that the dietitian re-assessed her nutritional needs based on her gradual weight loss, which became significant between the

If continuation sheet 66 of

months of July 2001 and January 2002. There was no documented evidence that any dietary interventions were attempted to increase calories in resident 28's diet. Resident 28's weight had been on a downward

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING \_\_\_ 1/16/02 465108

E OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

			3706 WEST 9000 SOUTH WEST JORDAN, UT 84088			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETE DATE	
PREFIX	Continued From Page 66 trend since September 2001.  h. Resident 50 was an 83 year old female a the facility on 4/4/01 with diagnoses of dem depressive features, non insulin dependent of mellitus, osteoarthritis, agitation and general A review of resident 50's admission weight, documented in the physician's admit note, re that she weighted 145 pounds on 4/4/01. A resident 50's monthly weights from June 20 January 2002, completed by the restorative aides and obtained from the dietary supervit documented the following weight for reside  June 2001: 140 pounds.  July 2001: 142 pounds.  August 2001: 142 pounds.  September 2001: 139 pounds.  October 2001: 137 pounds.  November 2001:134 pounds.  December 2001: 128.5 pounds.  January 2002: 131.5 pounds. On 1/11/02, request of the survey team, resident 50 was weighed. Resident 50's weight was 128 por represents a significant weight loss of 14 pounds 2002 (using the July weight of 142 pounds January re-weight of 128 pounds). There weight decrease noted from September 200 January 2002.  A review of dietary notes completed since re 50's admission did not evidence that the die	dmitted to mentia with diabetes alized pain.  evealed review of 01 through nurses sor, ent 50:  at the re- unds. This bunds, or January and the was steady 1 to resident entitian	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE	
	re-assessed her nutritional needs based on he weight loss, which became significant between months of July 2001 and January 2002. The documented evidence that any dietary intervere attempted to increase calories in residuet. Resident 50's weight had been on a documented to increase calories in residuet.	een the ere was no ventions ent 50's				

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

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REALII	1 CARE FINANCING	ADMINISTRATION		<del></del>			2567	
		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	NUMBER: A. BUILI				(X3) DATE SURVEY COMPLETED	
		465108	B. WING			1	/16/02	
ME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE			
SOUTH	VALLEY HEALTH CE	INTER	3706 WEST WEST JOR	' 9000 SOUT DAN, UT 84				
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
	interview it was deter store, prepare, distrib sanitary conditions as being properly stored florescent kitchen light areas of the kitchen in items not being labeler refrigerator, outdated walk in refrigerator, ditems in the dry store powdered dry milk, the holding perishable foo and the facility grease food debris which cau flood and smell of sew dishwashing sink was properly drain through (Refer to tag F-371).  Based on observation, documentation, it was not follow the approve was unaware of the proresidents, which result and variances in the another nutrients provide F-363).	ions, temperature chec mined that the facility ute, and serve food und evidenced by cleaning in sanitizing solution, its not being properly of a need of cleaning, mul- ed and or dated in the way food items being stored ented cans and unlabel room, a scoop was lying the walk in refrigerator re- ods at the proper tempe trap being full of old go sed the facility kitchen wage when the three con-	ks and did not der grags not the covered, tiple food valk in d in the led food ing in the coverase and floor to impartment ould not  riew of cility did ry staff to serve servings sin and efer to tag	F 361				
	meal, temperature chec refrigerator and statem group interview with re the facility did not serv temperature. Hot food	ture checks during a lucks of foods in the walk ents made in a confider esidents it was determine food that was at the part of the maintained also when served and	c-in ntial ned that proper at 140					

DEPARTMENT OF HEALTH AND HUMA. SERVICES PRINTED: 1/25/ FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02 IE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 361 Continued From Page 68 F 361 foods are to be maintained at or below 41 degrees Fahrenheit when served from tray line. Reference guidance: U.S. Public Health Service FDA 1999 Food Code, page 63. Foods, which are not kept at the proper temperature, pose a possible health risk to residents and can affect the palatability and consumption of foods. An interview with the Dietary Manager was done on 1/8/02 at 9:14 AM. She stated that the consultant dietitian visited the facility 10 hours each month. When asked if the consultant dietitian ever did sanitation checks of the kitchen, monitored the tray line, checked food temperatures or gave in-services regarding any of these or other issues to the dietary staff she stated no. She stated none of the above had been done she she'd taken over as the dietary manager in August 2001. She expressed frustration with the fact that since she'd become the dietary manager in August 2001 she'd received no training regarding how to properly operate the dietary department. An interview with the facility administrator was done on 1/8/02 at 4:15 PM. He confirmed that the consultant dietitian was allowed 10 hours each month to visit the facility. He stated that this was a corporate decision. During earlier interviews with the dietary manager on 12/31/01 at 8:48AM and 1/2/02 at 3:00 PM she stated that she was unsure of exactly what her responsibilities were in regards to running the kitchen. She stated that

since she'd taken over she felt as if kitchen operations had improved but still felt like there were many areas where she needed further guidance. She stated that no one had trained her regarding proper sanitation of the kitchen, the need to follow the menus and the extended menus as written. She stated that since she'd been the dietary manager the facility did not have extended

## DEPARTMENT OF HEALTH AND HUMA: SERVICES HEALTH CARE FINANCING ADMINISTRATION

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AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		465108	465108		B. WING		1/16/02
ME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S7	TATE, ZIP CODE .	<u></u> .	120,02
SOUTH	VALLEY HEALTH CE	INTER		ST 9000 SOUT PRDAN, UT 8			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(XS) COMPLETE DATE
	menus for the dietary there were any classed help her better performanager.  (Refer to tag F-364).  Based on observation review the facility did any resident prescribe orders.  On 12/31/01 at 10:50 interviewed. He was facility had extended currently being follow any extended menus being served was sweets. When asked I sizes were appropriate therapeutic diets were extended menu to specific provide an answer.  (Refer to tag F-326).  Based on observations 1/2/02 and 1/3/02 it with manager and dietary still leadership to direct the including sanitation and handling and distributive vidence that the constructions of the dietary and manage dietary set documented evidence, which indicated the cost temperatures or providin-service training. The	staff to follow. She as set that she could take them her duties as the diet on her duties as the diet on her duties as the diet on her duties as the diet on hot follow therapeutice of these diets per physical AM, the consultant die asked whether he knew menus for the menu cycled. He stated the as low in salt and concern how the staff knew what e or what foods resident to receive if they had recify this, he was unable as in the kitchen on 12/3 was determined that the staff lacked supervision em in proper dietary produced in the storage, preparation of food. There was cultant dietitian was avary manager or to help or	al record c diets for ician  etitian was wif the vole unaware of that the entrated at servings ats on no e to  81/01, dietary and rocedures tion, s no ailable as a versee produce, e routine ood the hat the	F 361			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIE IDENTIFICATION NO			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED		
4651		465108	B. WING			1	/16/02
ME OF P	ROVIDER OR SUPPLIER		STREET ADI	ORESS, CITY, ST.	ATE, ZIP CODE	•	
			T 9000 SOUT RDAN, UT 84				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
F 361 Continued From Page 70 correct any of the deficient practices found during the re-certification survey.			F 361				
F 363 SS=E	483.35(c)(1)-(3) DIE	TARY SERVICES		F 363			
Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of documentation, it was determined that the facility did not follow the approved menus.  Findings include:  1. Review of the menu, Week 2 of the fall and winter menu set, revealed that the menu was not followed as written for the breakfast meal on 1/2/02, for the puree lunch meal on 1/2/02, for the breakfast meal on 1/3/02, and for the lunch meal on 1/3/02.							
	revealed that corned to cream of wheat or col 8 ounce carton of mill menu for 1/2/02 docu	breakfast meal on 1/2, beef hash, toast, 1 slice d cereal, 4 ounces of juk was served. The breamented the following wheat hearts, posched	of bacon, nice and an akfast was to be				
	corned beef hash, to as and choice of beverag served. No egg of any source was offered to followed and the resid serving. Observations	wheat hearts, poached at with margarine and judge. No poached eggs way type or an alternative the residents. The medents were short one property of all trays also reveation beef hash varied grounds.	elly, milk vere protein nu was not otein led that				

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED
	465108	B. WING	1/16/02
ME OF PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	

ME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
COUTH VALLEY HEALTH CENTED			ST 9000 SOU' RDAN, UT 8			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETE DATE		
F 363	approximately 2 tablespoons to a ½ cup from to resident regardless of what diet they were prescribed. This would allow for variances calories and protein provided to each resident.  3. Observation of the lunch meal on 1/2/02 that residents on puree diets received pureed chicken, pureed mashed potatoes, pureed bruilded documented the following was to be served, chicken, buttered parsley potatoes, buttered and pumpkin cake. The residents prescribed diets were not served broccoli or any alternate vegetable at the lunch meal. The menu was affollowed and the resident's receiving a puree short one vegetable serving. Observations of also revealed that the serving sizes of both thand the potatoes varied greatly from approximate of a cup to greater that ½ cup from resident to regardless of what diet they were prescribed, would allow for variances in the number of composited to each resident.  4. Observation of the breakfast meal on 1/3/revealed that 1 slice of toast, 1 banana, a bown oatmeal, 1 sausage link, 4 ounces of juice and ounces of milk were served to residents who meals in their room, the east dining room or the Alzheimer's unit dining room. The resident's in the main dining room were observed to als hash browns in addition to the above listed for The breakfast menu for 1/3/02 documented the following was to be served, orange juice, oat cinnamon French toast, hot buttered syrup, sa links and milk. French toast and buttered syrup not served as identified on the menu. This we decrease the calories being provided at the brimeal.	in both the nt.  revealed barbeque ead and barbeque broccoli puree tive not diet were f all trays he broccoli mately ¼ o resident This alories  02 wl of d 8 ate their the who ate to receive he od items. The neal, ausage up were ould	F 363	The following is a plan of correction and is in reference to: F-325 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) Quality of Care, F-360 483.35 Dietary Services, F-361 483.35 1-2, F-363 483.35 (c) Dietary Services, F-364 483.35 (d) (1) & (2),F-371 483.35 (h) (2). Action for each resident found to have been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74.  1. Licensed staff will be in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary progress notes, the dietary intake records, and the current weights, and diagnosis and medications as warranted.  2. NIT committee will address any medical conditions i. h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional interventions.  3. Dietary intake record has been changed so that percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor.  4. C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion.  5. 4 way drug check will be done monthly by ADON and QA to ensure that all orders regarding house supplement will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address diagnosis's to medication and any drug interactions and/or side effects.  6. Licensed staff has been instructed to inform NIT committee of any dietary problems so that other interventions can be implemented as warranted.  7. Monthly weights provided each month upon completion to each hall with current weights to be placed MAR binder so that monthly summaries can address current weights.  8. C.N.AN.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. Importance of communicating to nurses so that interventions are implemented as warranted.  9. Speech consultant will report any evaluations, outcomes, and recommendations to the NIT committee.  10. NIT comm		
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HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDIN	TIPLE CONST	RUCTION	(X3) DATE SU COMPLET	
_		465108		B. WING			1/10	6/02
AE OF P	PROVIDER OR SUPPLIER	!	1	DRESS, CITY, ST	TATE, ZIP CO	DDE	1 4/4	DI U L
SOUTH '	VALLEY HEALTH CE	INTER		ST 9000 SOUT PRDAN, UT 8				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOW SS-REFERENCED TO THE APPRODEFICIENCY)	ULD BE	(X5) COMPLETE DATE
F 363	5. Observation of the that residents on pure meatballs, pureed many and the lunch menu for 1 was to be served, meating rice, oriental ble margarine and mandar prescribed puree diets vegetables or any alter meal. The menu was receiving a puree diet serving. The resident mashed potatoes insteresidents prescribed papplesauce or vanillar mandarin oranges white residents receiving varifruit serving and one withose residents receiving varifruit serving and one withose residents receiving varifruit serving and one withose residents receiving rescribed were served. Observation of the lunt 1/3/02. The cook was instead of a standardiz serve the oriental mixed vegetable servings white residents receiving regonated the resident with resident served to use a ½ curbowever, the amount or resident to resident with filled and at times over for variances in the call	e lunch meal on 1/3/02 be diets received pureed ashed potatoes and pure 1/3/02 documented the atballs in sweet and south the swere not served orient ernative vegetables, bread as arin oranges. The residus were not served orient ernative vegetable at the not followed and the ret were short one vegetal atts receiving pureed fried rice pureed diets also receive pudding instead of pureich would either mean the initial pudding were shown the day. The menu water, regardless of the diet died white rice instead of the meal tray line was on the day. The menu water, regardless of the diet died white rice instead of the meal tray line was on the day. The menu water, regardless of the diet died white rice instead of the meal tray line was on the day. The menu water, regardless of the diet died white rice instead of the meal tray line was on the day. The menu water, regardless of the diet diet white rice instead of the were not consistent gular or mechanical soft and asking a dietary aid meatballs should I give ed to serve 3-6 meatbal gular diets. The cook way scoop to serve the rief rice he scooped varied the scoop at times be defilled. All of this would lories and/ or the protein the scoop at times be defilled. All of this would lories and/ or the protein the scoop at times be defilled. All of this would lories and/ or the protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times be defilled. Some residents protein the scoop at times the scoop at times be defilled. Some residents protein the scoop at times the sc	d eed bread. following ur sauce, and lents ntal blend as lunch resident's able is received in that those ort one the day and hort one was not et fried rice. done tted spoon is il to sulted in at for ft diets. le on the e?". The lls to was ice, ied from being under uld allow ein	F 363	16. 17. 18. 19. 20.	discuss all survey issues, training, ar with the dietary services.  RD will ensure that each resident witherapeutic diet when there is a nutri. The RD will assess in identifying an serving of therapeutic diets to ensure of the residents.  Temperatures are monitored by the cand recorded. The dietary manager random resident's trays for proper for record.  The dietary services have a daily cleensure the sanitation of the kitchen, the labeling and dating of foods, tem refrigerator. The dietary manager we concerns weekly.  The RD will be employed by SVHC consultant, who will provide adequate both the dietary manager and dietary Accurately monitoring and assessing for weight loss. 2) Monitor the sanit kitchen, ensuring proper storage, predistribution and serving of foods, desimplementing educational in-services staff.  A new steam table with 4 wells is be foods will stay at the appropriate tem degrees.  The walk-in refrigerator was fixed at maintained 40 degrees and below. Dinstructed to keep refrigerator door cout.  The dietary staff will be in-serviced 1 on how to store, prepare, distribute, a under sanitary conditions.	to appropriately  I, ensuring proper  Ition and serving of  ving foods at the  Ily-Tuesday 3pm to  Ind any problems  Ill receive a  Itional problem.  Id correct improper  It the dietary needs  Idetary cooks daily  will monitor at  bood temps and  Is aning schedule to  record to monitor  inso of the walk-in  ill audit the above  as a dietary  te supervision to  staff regarding:  If residents at risk  tation of the  sparation,  veloping and  s for the dietary  sing purchased so  nperature above 140  temperature have  bietary staff  closed going in or  February 19, 2002  and serve food  al plumbing  e out routinely.	

## DEPARTMENT OF HEALTH AND HUMAIN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE S COMPLE	
		465108		B. WING		1/	16/02
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE	·	
SOUTH	ALLEY HEALTH CE	NTER		T 9000 SOUT RDAN, UT 8			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 363	a no concentrated swe applesauce instead of them a vitamin C served. On 12/31/01 at 8:48 a was interviewed. She team with the extended would document the aprovided for resident diet modifications, if resident's receiving the diets. She stated she to and stated that since manager in August, 2 extended menus. She served the same diet, cooked with salt and that they don't serve to the cooked with salt and that they don't serve to the currently being follow any extended menus in menu being served was sweets. When asked sizes were appropriate therapeutic diets were	eet diet were observed mandarin oranges whizing for the day.  AM, the food service states was asked to provide ad menu for the week was appropriate serving size on all diets and documany, would need to be derapeutic or texture may was not sure what I was not sure what I was see she'd taken over as do 001 the facility had not stated that all resident She stated that foods at that if a resident is on a	upervisor the survey which es to be nent what made for odified as referring lietary t had the ts are are not a renal diet etitian was w if the vole unaware of that the entrated at servings nts on no	F 363			
F 364 SS=E	Each resident received prepared by methods	s and the facility provi that conserve nutritive e; and food that is pala	value,	F 364			

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PRINTED: 1/25/ DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 1/16/02 465108 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES IĐ (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) F 364 The following is a plan of correction and is in reference to: F-325 Continued From Page 74 F 364 483.25 (i) Quality of Care. This will include corrective F-326 483.25 (i) (2) Quality of Care, F-360 483.35 Dietary Services, F-361 This REQUIREMENT is not met as evidenced by: 483,35 1-2, F-363 483,35 (c) Dietary Services,F-364 483,35 (d) ( &(2),F-371 483.35 (h) (2). Action for each resident found to have Based on food temperature checks during a lunch been affected and were identified as 13, 20, 28, 40, 50, 70, 72, 74 meal, temperature checks of foods in the walk-in 2/20/02 Licensed staff will be in-serviced on how to complete refrigerator and statements made in a confidential the malnutrition/dehydration-pressure sore risk assessment done by the RD, the MDS, the dietary group interview with residents it was determined that progress notes, the dietary intake records, and the the facility did not serve food that was at the proper current weights, and diagnosis and medications as warranted. temperature. NIT committee will address any medical conditions i.e.: h-pylori on the residents' careplan and consult with residents' physician for medical and nutritional Findings include: interventions. Dietary intake record has been changed so that On 1/3/02, temperature checks of the lunch meal percentage of what resident ate is now what is accurately recorded rather than good-fair-or poor. revealed: C.N.A. scheduler will audit dietary intake record weekly to ensure accuracy and completion. 4 way drug check will be done monthly by ADON and At 11:06 AM, the pureed foods for the lunch meal QA to ensure that all orders regarding house supplemental were observed to be sitting on the shelf attached to the will be on residents' MAR's as warranted and to ensure percentage documentation. As well as to address steam table but not in the steam table heating wells. diagnosis's to medication and any drug interactions and/or side effects. Licensed staff has been instructed to inform NIT At 11:23 AM, a temperature check of the pureed foods committee of any dietary problems so that other half way through tray line, included pureed meatballs interventions can be implemented as warranted. Monthly weights provided each month upon completion at 100 degrees Farenheit, pureed mashed potatoes at to each hall with current weights to be placed MAR 118 degrees Farenheit and juice at 66 degrees binder so that monthly summaries can address current weights. Farenheit. C.N.A.-N.A will be in-serviced February 20, 2002 regarding interventions for residents' experiencing eating, swallowing, and chewing difficulties. At 11:38 AM, a temperature check of the foods after Importance of communicating to nurses so that the completion of the tray line included regular interventions are implemented as warranted. Speech consultant will report any evaluations, meatballs, in the steam table heating well, at 130 outcomes, and recommendations to the NIT committee. degrees Farenheit and ground meatballs, in the steam NIT committee will calculate weight loss percentages weekly. table heating well, at 100 degrees Farenheit. The puree 11. Extended menus for the menu cycle is available and foods had been used so no temperatures were taken. currently being followed Dietary staff will be inserviced by the RD what servings sizes are appropriate and what foods residents on therapeutic diets are to At 11:26 AM, a temperature check of the food items in receive

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 Previous Registered Dietician has been replaced by RD, and whom will assume responsibilities to provide

loss. The RD will

services, support, and supervision, through assessment, monitoring and recommendations, to meet each

residents' nutritional needs to prevent significant weight

the dining room buffet steam table were taken prior to

the meal service and included mashed potatoes at 128

degrees Farenheit. The potatoes were not re-heated

Hot foods are to be maintained at 140 degrees

prior to being served to the residents.

HEALII	I CARE FINANCING	ADMINISTRATION						2567
L	I OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIN B. WING	TIPLE CONSTI	RUCTION	(X3) DATE ST COMPLE	TED
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE ZIPCO	DE	1/1	6/02
	VALLEY HEALTH CE	NTER	3706 WES	T 9000 SOU RDAN, UT	TH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO SS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	foods are to be maint: Fahrenheit when serv guidance: U.S. Public Code, page 63. On 1/2/02, observatio	when served from tray ained at or below 41 deed from tray line. Reference of the Health Service FDA 1 and temperature, according to the walk-in refrigerator neit. At 2:45 PM, the ingest of the two thermometers was 58 and 52 degrees for two thermometers was 58 and 52 degrees for the walk-in refrigerator neit. At 2:45 PM, the ingest of two thermometers was 58 and 52 degrees for the walk-in refrigerator neit. The properatures we through out the refrigeration and the properature with the properature of the	egrees erence 1999 Food ecks of ding to was 56 nternal in the Farenheit. hed at 41 vere taken rator and alloped t, ground arenheit, d been in d at 60 rees heit and heardous legrees hee	F 364	16. 17. 18. 19. 20. 21. 22.	ensure that the dietary manager and proper training and systems in plac monitor the sanitation of the kitche storage, preparation and the distribution foods, following Therapeutic diets as written and ser proper temperature. Dietary in-service will be held weed discuss all survey issues, training, a with the dietary services. RD will ensure that each resident with the dietary services. RD will ensure that each resident with the dietary services. RD will assess in identifying at serving of therapeutic diets to ensure of the residents. The RD will assess in identifying at serving of therapeutic diets to ensure of the residents. Temperatures are monitored by the and recorded. The dietary manager random resident's trays for proper for record. The dietary services have a daily cle ensure the sanitation of the kitchen, the labeling and dating of foods, ten refrigerator. The dietary manager we concerns weekly. The RD will be employed by SVHC consultant, who will provide adequate both the dietary manager and dietary Accurately monitoring and assessing for weight loss. 2) Monitor the sanikitchen, ensuring proper storage, predistribution and serving of foods, deimplementing educational in-services staff. A new steam table with 4 wells is be foods will stay at the appropriate ten degrees. The walk-in refrigerator was fixed at maintained 40 degrees and below. It instructed to keep refrigerator door cout. The dietary staff will be in-serviced on how to store, prepare, distribute, and was scheduled to company, and was scheduled to company, and was scheduled to company, and was scheduled to company, and was scheduled to company, and was scheduled to company, and was scheduled to company, and was scheduled to company the monager for out-dated food Alzheimer's unit refrigerator daily.	te to appropriately en, ensuring proper ution and serving or rving foods at the ekly-Tuesday 3pm in and any problems will receive a ritional problem. In discourage of the dietary needs dietary cooks daily will monitor at food temps and eaning schedule to record to monitor mps of the walk-in will audit the above as a dietary ate supervision to y staff regarding: If g residents at risk litation of the eparation, eveloping and es for the dietary et all engagements at the dietary staff closed going in or February 19, 2002 and serve food cal plumbing the out routinely.	f o

On 1/2/02, during an interview with the facility cook he was asked about the steam table wells. He stated that only 2 of the 5 wells in the steam table were working which did not leave him enough room to

1/16/02

# DEPARTMENT OF HEALTH AND HUMAIN SERVICES

2567 HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING

465108

NAME OF PROVIDER OR SUPPLIER

B. WING\_ STREET ADDRESS, CITY, STATE, ZIP CODE

	IAME OF PROVIDER OR SUPPLIER		ress, ch 4, sh f 9000 SOUT		
SOUTH V	ALLEY HEALTH CENTER		DAN, UT 84		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 364	Continued From Page 76 place all of the different consistency hot for steam table.  On 1/2/02, at 9:00 AM, a confidential intervield with a group of residents. Fourteen resparticipated in this interview. Seven (7) of fourteen residents complained that the hot foften cold when they received their trays.	view was sidents the	F 364		
F 371 SS=F	483.35(h)(2) DIETARY SERVICES  The facility must store, prepare, distribute, food under sanitary conditions.  This REQUIREMENT is not met as eviden	nced by:	F 371		
	Based on observations, temperature checks interviews it was determined that the facility store, prepare, distribute, and serve food un sanitary conditions as evidenced by cleaning being properly stored in sanitizing solution, florescent kitchen lights not being properly areas of the kitchen in need of cleaning, musterms not being labeled and or dated in the refrigerator, outdated food items being stor walk in refrigerator, dented cans and unlabed items in the dry store room, a scoop was ly powdered dry milk, the walk in refrigerator holding perishable foods at the proper temperand the facility grease trap being full of old food debris which caused the facility kitches flood and smell of sewage when the three conditions distributed in the dishwashing sink was drained as the water of properly drain through the grease.  Findings include:	y did not der g rags not , the covered, altiple food walk in ed in the eled food ving in the r not perature, I grease and en floor to compartment			
	The following observations were made dur	ing the			
<u></u>		LVD7W11	Facility ID:	LUTIONSO If cont	inuation sheet 77 of

If continuation sheet 77 of Event J XP7W11 Facility ID: UT0080 ATG112000 HCFA-2567L

## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		465108		B. WING_		1/1	6/02
	ROVIDER OR SUPPLIER VALLEY HEALTH CE	NTER	3706 WES	DRESS, CITY, ST T 9000 SOU' RDAN, UT 8			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
F 371	initial kitchen tour do AM – 8:35 AM:  1. A cleaning rag was sanitizing solution.  2. The florescent lighthe bulbs were exposincluding over food p shall be shielded, coas shatter-resistant in are clean equipment, utensingle-service and singuidance: U.S. Public Code, page 142.  3. The hood filters alt greasy.  Observation of the was following:  1. The internal temper thermometers in the was degrees Farenheit. Rebe maintained at 41 degrees Farenheit.	as lying on the sink not this were not properly contents were not properly content the kitch reparation areas. Light ted, or other wise teas where there is exponsils, and linens; or unwagle use articles. Refere the Health Service FDA 1 to the stove were durature, according to two valk-in refrigerator, was frigerator temperature egrees Farenheit or believed.	in proper  overed and ien t bulbs sed food; vrapped ince 1999 Food sty and aled the  os 46 s should ow. not s which not dated. our cream	F 371	the malnutrition/dehydrati assessment done by the R progress notes, the dietary current weights, and diagr warranted.  2. NIT committee will addre h-pylori on the residents' residents' physician for m interventions.  3. Dietary intake record has percentage of what reside accurately recorded rather  4. C.N.A. scheduler will and weekly to ensure accuracy  5. 4 way drug check will be QA to ensure that all orde will be on residents' MAF percentage documentation diagnosis's to medication and/or side effects.  6. Licensed staff has been in committee of any dietary interventions can be imple  7. Monthly weights provided to each hall with current w binder so that monthly sur weights.  8. C.N.AN.A will be in-ser regarding interventions fo eating, swallowing, and cl Importance of communica interventions are impleme  9. Speech consultant will repoutcomes, and recomment  10. NIT committee will calcul weekly.  11. Extended menus for the m currently being followed I serviced by the RD what a and what foods residents or receive.  12. Previous Registered Dietic and whom will assume reservices, support, and supmonitoring and recommer	aclude corrective F-326 83.35 Dietary Services, F-36 83.35 Dietary Service	2.2002 2.2702 e.:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

1/16/02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING\_

(X3) DATE SURVEY COMPLETED

465108

STREET ADDRESS, CITY, STATE, ZIP CODE

11 LIVIE ()1 1 I	ROVIDER OR SUFFLIER	STALLT ADDI		,			
SOUTH V	VALLEY HEALTH CENTER		ST 9000 SOUTH DRDAN, UT 84088				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETED DATE			
F 371	Continued From Page 78 which was not properly covered which could contamination of the food.  7. There was package of bacon, which was onot dated.  8. There was large pan of what appeared to be	opened but	F 371	ensure that the dietary manager and dietary staff have proper training and systems in place to appropriately monitor the sanitation of the kitchen, ensuring proper storage, preparation and the distribution and serving of foods, following  Therapeutic diets as written and serving foods at the proper temperature.  13. Dietary in-service will be held weekly-Tuesday 3pm to discuss all survey issues, training, and any problems with the dietary services.  14. RD will ensure that each resident will receive a			
	salad, which was not labeled or dated.  9. There were three bowls of salad dressing, were not labeled or dated.			therapeutic diet when there is a nutritional problem.  The RD will assess in identifying and correct improper serving of therapeutic diets to ensure the dietary needs of the residents.  15. Temperatures are monitored by the dietary cooks daily and recorded. The dietary manager will monitor at			
	10. There was a pan of chocolate pudding, a banana pudding and a pan of reduced calorie pudding, which were not dated.			random resident's trays for proper food temps and record.  16. The dietary services have a daily cleaning schedule to ensure the sanitation of the kitchen, record to monitor the labeling and dating of foods, temps of the walk-in refrigerator. The dietary manager will audit the above concerns weekly.			
	11. There was a pan of cherry gelatin dated 1 (5 days old), a pan of sugar free strawberry gelated 12/24/01 (7 days old) and a pan of sugar raspberry gelatin dated 12/26/01 (5 days old). Leftovers foods should be used or throw away 72 hours of initial use.	elatin ar free		17. The RD will be employed by SVHC as a dietary consultant, who will provide adequate supervision to both the dietary manager and dietary staff regarding:  Accurately monitoring and assessing residents at risk for weight loss. 2) Monitor the sanitation of the kitchen, ensuring proper storage, preparation, distribution and serving of foods, developing and implementing educational in-services for the dietary staff.  18. A new steam table with 4 wells is being purchased so			
	12. There were four 32ounce cartons of expir vanilla yogurt dated 12/27/01. There were 26 containers of expired mixed berry/strawberry dated 12/27/01. There were two cases of exprinced berry/strawberry yogurt one dated 12/6 one dated 12/27/01. There were two cases of blueberry/strawberry yogurt dated 11/10/01 at case dated 12/26/01.	small yogurt ired 5/01 and expired		foods will stay at the appropriate temperature above 140 degrees.  19. The walk-in refrigerator was fixed at temperature have maintained 40 degrees and below. Dietary staff instructed to keep refrigerator door closed going in or out.  20. The dietary staff will be in-serviced February 19, 2002 on how to store, prepare, distribute, and serve food under sanitary conditions.  21. The grease trap was cleaned by a local plumbing company, and was scheduled to come out routinely.  22. The unit manager for out-dated food will check the Alzheimer's unit refrigerator daily.			
	Observations in the dry storage room revealed following:	i the					
	1. There was a scoop in the dry milk storage container.						
	2. There was can a sweet potatoes and a can o	of					

DEPART	MENT OF HEALTH	AND HUMAN SERV	/ICES			FOR	м арркоve 2567
STATEMENT	CARE FINANCING TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIED IDENTIFICATION NU	R/CLIA		E CONSTRUCTION	(X3) DATE : COMPL	SURVEY
AND PLAN C	of CORRECTION	465108		A. BUILDING B. WING		1,	/16/02
	ROVIDER OR SUPPLIER	ENTER	3706 WES	oress, city, sta T 9000 SOUTI RDAN, UT 840	H		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEEDED BY  LSC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
F 371	the can.  The following obser	79 I large dents by the top vations were made in to 2 from 2:15 PM - 2:4	he kitchen	F 371			
	1 There were two c	leaning rags on the foo	od				
	properly covered and	the florescent lights w d the bulbs were expos en including over food	sed				
	Observations in the following:	walk-in refrigerator re	vealed the				
	two thermometers in and 58 degrees Fare temperature, according walk-in refrigerator, Refrigerator temperategrees Farenheit or of random foods the included 2% milk at potatoes from lunch	internal temperature, and the walk-in refrigerate their. At 2:45 PM, their to two thermometer was 58 and 52 degrees atures should be maintained below. Temperatures ough out the refrigerate 52 degrees Farenheit, at 120 degrees Farenhom lunch at 98 degree	or, was 56 e internal ers in the es Farenheit. ained at 41 s were taken or and scalloped neit, ground				

2. As observed on 12/31/01, there were three expired containers of sour cream dated 12/13/01.

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Service FDA 1999 Food Code, page 63

Facility ID:

Event I XP7W11

UT0080

crab salad at 60 degrees Farenheit, banana pudding at 50 degrees Farenheit, patty sausage at 50 degrees Farenheit and yogurt at 52 degrees Farenheit.

Potentailly hazardous cold foods are to be maintained

between 45 degrees Farenheit and 41 degrees Fahrenheit. Reference guidance: U.S. Public Health

1/16/02

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES	S
AND PLAN OF CORRECTION	

NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING \_

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(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) COMPLETE DATE
F 371	Continued From Page 80  3. As observed on 12/31/01, there was a pan of cherry gelatin dated 12/26/01 (7 days old) and a pan of sugar free raspberry gelatin dated 12/26/01 (7 days old). Leftovers foods should be used or throw away within 72 hours of initial use.  4. As observed on 12/31/01, there were four 32ounce cartons of expired vanilla yogurt dated 12/27/01. There were 26 small containers of expired mixed berry/strawberry yogurt dated 12/27/01. There were two cases of expired mixed berry/strawberry yogurt one dated 12/6/01 and one dated 12/27/01. There were two cases of expired blueberry/strawberry yogurt dated 11/10/01 and one case dated 12/26/01.  5. There was a container of pooled, raw eggs which was dated 1/1/02.  6. There was a package of Parmesean cheese, which was opened but not dated.  7. There was a package of American cheese slices, which were opened but not dated.  8. There was a package of frozen chicken thawing with a note, which stated, " pulled for Monday lunch". The note was not dated and the next Monday would be 1/7/02, 5 days later.  9. There was a bowl of salad and two bowls of salad dressing, which were not dated.  10. The floor underneath the shelving units was dirty with food debris and grime.  Observations in the dry storage room revealed the following:	F 371	DEPALENCY	

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ATG112000

Event I XP7W11

Facility ID:

UT0080

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

A. BUILDING B. WING\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

#### 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER

SOUTH	ALLEY HEALTH CENTER	WEST JOI	RDAN, UT 8	4088	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY I REGULATORY OR LSC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
PREFIX	(EACH DEFICIENCY MUST BE PRECEEDED BY I REGULATORY OR LSC IDENTIFYING INFORMAT	bop in the a sweet arge dents bag of at were diallow for ekitchen by the continuous befull of aled the cording to was 52 should be	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
	On 1/2/02, an interview with the facility cool done. He stated that the walk-in refrigerator too warm for approximately two weeks. He cooler was not working. He further stated, "came in this morning, I was afraid the meat h	k was had been stated the When I			

## DEPARTMENT OF HEALTH AND HUMAN SERVICES **HEALTH CARE FINANCING ADMINISTRATION**

PRINTED: 1/25/ FORM APPROVE

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

A. BUILDING B. WING \_\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH V	COULTH CALLEY BEATTHE ENTED		ZEST 9000 SOUTH JORDAN, UT 84088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUR REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
F 371	Continued From Page 82 spoiled".	F 371			
	On 1/2/02, an interview with the food service supervisor was done. She was asked about the improper temperature in the walk-in refrigerate stated that the walk-in refrigerator had not been holding the proper temperature for about two visual She stated that the system needed to be switched from the old type of coolant used to a new type coolant. She further stated that the dietary staff opening the freezer door, which was attached the walk-in refrigerator, to try and keep the foods of the walk-in and that the dietary staff was trying frequently open the refrigerator door to help made a cooler temperature.  On 1/3/02, the food service supervisor was interviewed regarding the grease trap. She state the grease trap did flood each time that all of the compartments of the three compartment sink we emptied at the same time. She stated that the state of the compartment is the same time.	or. She n weeks. ed over e of ff was o the colder in g to not aintain  ed that ne eree taff			
	were trying to empty one sink at a time to preve grease trap from overflowing.  The following observations were made 12/31/01:15 PM in the Alzheimer's unit refrigerator:				
	1. One expired eight ounce carton of fat free m dated 10/27/01.	nilk			
	2. Two expired eight ounce cartons of fat free adated 11/10/01.	milk			
	3. Two expired eight ounce cartons of whole m dated 12/22/01 and two expired eight ounce car whole milk dated 12/29/01.	,			
	4. One expired eight ounce carton of whole mil opened with the carton crushed dated 12/8/01.	lk,			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING
B. WING

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

			/EST 9000 SOUTH JORDAN, UT 84088		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUI REGULATORY OR LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 387 SS=F	483.40(c)(1)&(2) PHYSICIAN SERVICES  The resident must be seen by a physician at lea every 30 days for the first 90 days after admiss and at least once every 60 days thereafter.  A physician visit is considered timely if it occulater than 10 days after the date the visit was returned. This REQUIREMENT is not met as evidenced Based on record review and interviews, it was determined that 15 of 26 sample residents, required requent physician intervention, were not seen physician as required after admission and perioduring their stay. Residents  Findings include:  1. Resident 74 was a 60 year old male who was admitted to the facility on 10/10/01 with diagnost hypotension, protein calorie malnutrition, dehy cerebral vascular accident and situational depresident 74 was seen by a physician on 11/30/0 There was 52 days from the time of admission resident 74 was seen by a physician. There we other documented physician visits in resident 7 clinical record.  2. Resident 61 was a 63 year old male who was admitted to the facility on 2/6/01 with diagnose end stage chronic obstructive pulmonary diseas depression, and anxiety. Resident 61 was seen physician on the following dates: 2/5/01, 2/19/03/5/01, 3/27/01, 5/24/01, 8/12/01, and 12/2/01. were 58 days between the 3/27/01 and the 5/24/physician visits. There were 80 days between the 5/24/01 and the 8/12/01 physician visits. There	ast once sion,  ars not equired.  d by: quiring by a odically  as oses of varion ession.  01. before are no 4's  ses of see, by a  01, There  1/01 the	387	The following is a plan of correction and is in reference to F-378 483.40 (c) 1 & 2 Physician services. This will include corrective action for each resident found to have been affected and were named as residents 74, 61, 10, 86, 70, 67, 35, 16, 30, 34, 11, 15, c2.  1. A new house physician was hired as SVHC medical director November 2002. 2. Medical records is responsible to provide the doctor with a up-dated list weekly for residents to be seen, to include every 30 days for the first 90 days after admission and then every 60 days there after. 3. Medical records will audit Dr.'s progress notes monthly to ensure a physician visit. 4. Medical records is to be on the QA committee and this problem will be addressed in QA, February 22, 2002 until compliance is met.	•

HCFA-2567L

ATG112000

Event I XP7W11

Facility ID:

UT0080

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**HEALTH CARE FINANCING ADMINISTRATION** 

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2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

B. WING\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE.

SOUTH	VALLEY HEALTH CENTER	3706 WES WEST JO	T 9000 SOU RDAN, UT	JTH 84088			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUR REGULATORY OR LSC IDENTIFYING INFORMATION OF THE PROPERTY OF THE P	JLL ON)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTIVE ACTION SE EFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
F 387	Continued From Page 84 112 days between the 8/12/01 and the 12/2/01 physician visits.		F 387				
ŀ	3. Resident 10 was a 86 year old male who we admitted to the facility on 5/18/99 with diagnost cerebral vascular accident, depression, benign prostatic hypertrophy, constipation, osteoarthr coronary artery disease, hypertension, gastroesophageal reflux disease and hyperlipid Resident 10 was seen by a physician on the foldates:3/5/01, 8/14/01, 8/21/01 and 11/4/01. To were 162 days between the 3/5/01 and the 8/14 physician visits.  4. Resident 86 was an 84 year old male who we admitted to the facility on 8/7/00 with diagnost pneumonia, septicemia, senile dementia, renal insufficiency, cerebral vascular accident, hypertension, arthritis, seizure disorder, and depression. Resident 86 was seen by a physician following dates: 6/28/01 and 11/11/01. There 136 days between the physician visits.  5. Resident 70 was an 83 year old male who we admitted to the facility on 8/10/01 with diagnost congestive heart failure, hypertension, peripher vascular disease, hypothyroidism, cerebrovascular disease, hypothyroidism, cer	oses of itis, lemia. llowing here 4/01  was es of an on the were  ras ses of ral illar n by a					
	6. Resident 67 was an 84 year old female admit this facility on 6/15/01, with diagnoses of cerebrovascular accident, hypercholesteremia, constipation, diabetes, hypertension, hypothyroi and insomnia. Resident 67 had a physician's						
CFA-25671	ATGI12000 Event I XP7	7W11 F	acility ID:	TITOORO		If one time time	

HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

A. BUILDING B. WING\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH V			ST 9000 SOU PRDAN, UT		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FUREGULATORY OR LSC IDENTIFYING INFORMATION OF THE PROPERTY OF THE PRO		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETE
F 387	Continued From Page 85 evaluation on 6/27/01 and 11/23/01. There w days between resident 67's first physician's eva and her next physician's evaluation.  7. Resident 35 was a 95 year old female admit this facility on 4/15/99, with diagnoses of here cerebrovascular accident, hypertension, conge heart failure and anemia. Resident 35 had a physician's evaluation on 8/26/01 and 11/30/0 was 94 days between resident 35's last two phy evaluations.  8. Resident 83 was an 83 year old female adm the facility on 6/27/00 with diagnoses includin dementia, psychosis and depression associated dementia, peripheral vascular disease and arth review of resident 83's medical record was do was documented that resident 83 was evaluate physician or nurse practitioner on the followin 3/12/01, 6/12/01 and 11/11/01. There were 91 between the 3/12/01 physician visit and the nex	ras 118 aluation itted to norrhagic estive  1. There ysician's nitted to ng I with ritis. A ne. It d by a ng dates: I days	F 387		OPRIATE DATE
	physician visit on 6/12/01. There were 152 da between resident's 83's 6/12/01 physician visit physician visit on 11/11/01.  9. Resident 16 was a 72 year old female admit the facility on 10/6/97 with diagnoses includin hypothyroidism, Alzheimer's disease and pepti disease. A review of resident 16's medical recodone. It was documented that resident 16 was evaluated by a physician on the following date: 4/2/01, 6/27/01, 7/4/01, and 11/11/01. There was between the 4/2/01 physician visit and the physician visit on 6/27/01. There were 129 days between resident 16's 7/4/01 physician visit and physician visit on 11/11/01.  10. Resident 50 was an 83 year old female admit the facility on 4/4/01 with diagnoses including dementia with depressive features, diabetes with	and the  tted to g ic ulcer ord was s: were 85 e next ys d the			
UCCA 25671	ATGU2000 Fvent I YP	27W11	Facility ID:	LITAGEA	If continuation should 90 of

## DEPARTMENT OF HEALTH AND HUMAIN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE <u>2</u>567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

A. BUILDING B. WING

1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH VALLEY HEALTH CENTER		T 9000 SOUT) RDAN, UT 84		
(X4) ID SUMMARY STATEMENT OF DEFICE PREFIX (EACH DEFICIENCY MUST BE PRECEED REGULATORY OR LSC IDENTIFYING INIT	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 387 Continued From Page 86 peripheral neuropathy, hypertension, of generalized pain. A review of resident done. It was documented that resident evaluated by a physician on the follow 4/5/01, 5/5/01, 6/5/01, 10/21/01 and 1 were 137 days between resident 50's 6 visit and the next physician visit on 10 11. Resident 63 was a 78 year old fem admitted to the facility on 5/13/97 with of bipolar with psychotic features, hyp dementia with aggressive features, lundiabetes and chronic UTI (urinary trace Resident 63 was evaluated by a physic following dates: 3/06/01, 6/19/01, and There were 105 days between the 3/06/6/19/01 physician's visits for resident 6118 days between the 6/19/01 and the physician's visit for resident 63. Upon for resident 63, on 12/31/01, it had been her last physician's visit that was on 10 12. Resident 34 was a 79 year old fem admitted to the facility on 1/15/01 with of DVT (deep vein thrombosis), senile depressive features, hypothyroidism, in anemia, back pain, decubitus ulcer, ost (peripheral vascular disease), and histe Resident 34 was evaluated by a physici following dates: 1/15/01, 6/27/01, 7/19 and 12/02/01. There were 163 days be admission physician's evaluation on 6/27/01, There were 82 days between the 7/19/010/09/01 physician's visits for resident 13. Resident 11 was a 70 year old fem re-admitted to the facility on 11/05/01 vidiagnoses of HTN (hypertension), hypocoPD (chronic obstructive pulmonary)	at 50's chart was at 50 was wing dates: 1/25/01. There is/5/01 physician 0/21/01. The children of the diagnoses bertension, grancer, et infection). Sian on the diagnoses of the children of t	F 387		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)(EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From Page 87 F 387 F 387 (congestive heart failure), diabetes, UTI, right ankle fracture, MI (myocardial infarction), and CAD (cardiac artery disease). Resident 11 was evaluated by a physician on 11/15/01. As of 1/03/01, during record review of resident 11's chart, she had not been evaluated by a physician for 79 days. 14. Resident 15 was a 67 year old female who was admitted to the facility on 5/7/01 with the diagnoses of multi infarct dementia, weight loss, diabetes mellitus insulin required, hypertension, hyperlipidemia, onychomycosis, bilateral pedal edema, and proteinuria. Documentation in the medical record evidenced that resident 15 was evaluated by a physician on 8/25/01, which was 109 days after admission. Documentation further evidenced that resident 15 was seen again on 11/23/01 by a physician, which was 89 days after the physicians first visit. 15. Resident C2 was a 76 year old who was re-admitted to the facility on 6/26/01 and discharged on 8/21/01 with the diagnoses of arthritis, HTN, dysuria, TIA (transient ischemia accident), CHF, macular degeneration, and psoriasis. Resident C2 was evaluated by a physician on 6/27/01. Resident C2 was discharged on 8/21/01 without a physician's note, thus, 55 days had passed since the last physician's visit at the time of discharge. F 426 483.60(a) PHARMACY SERVICES F 426 SS=E A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

HCFA-2567L

ATG112000

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 88 of

DEPARTMENT OF HEALTH AND HUM. I SERVICES HEALTH CARE FINANCING ADMINISTRATION

DEALIF	<u>1 CARE FINANCING</u>	ADMINISTRATION					2567
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MUL A. BUILD B. WING		(X3) DATE SU COMPLE	URVEY TED
NAME OF D	ROVIDER OR SUPPLIER	465108	CTDEET AND	ODECC CYTY		1/1	6/02
NAME OF F	KOVIDER OR SUPPLIER				STATE, ZIP CODE		
	VALLEY HEALTH CE		WEST JO	T 9000 SOURDAN, UT	84088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
	1. Resident 76 was a admitted to the facilit of gastric ulcers, resp. (insulin dependant dia pneumonia, CAD (car failure, respiratory fai acute MI (myocardial vascular accident).  A physician's order da "sliding scale AC [bef The sliding scale for t levels were ordered as Blood glucose level 1 insulin.  Blood glucose level 2 insulin.  Blood glucose level 3 insulin.	T is not met as eviden 53 year old male who y on 10/15/01 with the iratory distress syndromates mellitus), aspirar diac artery disease), as lure, gangrenous chole infarction), and CVA atted 10/15/01, documentore meals] and HS [at the following blood glus:  50 to 250 give 4 units in 51 to 350 give 6 units in 51 to 450 give 10 units in 51 to 450 give 10 units in 51 to 450 give 10 units in 51 to 450 give 10 units in 51 to 450 give 10 units in 51 to 450 give 10 units in 52 to 450 give 10 units in 55 to 450 give 10 units in 55 to 450 give 10 units in 55 to 450 give 10 units in 55 to 450 give 10 units in 55 to 450 give 10 units in 55 to 450 give 10 units in 55 to 450 give 10 units in 55 to 450 give 10 units in 55 to 450 give 10 units in 56 to 450 give 10 units in 57 to 450 give 10 units in 58 to 450 give 10 units in 59 to 450 give 10 units in 50 to 450	was. diagnoses me, IDDM tion cute renal cystitis, (cerebral  mted, bedtime]". cose  regular regular regular regular a regular  resular  173; no 220; no	F 426	The following is a plan of correction a to F-329 483.25 (I) (I) Quality of Cars (a)Pharmacy Services. This will include action for each resident found to have and were identified as 4, 15, 24, 76.  1. The house physician ordered scale for the diabetic.  Residents—who are the house patients 150-200= 2 units received a units received a units received a units received a units received at aff was in service missed blood sugars and standards will audit the unitoring flow sheet weekly	e, F-426 483.60 de corrective heen affected to standard strain physicians' egular egular regular regular or >450 de regarding dard sliding on 2/6/02, e Diabetic	2/1/02
	<del></del>						i

HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE 2567

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	465108	B. WING	1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH	VALLEY HEALTH CENTER		ST 9000 SOU RDAN, UT	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY F REGULATORY OR LSC IDENTIFYING INFORMATI	ULL ION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5)  COMPLETE DATE
	Continued From Page 89 insulin documented as being given.  10/20/01 at 4:30 PM, blood glucose level of insulin documented as being given.  10/20/01 at 6:00 AM, blood glucose level of insulin documented as being given.  10/20/01 at 5:00 PM, blood glucose level of insulin documented as being given.  10/23/01 at 6:00 AM, blood glucose level of insulin documented as being given.  10/25/01 at 500 PM, blood glucose level of insulin documented as being given.  10/27/01 at 6:00 AM, blood glucose level of insulin documented as being given.  10/27/01 at 5:00 PM, blood glucose level of insulin documented as being given.  10/28/01 at 11:30 AM, blood glucose level of insulin documented as being given.  10/28/01 at 5:00 PM, blood glucose level of insulin documented as being given.  10/28/01 at midnight, blood glucose level of insulin documented as being given.  10/30/01 at 4:30 PM, blood glucose level of 1 insulin documented as being given.  10/31/01 at 4:30 PM, blood glucose level of 2 insulin documented as being given.  10/31/01, blood glucose level of 243; no insul documented as being given.  MAR- labeled for 4:00 PM  10/19/01, blood glucose level of 89; 4 units in documented as being given.  10/20/01, blood glucose level of 89; 4 units in documented as being given.  10/22/01, no blood glucose level of 256; 4 units in documented as being given.  10/28/01; no blood glucose level documented obtained; 4 units insulin documented as being given.  10/28/01; no blood glucose level documented obtained; 6 units insulin documented as being given.	152; no 173; no 158; no 239; no 199; no 313; no 6201; no 314; no 158; no 68; no 16; no tin as being given. nsulin as being given.	F 426	
CEA 25671	ATGUERON FVENT L YE	L	Facility ID:	LITTOPO

HCFA-2567L

ATG112000

Event I XP7W11 Facility ID:

UT0080

If continuation sheet 90 of

#### DEPARTMENT OF HEALTH AND HUMA., SERVICES HEALTH CARE FINANCING ADMINISTRATION

NAME OF PROVIDER OR SUPPLIER

PRINTED: 1/25/ FORM APPROVE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING

(X3) DATE SURVEY COMPLETED

1/16/02

465108

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

## 3706 WEST 9000 SOUTH

WIHV	VALLEY HEALTH CENTER	3706 WEST 9000 SO WEST JORDAN, U	Г 84088		
X4) ID REFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION	IL PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLE DATE
F 426	Continued From Page 90	F 426			
	recorded resident 76's blood glucose level on a	i			
I	"Patient Diabetic Record" (PDR) with the slid	ling			
	scale insulin. The following were dates and tir	nes of			
	incorrect insulin doses, documented as being g	iven,	- 1		
	for resident 76's blood glucose levels.				
	6:00 AM blood glucose levels without insulin				
	documented as being given.				
-	11/02/01, blood glucose level of 195.		İ		
	11/03/01, blood glucose level of 161.	İ	j		
	11/06/01, blood glucose level of 217.				i
İ	11/08/01, blood glucose level of 209.				
	11/13/01, blood glucose level of 181.				
	11/14/01, blood glucose level of 208.				
İ	11/15/01, blood glucose level of 253.				
	11/18/01, blood glucose level of 220.				
	11/19/01, blood glucose level of 152.				
	11/23/01, blood glucose level of 252.	į			
	11/24/01, blood glucose level of 150.				
	11/27/01, blood glucose level of 178.				
	11/29/01, blood glucose level of 222.				
	4:30 PM blood glucose levels with incorrect ins	ulin			1
İ	documented as being given.				
	11/06/01, blood glucose level of 364, 6 units				
	documented as being given.				1
	11/13/01, blood glucose level of 246, no insulin	ı			
	documented as being given.				
	11/18/01, blood glucose level of 224, 6 units				
'	documented as being given.				
9	9:00 PM blood glucose levels with incorrect inst	ulin			
	documented as being given.				
	11/06/01, "Re-checked 0400- 199 " no insulin				1
	documented as being given.				
	11/08/01, blood glucose level of 259, no insulin				
	documented as being given.				
	11/12/01, blood glucose level of 179, no insulin			!	
	documented as being given.		!		1

HCFA-2567L

ATG112000

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 91 of

## DEPARTMENT OF HEALTH AND HUMAI. JERVICES **HEALTH CARE FINANCING ADMINISTRATION**

2567

STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 465108 1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH V	VALLEY HEALTH CENTER		ST 9000 SOUTI RDAN, UT 840		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEEDED B' REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From Page 91 11/13/01, blood glucose level of 155, no ir documented as being given. 11/17/01, blood glucose level of 387, 6 und documented as being given. 11/29/01, blood glucose level of 182, no ir documented as being given.	its	F 426		
	Resident 76 had sliding scale insulin orders. November 2001, MAR. The November, 20 had some days marked with the number of insulin documented as being given but no be glucose level or time was provided. The N 2001, MAR had the following days marked number of units of insulin documented as be the rest of the days were left blank:	001, MAR units of blood ovember I with the			
	11/07/01 6 units of insulin documented a given. 11/09/01 10 units of insulin documented given. 11/11/01 two blocks were marked with 4 insulin documented as being given. 11/13/01 4 units of insulin documented as given.	as being units of			
	11/14/01 two blocks were marked with 4 minsulin documented as being given. 11/15/01 0 units of insulin documented as given. 11/16/01 two blocks were marked with 6 minsulin documented as being given. 11/17/01 10 units of insulin documented as given.	being units of		•	
	given. 11/18/01 6 units of insulin documented as given. 11/19/01 4 units of insulin documented as given. 11/21/01 4 units of insulin documented as given. 11/22/01 6 units of insulin documented as	being being			

HCFA-2567L

Event I XP7W11 ATG112000

Facility ID:

UT0080

If continuation sheet 92 of

## DEPARTMENT OF HEALTH AND HUMAIN SERVICES **HEALTH CARE FINANCING ADMINISTRATION**

PRINTED: 1/25/ FORM APPROVE 2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

1/16/02

465108

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING\_

**3706 WEST 9000 SOUTH** WEST JORDAN HT 84088

555111	VALLET HEADTH CENTER	WEST JORDAN, UT 84	1088	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION	JLL PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From Page 92 given.  11/24/01 4 units of insulin documented as be given.  11/26/01 4 units of insulin documented as be given.  11/29/01 4 units of insulin documented as be given.  For the month of December, the facility nurse recorded resident 76's blood glucose level on a "Patient Diabetic Record" (PDR) with the slic scale insulin. The following were dates and the incorrect insulin or missed doses documented, resident 76's blood glucose levels.  6:00 AM blood glucose levels without insulin documented as being given.  12/03/01, blood glucose level of 214 12/06/01, blood glucose level of 189 12/10/01, blood glucose level of 172 12/14/01, blood glucose level of 172 12/14/01, blood glucose level of 166 12/17/01, blood glucose level of 201 12/19/01, blood glucose level of 275 12/24/01, blood glucose level of 152  11:30 AM blood glucose levels without insulin documented as being given. 12/26/01, blood glucose level of 156, 0 units documented as being not given.  4:30 PM blood glucose levels without insulin documented as being not given.  4:30 PM blood glucose level of 317, no insulin documented as being given. 12/06/01, blood glucose level of 229, no insulin documented as being given.	eing eing es a ding mes of for	· ·	

HCFA-2567L

ATG112000

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 93 of

HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE

STATEMENT OF DEFICIENCIES	;
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

A. BUILDING B. WING

1/16/02

NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

#### SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 426 Continued From Page 93 F 426 documented as being given. 12/29/01, blood glucose level of 243, 6 units of insulin documented as being given. 9:00 PM blood glucose levels without insulin documented as being given. 12/13/01, blood glucose level of 156, 0 units documented as being not given 12/16/01, blood glucose level of 227, 6 units of insulin documented as being given.

For the month of January, 2002 (from 1/01/02 to 1/07/02), the facility nurses recorded resident 76's blood glucose levels on a "Patient Diabetic Record" (PDR) with the sliding scale insulin. The following were dates and times of incorrect insulin or missed doses of insulin, documented as being given for resident 76's blood glucose levels.

12/28/01, blood glucose level of of 232, no insulin

12/21/01, blood glucose level of 156, 0 units

12/24/01, blood glucose level of 160, 0 units

documented as being not given.

documented as being not given.

documented as being given.

6:00 AM blood glucose levels without insulin documented as being given. 1/07/02, blood glucose level of 181, no insulin documented as being given.

4:30 PM blood glucose levels with incorrect insulin documented as being given.
1/06/02, blood glucose level of 326, 10 units of insulin documented as being given.

9:00 PM blood glucose levels greater than 400, 1/04/02, blood glucose level of 461, 10 units of insulin documented as being given. No nursing intervention documented for glucose greater than 400.

PRINTED: 1/25/

		G ADMINISTRATION				FOR	M APPROVE 2567
STATEMEN:	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA	(X2) MULTIP A. BUILDING B. WING	PLE CONSTRUCTION  G	(X3) DATE : COMPL	SURVEY LETED
MANAE OF PI	ROVIDER OR SUPPLIER	703100	T CTDEET ADI	OBECC CITY OF	· TE CONE		/16/02
	VALLEY HEALTH CE	ENTER	3706 WES	DRESS, CITY, STA ST 9000 SOUT RDAN, UT 84	TH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
	documented as being documented for gluco documented for gluco that the facility did no adequate pharmaceutic procedures that assure receiving, dispensing, and biologicals) to me residents.  Resident Identifier: 4,  Findings include:  Resident 4 was admitted with diagnoses which in hypertension, heart disfracture, congestive he osteoarthritis, hypercheobstruction, and diabeted the content of th	se level of 451, 10 units given. No nursing interest of the segmen	ervention  ermined received ag g, all drugs 6 sampled  6/23/97 right hip idism, owel	F 426			

Resident 4's medication administration record (MAR), patient diabetic record, and the diabetic monitoring flowsheet were reviewed, for the dates of 10/01/01 through 1/07/02. Documentation evidenced

of blood glucose monitoring. Resident 4's sliding scale insulin orders were: glucose 250-300 give 4 units regular insulin, 301-350 give 6 units regular insulin,

351-400 give 8 units regular insulin.

the following:

DEPARTMENT OF HEALTH AND HUMAN JERVICES PRINTED: 1/25/ FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION 2567 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 426 Continued From Page 95 F 426 On 10/10/01 the MAR documented resident 4's glucose level was 410. Eight units of regular insulin was given. There was no documentation to indicate that resident 4's glucose stabilized, or that the physician was notified. On 10/19/01 the MAR documented that resident 4's glucose level was 279. No regular sliding scale insulin was documented as being given. Resident 4 should have received 4 units of regular insulin according to physician's orders. On 11/15/01 the MAR documented that resident 4's glucose level was 303. No regular sliding scale insulin was documented as being given. Resident 4 should have received 4 units of regular insulin according to physician's orders. Resident 15 was admitted to this facility on 5/7/01 with the diagnoses which include the following: Multi infarct dementia, weight loss, Diabetes Mellitus-II insulin required, hypertension, hyperlipidemia, onychomycosis, bilateral pedal edema, and proteinuria. Resident 15 had physician's orders dated 5/7/01 to check blood glucose levels every AM, every PM, and at hour of sleep. Sliding scale insulin orders were as follows: glucose 200-250 give 2 units regular insulin, 251-300 give 4 units regular insulin, 301-350 give 6 units regular insulin, 351-400 give 8 units of regular

1/8/02. Documentation evidenced the following:

HCFA-2567L

physician.

ATG112000

insulin, 401-450 give 10 units, if greater than 450, call

Resident 15's MAR, patient diabetic record, and diabetic flowsheet were reviewed for the dates of 10/25/01 through 11/30/01, and 1/1/02, through

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 96 of

HEALTH CARE FINANCING ADMINISTRATION

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI	111/11/11	1 CIMED A HARMON TO	110111111011011					2307
SOUTH VALLEY HEALTH CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  3706 WEST 9000 SOUTH WEST JORDAN, UT 84088  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 426  Continued From Page 96 On 10/26/01, the MAR documented that resident 15's glucose level was 272. No regular sliding scale insulin was documented as being given. Resident 15 should have received 4 units of regular insulin according to physician's orders.  On 10/28/01, the MAR documented that resident 15's glucose level was 207. No regular sliding scale insulin was documented as being given. Resident 15 should have received 2 units of regular insulin according to physician's orders.  On 10/30/01, the MAR documented that resident 15's CACH CORRECTIVE ACTION SHOULD BE PROVIDERS PLAN OF CORRECTION (X5) COMPLIANCE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 426  On 10/26/01, the MAR documented that resident 15's glucose level was 272. No regular sliding scale insulin was documented as being given. Resident 15 should have received 2 units of regular insulin according to physician's orders.  On 10/30/01, the MAR documented that resident 15's  On 10/30/01, the MAR documented that resident 15's			IDENTIFICATION NUM		A. BUILDIN		СОМРІ	ETED
SOUTH VALLEY HEALTH CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 426  Continued From Page 96  On 10/26/01, the MAR documented that resident 15's glucose level was 272. No regular sliding scale insulin was documented as being given. Resident 15 should have received 4 units of regular insulin according to physician's orders.  On 10/28/01, the MAR documented that resident 15 should have received 2 units of regular insulin according to physician's orders.  On 10/30/01, the MAR documented that resident 15 should have received 2 units of regular insulin according to physician's orders.  On 10/30/01, the MAR documented that resident 15's glucose level was 207. No regular sliding scale insulin was documented as being given. Resident 15 should have received 2 units of regular insulin according to physician's orders.  On 10/30/01, the MAR documented that resident 15's	NAME OF P	POVIDER OR SUPPLIER		STREET ADD	RESS CITY ST	ATE ZIP CODE		10/02
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 426  Continued From Page 96  On 10/26/01, the MAR documented that resident 15's glucose level was 272. No regular sliding scale insulin was documented as being given. Resident 15 should have received 4 units of regular insulin according to physician's orders.  On 10/28/01, the MAR documented that resident 15 should have received 2 units of regular insulin according to physician's orders.  On 10/30/01, the MAR documented that resident 15 should have received 2 units of regular insulin according to physician's orders.  On 10/30/01, the MAR documented that resident 15's			NTER	3706 WES	Г 9000 SOU7	гн		
On 10/26/01, the MAR documented that resident 15's glucose level was 272. No regular sliding scale insulin was documented as being given. Resident 15 should have received 4 units of regular insulin according to physician's orders.  On 10/28/01, the MAR documented that resident 15's glucose level was 207. No regular sliding scale insulin was documented as being given. Resident 15 should have received 2 units of regular insulin according to physician's orders.  On 10/30/01, the MAR documented that resident 15's	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
was documented as being given. Resident 15 should have received 4 units of regular insulin according to physician's orders.  On 11/15/01 the MAR documented that resident 15's glucose level was 262. Two units of regular sliding scale insulin was given. Resident 6 should have received 4 units of regular insulin according to physician's orders.  On 11/16/01, the MAR documented that resident 15's glucose level was 77. There was documentation to show that juice was given. There was no documentation to show that any further blood glucose monitoring was done.  On 11/22/01, the MAR documented that resident 15's glucose level was 42. There was documentation to show that juice was given. There was no documentation to show that juice was given. There was no documentation to show that any further blood glucose monitoring was done.	F 426	On 10/26/01, the MA glucose level was 272 was documented as behave received 4 units physician's orders.  On 10/28/01, the MA glucose level was 207 was documented as behave received 2 units physician's orders.  On 10/30/01, the MA glucose level was 299 was documented as behave received 4 units physician's orders.  On 11/15/01 the MAR glucose level was 262 scale insulin was giver received 4 units of reg physician's orders.  On 11/16/01, the MAR glucose level was 77. show that juice was girdocumentation to show monitoring was done.  On 11/22/01, the MAR glucose level was 42. show that juice was girdocumentation to show monitoring was documentation to show that juice was girdocumentation cumented that research is a considered that research is a cons	cale insulin 15 should ording to  sident 15's cale insulin 5 should ording to  ident 15's cale insulin 5 should ording to  dent 15's sliding have to  ident 15's tion to  d glucose	F 426		,		

ATG112000

glucose level was 282. No regular sliding scale insulin was documented as being given. Resident 15 should

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 97 of

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DEPARTMENT OF HEALTH AND HU? SERVICES HEALTH CARE FINANCING ADMINISTRATION

P. 02 FORM APPROVE

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIES AND PLAN OF CORRECTION (DENTIFICATION NUMBER OF CORRECTION NUMBER			A BUILDING	LE CONSTRUCTION	(X3) DATE S COMPLI		
465108			B. WING	· · · · ·	1/1	6/2002	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SOUTH	valley health ce	NTER		T 9000 SOUTI RDAN, UT 84			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL		FULL	ID PPEFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO TI DEFICIENCE	ion should be He appropriate	(X5) COMPLETE DATE
F 521	was done on 1/16/02. that the meeting was documentation of the issues involving weig facility quality assura meeting notes.  6. The facility's quality committee did not identified in the establish corrective as residents needs were nutritional services we administration did not systemic processes to have significant weight residents nutritional in (Refer to Tag F-325)  7. The facility's quality committee did not identified in the establish corrective at adequate supervision dietitish was taking ple not sufficient oversight dietary staff to ensure met. There was no symonitor the sanitation storage, preparation at foods. There was prother apeutic diets were also no effective syste were served at the prodiction, through a recommendations, to a	rality assurance meetin. The documentation in held on 10/9/01. In reseminates, it was note that loss had been identify, and subsequently ction plans to ensure the being met and that necesses being provided. The operationalize and purensure that residents do hi loss and ensure that needs were met.  The sy assessment and assurantify, and subsequently ction plans to ensure that needs were met.  The sy assessment and assurantify, and subsequently ction plans to ensure that and oversight by the collect. Consequently, the of the dictary manages all residents' dietary manages all residents' dietary manages of the kitchen, ensuring that reserved as ordered. The im in place to ensure the per temperature. Furtified services, supports an assessment, monitoring meet each client's nutri-	dicated viewing the diffact no fied by the ing to the ing to the ing to the ing to the ing to the ing to the ing to the ing to the ing to the ing to the ing to the ing to the ing to the ing to the ing proper serving of esidents incre was at foods incre, the indicated and ing the indicated ing the indicated ing the indicated	F 521			
	needs to prevent signi (Refer to TAG F-360)						

HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3706 WEST 9000 SOUTH** SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION  $\mathbf{ID}$ (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 426 Continued From Page 98 F 426 glucose level was 241. Two Units of regular sliding scale insulin was given. Resident 24 should have received 4 units of regular insulin according to physicians orders. On 11/5/01, the MAR documented that resident 24's glucose level was 161. No regular sliding scale insulin was given. Resident 24 should have received 2 units of regular insulin according to physicians orders. On 11/6/01, the MAR documented that resident 24's glucose level was 168. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/7/01, the MAR documented that resident 24's glucose level was 189. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/8/01, the MAR documented that resident 24's glucose level was 170. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. On 11/9/01, the MAR documented that resident 24's glucose level was 72. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done. On 11/11/01, the MAR documented that resident 24's glucose level was 72. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done.

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Event I XP7W11

Facility ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES

(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

A. BUILDING B. WING

1/16/02

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

			F 9000 SOUTH LDAN, UT 84088	3	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 426	Continued From Page 99		F 426		
	On 11/12/01, the MAR documented that res glucose level was 169. No regular sliding so was documented as being given. Resident 2 have received 2 units of regular insulin accorphysician's orders.	cale insulin   4 should			
	physician's orders.  On 11/15/01, the MAR documented that resident 24's glucose level was 156. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders.  On 11/15/01, the MAR documented that resident 24's glucose level was 205. No regular sliding scale insulin was documented as being given. Resident 24 should have received 4 units of regular insulin according to physician's orders.				
			-		
	On 11/20/01, the MAR documented that resignates level was 171. No regular sliding s was documented as being given. Resident 2 have received 2 units of regular insulin accomplysician's orders.	cale insulin 24 should			
	On 11/21/01, the MAR documented that resident 24's glucose level was 185. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders.				
	On 11/22/01, the MAR documented that resiglucose level was 169. No regular sliding swas documented as being given. Resident 2 have received 2 units of regular insulin accorphysician's orders.	scale insulin 24 should			
	On 11/25/01, the MAR documented that regular sliding s	sident 24's scale insulin			

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UT0080

## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

TATEMENT OF DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	465108	B. WING	1/16/02

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH

		WEST JORD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
PREFIX	REGULATORY OR LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIATE	
	was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders.  On 12/8/01, the MAR documented that resident 24's glucose level was 71. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done.  On 12/21/01, the MAR documented that resident 24's glucose level was 156. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders.				

HCFA-2567L

Event I XP7W11 Facility ID: ATG112000

UT0080

If continuation sheet 101 of

HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465108 1/16/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3706 WEST 9000 SOUTH** SOUTH VALLEY HEALTH CENTER **WEST JORDAN, UT 84088** SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 426 F 426 Continued From Page 101 On 12/24/01, the MAR documented that resident 24's glucose level was 73. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done. On 12/25/01, the MAR documented that resident 24's glucose level was 79. There was no documentation to evidence that a nursing intervention was implemented. There was no documentation to evidence that resident 24 had further glucose monitoring done. On 1/5/02, the MAR documented that resident 24's glucose level was 151. No regular sliding scale insulin was documented as being given. Resident 24 should have received 2 units of regular insulin according to physician's orders. An interview was conducted with the Director of Nurses (DON)on 1/16/02, regarding the facility's blood glucose monitoring and insulin administration. The DON stated the facility did not have policies to instruct nursing staff on what to do when residents glucose levels are less than 80 or greater than 400. F 490 483.75 ADMINISTRATION F 490 SS=H A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:

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Based on a recertification survey with subsequent extended survey, conducted December 31, 2001

Event I XP7W11

Facility ID:

UT0080

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HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE

1/16/02

(X5)

COMPLETE

DATE

3/1/02

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**  (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

(X4) ID

PREFIX

TAG

465108

B. WING

A. BUILDING

STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

PREFIX

TAG

F 490

SOUTH VALLEY HEALTH CENTER

unavoidable.

Findings include:

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F 490 Continued From Page 102 through January 16, 2002, and resultant finding of Sub-Standard Quality of Care, it was determined that the facility was not being administered in a manner that enabled it to use its resources either efficiently or effectively to ensure that residents were provided the opportunity to attain or maintain their highest practicable physical well-being. Sub-Standard Quality of Care was identified in the facility in the area of maintaining acceptable parameters of nutritional status including body weight when residents' clinical

conditions did not indicate weight loss was

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Additionally, during the annual and the extended survey, the facility was found to be non-compliant in the areas of assessment of a resident for safe self administration of medications, timely answering of call lights, providing a safe, clean, comfortable and homelike environment, providing therapeutic diets, providing foot care for a resident with diabetes, lack of blood glucose monitoring as ordered by the physician, lack of an effective dietary system including lack of adequate registered dietitian intervention, not following menus, not meeting the nutritional needs of the residents, not holding and serving foods at the proper temperature, lack of storing, preparing, distributing and serving food under sanitary conditions, lack of timely physician visits, lack of proper administration of insulin, lack of nurse aide verification and nurse aides working longer than 4 months without completing a training and competency program, failure to obtain laboratory tests ordered by physicians, and not having an effective quality assurance committee that identified and implemented plans of action to correct quality issues.

The following is a plan of correction and is in reference to F 490, F-495 483.75 (e),F-496, for administration. This will include corrective action for each resident found to have been affected.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

- The facility will not use any individual who has worked more than 4 months as a N.A. unless the individual is a full-time employee in a stateapproved training and competency eval. Program and has demonstrated competence through satisfactory participation in a state approved nurse aide training and competency eval. Program or competency eval. Program or has been deemed or determined competent as provided in S483.150 (a) and (b).
- The C.N.A. scheduler will receive registry verification that the individual has met competency evaluation requirements and seek information from every state registry established under sections 1819 (e) (2) (A) or 1919 (c) (2) (A) of the act the facility believes will include information on the individual.
- The C.N.A. scheduler will record the staff member-verifying competency of C.N.A.'s with the state registry.

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Facility ID: UT0080 If continuation sheet 103 of

HEALTH CARE FINANCING ADMINISTRATION 2567 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING\_ 1/16/02 465108 NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SOUTH			Γ 9000 SOU WAN, UT		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FU 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) COMPLETE DATE
F 490	Continued From Page 103 On 12/31/01, a recertification survey was initi 1/11/02, facility administration was noticed of elements of Sub-Standard Quality of Care. To determination of Sub-Standard Quality of Care based on the findings of significant non-comp the area of Quality of Care/Nutrition [42 Code Federal Regulations (CFR) 483.25 (i) (1) Tag 1. Facility administration failed to have a syst place that would ensure that residents of the fadid not have avoidable weight loss. There was of sufficient administrative oversight, supervision monitoring of the facility staff in identification correction and prevention of weight loss and the residents' needs were being met. (Refer to Tag F-325)  2. In addition to the area of Sub-Standard Quality and efficiently use it resources to enthat each resident attained or maintained their practicable, physical, mental and psychosocial well-being in the following areas of deficient practicable, physical, mental and psychosocial well-being in the following areas of deficient practicable (1/16/02).  a. Facility administration did not ensure that a was safe to self administer medications. (Refer to Tag F-176)  b. Facility administration did not ensure that the facility promoted care for residents in a manner maintained or enhanced the resident's dignity. (Refer to Tag F-241)  c. Facility administration did not ensure that the resident environment was clean, safe and come (Refer to Tag F-252)	f the he he was cliance in e of F-325].  tem in acility is a lack sion and n, that  ality of failed to consure highest practice ey a resident  the er that	F 490	Please refer to corrective actions in reference to tag F-325, F-176, F-241, F-252, F-326, F-328, F-329, F-360, F-361, F-363, F-364, F-371, F-387, F-426, F-495, F-496, F-502, F-521	

If continuation sheet 104 of ATG112000 Event I XP7W11 Facility ID: UT0080 HCFA-2567L

2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

465108

B. WING\_

1/16/02

## SOUTH VALLEY HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

SOUTH VALLET HEADTH CENTER		EST JORDAN, U			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
PREFIX	Continued From Page 104 d. Facility administration did not ensure that resi received therapeutic diets as ordered by the phys (Refer to Tag F-326) e. Facility administration did not ensure that a re with diabetes received foot care as needed. (Refer to Tag F-328) f. Facility administration did not ensure that resi with diabetes mellitus received blood glucose monitoring in accordance with physician's orders (Refer to Tag F-329) g. Facility administration did not ensure that resi were provided with meals that met the nutritional special dietary needs of each resident. (Refer to Tag F-360) h. Facility administration did not ensure that the registered dietitian provided adequate consultatio provide training to dietary staff and identify dieta needs of the residents. (Refer to Tag F-361) i. Facility administration did not ensure that men were followed and meals met the nutritional need the residents. (Refer to Tag F-363)	PREFIX TAG  F 490  idents sician.  dents and  idents and  idents and	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE	COMPLETE
	j. Facility administration did not ensure that food held and served at the proper temperatures. (Refer to Tag F-364)				
	k. Facility administration did not ensure that food were stored, prepared, distributed and served undesanitary conditions. (Refer to Tag F-371)				
	1. Facility administration did not ensure that resid	ents			
ICEA 25/21	ATCHAGO Event I VP731/	11 Facility ID.	LTTOORO		1

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Event I XP7W11

Facility ID:

UT0080

HEALTH CARE FINANCING ADMINISTRATION

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AND PLAN OF CORRECTION IDENTIFICATION NO		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER 465108		(X2) MULT: A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE COMPI	
NAME OF D	ROVIDER OR SUPPLIER	100100	STREET ADD	DRESS, CITY, ST	FATE, ZIP CODE	<u>_</u>	710/02
SOUTH VALLEY HEALTH CENTER		NTER	3706 WES	T 9000 SOU? RDAN, UT 8	ТН		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEEDED)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE Œ APPROPRIATE	(X5) COMPLETE DATE
F 490	m. Facility administration with physician orders received the accurate (Refer to Tag F-426)  n. Facility administration individuals working a work longer than 4 m training and competer (Refer to Tag F-495)  o. Facility administration aide registry was contended previous to providing (Refer to Tag F-496)  p. Facility administration laboratory services m (Refer to Tag F-502)  q. Facility administration quality assurance comparison.	ation did not ensure the to receive sliding scal doses.  Ation did not ensure the nurse aide in the facil onths without complete new evaluation programment of the did not ensure the facted on new nursing a patient care.  Ation did not ensure the et the resident needs.	at residents e insulin  at ity did not ing a n.  at the nurse assistants  t	F 490			
F 495 SS=E			ility ·	F 495			

ATG112000 HCFA-2567L

State-approved training and competency evaluation program; has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or

Event I XP7W11

Facility ID:

UT0080

If continuation sheet 106 of

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 465108 1/16/02 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL). (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 495 Continued From Page 106 F 495 The following is a plan of correction and is in reference to Fcompetency evaluation program; or has been deemed 490, F-495 483.75 (e),F-496, for administration. This will include corrective action for each resident found to have been or determined competent as provided in s483.150(a) affected and (b). 3/1/02 The facility will not use any individual who has This REQUIREMENT is not met as evidenced by: worked more than 4 months as a N.A. unless the individual is a full-time employee in a state-Based on employee records and interview with the approved training and competency eval. Program and has demonstrated competence through facility certified nurse aide (CNA) coordinator, it was satisfactory participation in a state approved nurse determined that 8 of 8 facility nurse aides were not aide training and competency eval. Program or certified and had been working as a nurse aide (NA) competency eval. Program or has been deemed or for more than four months. determined competent as provided in S483.150 (a) and (b). The C.N.A. scheduler will receive registry Findings include: verification that the individual has met competency evaluation requirements and seek information from On 1/02/02 at 3:15 PM, an interview with the CNA every state registry established under sections 1819 (e) (2) (A) or 1919 (c) (2) (A) of the act the facility coordinator revealed that she was not aware that nurse believes will include information on the individual. aides required certification within 4 months of hire. The C.N.A. scheduler will record the staff member-verifying competency of C.N.A.'s with the state registry. On 1/08/02, a review of 8 facility nurse aide records revealed no documentation of certification. The 8 employees were hired as early as 5/07/01 to the most recent date of 8/20/01. F 496 483.75(e)(5)-(7) ADMINISTRATION SS=E Before allowing an individual to serve as a nurse aide. a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an

ATG112000

If, since an individual's most recent completion of a

individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on

Event I XP7W11

Facility ID:

UT0080

If continuation sheet :107 of

the individual.

PRINTED: 1/25/ FORM APPROVE

HEALTH	CARE FINANCIN	256					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIED IDENTIFICATION NUMBER 1		A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		465108	<del>~~~~</del>	B. WING		1/1	6/02
NAME OF PR	OVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SOUTH V	ALLEY HEALTH O	ENTER		T 9000 SOUTH RDAN, UT 840	=		
(X4) ID		TATEMENT OF DEFICIENCIE	_	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)

30011	WEST.	JORDAN, UT	84088	
(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) COMPLETE DATE
F 496	Continued From Page 107 training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.  This REQUIREMENT is not met as evidenced by: Based on a review of five employee records, interviews with the facility administrator, certified nurse aide coordinator, and a staff member with registry verification, it was determined that the facility had not contacted the nurse aide registry on five of five employees before allowing them to serve as nurse aides.  Findings include:  A review of five employee records was done on 1/3/02. The review revealed that five employees did not have documentation in their records that the nurse aide registry had been contacted prior to the employees being allowed to serve as nurse aides.  On 1/03/02 at 9:10 AM, an interview with the facility administrator revealed that prior to November of 200 the facility had not been verifying competency of new nurse aides with the state registry. The facility administrator stated that the facility had a new certific nurse aide coordinator that handled calling the state registry.  On 1/03/02 at 9:25 AM, an interview with a staff member of the registry verification agency revealed that they had no record of the facility calling to verify competency for the five employees that were reviewed.	y ve	The following is a plan of correction and is in reference to F-490, F-495 483.75 (e),F-496, for administration. This will include corrective action for each resident found to have been affected.  1. The facility will not use any individual who has worked more than 4 months as a N.A. unless the individual is a full-time employee in a state-approved training and competency eval. Program and has demonstrated competence through satisfactory participation in a state approved nurse aide training and competency eval. Program or competency eval. Program or has been deemed or determined competent as provided in S483.150 (a) and (b).  2. The C.N.A. scheduler will receive registry verification that the individual has met competency evaluation requirements and seek information from every state registry established under sections 181 (e) (2) (A) or 1919 (c) (2) (A) of the act the facility believes will include information on the individual 3. The C.N.A. scheduler will record the staff member-verifying competency of C.N.A.'s with the state registry.	3/1102

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Event I XP7W11

Facility ID:

UT0080

PRINTED: 1/25/

2/14/02

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVE HEALTH CARE FINANCING ADMINISTRATION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING\_ 1/16/02 465108 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3706 WEST 9000 SOUTH SOUTH VALLEY HEALTH CENTER WEST JORDAN, UT 84088 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 496 Continued From Page 108 On 1/03/02 at 4:00 PM, the facility's certified nurse aide coordinator stated that she currently calls the registry to verify competency of the CNA's (certified

F 502 483.75(i) ADMINISTRATION SS=G

was hired on 11/27/01.

£.

F 502

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

nurse aides). The CNA coordinator stated that she started to verify CNA's with the registry on 11/12/01.

One of the five employee record's that were reviewed,

This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not ensure that laboratory services were provided for a resident per physicians orders to monitor blood clotting time resulting in the resident requiring hospitalization for over anticoagulation.

Findings include:

Resident C3 was admitted to the facility on 10/12/01 with diagnoses of fractured pelvis, peripheral vascular disease, emphysema, arthritis, gout and gastrointestinal reflux disease.

Review of resident C3's clinical record revealed the following:

Resident C3 had a physician order dated 10/12/01 for Coumadin 2.5 mg daily. (Coumadin is a medication used to thin the blood which requires monitoring to prevent the blood from becoming too thin and causing bleeding problems.)

The following is a plan of cofrection and is in reference to F-502 483.75 (j) administration. This will include corrective action for each resident found to have been affected and were named as resident C3. The following POC has been instituted to be in effect on 2/14/02.

- 1. SVHC has ensured that the lab will provide lab services per physician's orders to meet the resident's needs.
- The lab will notify SVHC nursing staff of critical lab values for immediate interventions.
- The lab will provide SVHC with a logbook to monitor for laboratory draws.
- QA committee will monitor and audit lab log for accuracy.

If continuation sheet 109 of

## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 1/25/ FORM APPROVE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	465108	B. WING			1/16/02	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	FATE, ZIP CODE		
SOUTH VALLEY HEALTH CENT	ГER		T 9000 SOU RDAN, UT 8			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES TUST BE PRECEEDED BY I IDENTIFYING INFORMAT	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 502 Continued From Page 109	)		F 502			
The treatment sheet for October 2001 document (prothrombin and intermused to measure blood of three weeks then monthly dates 10/15/01, 10/22/01 dates the PT/INR was to 10/22/01 dates did not tests had been done. The documented as being do A physician order dated "Draw P.T INR AM 10/I [physician] for further lad documentation to indicate done.  Review of the laboratory revealed that a PT/INR was and the INR was 6.68 (note a provided the end of the laboratory revealed that a PT/INR was and the INR was 6.68 (note a provided the end of the laboratory revealed that a PT/INR was and the INR was 6.68 (note a provided the end of the laboratory revealed that a PT/INR was and the INR was 6.68 (note a provided the end of the laboratory revealed that a PT/INR of the laboratory	ted to obtain a PT/IN national ratio, a labor clotting time), every yelly. The treatment shift, and 10/29/01 marks be drawn. The 10/2 indicate that the labor 10/29/01 date was one.  10/16/01 documented 16/01 then call MD ab orders." There was the that the PT/INR he was done on 10/29/0 55.3 (normal range shormal 1.0-3.0).  10/16/01 documented was done on 10/29/0 formal 1.0-3.0.  10/16/01 at 9:00 PM called with lab results led with results - V. [times] 2 days then iday each week"  10/16/01 documented, "For pious amount of fres m her rectumpt see director of nursing] documented to the hospital	atory test week for eet had the ked as the 15/01 and bratory  ed to as no ad been  lent C3 1. The 0.5 - 11.5)  ts-PT O. [verbal do  the blood int to irection  vealed for the				

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Event I XP7W11 ATG112000

Facility ID:

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If continuation sheet 110 of

## FORM APPROVE 2567

## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING B. WING\_

465108

1/16/02

## NAME OF PROVIDER OR SUPPLIER

## STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH

L COTINETT STATT ESTATE AT WIT CENTEED		RDAN, UT			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY I REGULATORY OR LSC IDENTIFYING INFORMAT	TULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 502	Continued From Page 110 The laboratory used by the facility was conta 1/8/02 to obtain the results of the 10/15/01, and 10/22/01 PT/INR's ordered by the physical laboratory had no record that the laboratory been completed. A review of the laboratory maintained by the facility on 1/8/02 revealed PT/INR's ordered by the physician had not b written in the log for the laboratory to draw.	t0/16/01, cian. The tests had log book that the	F 502	The following is a plan of correction and is in	2/22/02
F 521 SS=H	The quality assessment and assurance commmets at least quarterly to identify issues with to which quality assessment and assurance as are necessary; and develops and implements appropriate plans of action to correct identifiquality deficiencies.  A State or the Secretary may not require disc the records of such committee except insofar disclosure is related to the compliance of such committee with the requirements of this section. This REQUIREMENT is not met as evidence Based on a review of the facility quality assurance interviews with the facility administrator, the of nursing, and the dietary manager, it was detend that the facility did not ensure that the quality assurance committee effectively identified quality issues.  Findings include:  1. During an interview with the facility administrator and interviews with the facility administrator.	losure of as such h on.  ed by: rance and director etermined of ality	F 521	reference to F521 483.75 (o) (2) and (3) administration.  1. The QA committee has been appointed to meet monthly-the 4th Friday of each month to identify issues with respect to which QA activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies and issues.  2. The QA committee consists of the administrator, ADON, all department heads, pharmacist, and the medical director. The first scheduled meeting is February 22, 2002.  3. The QA committee will identify and establish corrective action plans to ensure the facility was administered in a manner that enabled it to use resources either efficiently or effectively to ensure residents were provided the opportunity to attain or maintain their highest practicable well being.	2122102
		ZDC11/11	English ID.	LITORGO If continue in a	

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Facility ID:

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

465108

A. BUILDING
B. WING \_\_\_

1/16/02

NAME OF PROVIDER OR SUPPLIER

SOUTH VALLEY HEALTH CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

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(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)	(XS) COMPLETE DATE
F 521	Continued From Page 111 on 1/8/02, he stated that the facility had a quality assurance committee consisting of the administrator, director of nursing, all department heads, a pharmacist, and the medical director. He stated that meetings were held on a quarterly basis. When asked if the facility had discussed weight loss as a concern, the administrator stated that they had not discussed resident weight loss, as a facility concern, in the quality assurance committee. The administrator, however, stated he had initiated a weight meeting that met weekly that consisted of the director of nursing, the dietary manager and the registered dietitian.  2. During an interview with the director of nursing on 1/8/02, she stated that the last quality assurance committee meeting was held on 10/9/01. She stated that there were a lot of areas she knew the facility had to work on but they just had not had time to do them all. When asked specifically what the facility had been working on she stated getting fully staffed without having to use pool nurses and getting caught up on the Minimum Data Sets and making sure they were correct. The director of nursing stated that there was a "dietary management team" that consisted of the dietary manager, the director if nursing and the registered dietitian that met weekly. She stated that if a resident was identified as losing weight, the team would implement a specific plan for that resident.  3. During an interview with the facility dietary manager on 1/8/02, she stated that she reviewed all the residents' weights on a monthly basis. She stated if any resident had lost 5 pounds from the previous month they were discussed in the "dietary management team" meeting. She stated that the meetings at the beginning of November 2001. She stated that the registered dictitian would make recommendations and	F 521		
	the director of nursing was responsible to follow			

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Facility ID:

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If continuation sheet 112 of

## DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

2567

	465108	A. BUILDING  B. WING	1/16/02
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(Ma) Moeth Ea construction	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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3706 WEST 9000 SOUTH

			T JORDAN, UT 84088				
(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)			
F 521	Continued From Page 112 through with the recommendations.  4. A review of the weekly "dietary manager minutes was done on 1/8/02. Several reside been identified as losing weight and had beer reviewed by the team including residents 13 40, 50 and 72. Although the team had ident weight loss, there was no documentation to that the team had followed through with recommendations, if any were made.  5. A review of the quality assurance meeting was done on 1/16/02. The documentation in that the meeting was held on 10/9/01. In redocumentation of those minutes, it was note issues involving weight loss had been identifacility quality assurance committee according meeting notes.	ents had en 3, 20, 28, tified the indicate  g minutes dicated viewing the d that no fied by the	F 521				
	6. The facility's quality assessment and assuce committee did not identify, and subsequently establish corrective action plans to ensure the residents needs were being met and that necessity needs were being provided. The administration did not operationalize and pure systemic processes to ensure that residents did not ensure that residents nutritional needs were met. (Refer to Tag F-325)  7. The facility's quality assessment and assure committee did not identify, and subsequently establish corrective action plans to ensure the adequate supervision and oversight by the condiction was taking place. Consequently, the not sufficient oversight of the dietary manage dietary staff to ensure all residents' dietary met. There was no system in place to approprimentior the sanitation of the kitchen, ensuring	y, did not essary he it in place lid not each  rance y, did not eat consultant ere was er and eeds were priately					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH	CARE FINANCING	ADMINISTRATION					2567	
AND PLAN OF CORRECTION IDENTIFICATION I		(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	ER/CLIA JMBER:  (X2) MULTIPL A. BUILDING		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		465108		B. WING	B. WING		/16/02	
NAME OF P	ROVIDER OR SUPPLIER	<u>.                                    </u>	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
	VALLEY HEALTH CE	ENTER		T 9000 SOUT RDAN, UT 84				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEEDED BY REGULATORY OR LSC IDENTIFYING INFORMA		FULL	ID PROVIDER'S PLAN OF COL PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
F 521	foods. There was protherapeutic diets wer also no effective syst were served at the pr dietitian did not prov supervision, through recommendations, to needs to prevent sign (Refer to TAG F-360).  7. The facility's qualicommittee did not idestablish corrective a was administered in resources either efficies idents were provided.	and the distribution and occess for ensuring that e served as ordered. There in place to ensure the oper temperature. Furtide services, supports assessment, monitoring meet each client's nutrilificant weight loss.  (b)  (c)  (c)  (d)  (d)  (e)  (e)  (e)  (e)  (e)  (f)  (e)  (f)  (e)  (f)  (e)  (f)  (e)  (f)  (e)  (f)  (e)  (f)  (e)  (f)  (f	residents' There was hat foods ther, the and g and citional  arance y did not hat facility it to use its ensure that attain or	F 521				

UT0080

The following is a response to the: Directed plan of correction for the recertification/extended survey ending 1/16/02 with the finding of sub-standard quality of care in nutrition/weight loss tag F-325 and non-compliance with dietary tags F-360, F-361, F-326, F-363, F-364, and F-371.

- 1. A new registered dietician has contracted with South Valley Health Care as our registered dietary consultant.
- 2. The registered dietician will complete nutritional assessments and make recommendations for the residents identified as have significant weight loss. As assessments are completed, nursing will contact the residents' physician and implement the recommendations as indicated and approved by the physician. The residents will be weighed 2 times per week (Monday and Thursday) by restorative and weights will given to the NIT committee members: appointed head of committee: The FSS. The aide scheduler will monitor the daily dietary intake sheets weekly for accuracy. Nourishments scheduled at 10am and 2pm will be charted by the dietary aides on the dietary intake sheets daily and again monitored weekly by the aide scheduler for accuracy. The licensed staff will record House supplement on the MAR's as ordered.
- 3. NIT committee has been established to include: the registered dietician, restorative aide, the dietary manager, aide scheduler, QA, will meet every Monday at 2pm. The team will monitor and review all weekly weights, dietary intake and supplement intake for all the residents with weight loss and at risk for weight loss as identified, until weight stabilizes. All residents will by weighted and malnutrition/dehydration assessment will be completed within the first 24 hours of admission for baseline information. Minutes of the NIT and weights will be submitted weekly-Wednesday to the Department of Health for review.
- 4. The registered dietician consultant will perform on site visits weekly to monitor for compliance with tags F-326, F-363, F-364, and F-371. The monitoring will include: 1) ensuring that the facility is accurately serving therapeutic diets as ordered by the physician. 2) That the menu is being followed as written daily with appropriate serving sizes used and if any substitutions are made that they are appropriate and documented accurately. 3) Monitoring will include food temperatures are being taken and accurately recorded for each meal. 4) Monitoring will include kitchen sanitation checks, foods are to be labeled and dated on all expired and outdated foods are disposed of. 5) Monitoring will include checks of the walk-in refrigerator temperatures and will be recorded daily by the dietary staff. The registered dietician consultant will check food temperatures, adherence to the menu, serving of therapeutic diets, walk-in refrigerator temperatures, facility compliance to the labeling and dating of foods and sanitation check personally during the weekly monitoring and document them on a consultant report. The on-site visits will vary in days, to include breakfast, lunch, and supper.
- 5. The registered dietician consultant will provide at least four mandatory in-services to address the following: 1) the importance of following the menu, as writer, with appropriate portions being served and the correct utensils to be used to ensure the accurately of serving size. 2) Appropriate menu substitutions and the need to accurately document any substitutions made to the menu. 3) Food safety issues

and the importance of serving foods at the proper temperatures. 4) Food temperatures maintenance techniques. 5) The importance of labeling and dating all foods. 6) Any other items that the consultant dietician feels as warranted. In-services regarding above issues is scheduled for February 19, 2002.

According to Quality Care policy all employees must be able to speak the dominant language-English.

A record of all the in-service will be submitted to the state survey agency with the itemized content of what was discussed as well as a sign-in sheet identifying the employees who attended.

- 6. The registered dietician consultant will submit written reports to the state survey agency outlining in-service training provided, the facility's movements towards correction and any problems identified by the consultant, which were not previously identified in the "statement of deficiencies" (HCFA-2567) These reports will be submitted weekly
- 7. The dietary food service manager will attend further training to include participation in which she attended and completed in the "Serve Safe Program"--February 12, 2002.

Utah Dept. of Health

MAR - 5 2002

Bur. of Medicare/Medicaid Prog. Certification and Res. Assessment #353390 +77

The following is a addendum to the Directed POC for the re-certification/extended survey ending 1-16-02 for South Valley Health Care. Date of alleged compliance for the POC is 3-7-02.

#### F-176

Charge nurse will monitor-evaluate and review meds. as ordered on Friday. Medical Records will perform weekly audits to ensure accuracy and completion. QA reviews 4th Friday of each month for compliance.

#### F-241

Call light check list was developed to be done randomly, at least twice a week, by all dept. heads-QA will review process monthly.

#### F-252

Areas of frayed carpet were repaired and patched 2-19-02. Formica was replaced in hallway window sills 2-25-02. Maintenance logs are reviewed each morning by maintenance manager. Plant op manager reviews, for completion and/or problem solving of maintenance logs, Tuesdays and Fridays. QA reviews 4th Friday of each month for compliance.

#### F-325

Resident identified 13, 20, 28, 40, 50, 70, 72, 74 was reviewed with Dr. for appropriate interventions starting 12-1-01. Licensed staff was in-serviced on how to complete the malnutrition/dehydration-pressure sore risk assessments 2-20-02. All nursing and dietary staff was in-serviced (Nov 21 and 28 2001) regarding dietary intake record. Dietary intake record was initiated on 12-01-01. NIT committee communication form developed and implemented 2-20-02 to assess NIT committee with dietary and weight issues. If weight loss is identified-the MD will be notified-diet will include enriched-assess for house supplement., speech eval. if warranted-monitor weight 2 times a week until stabilizes. The NIT committee will meet every week on Tuesday at 1 p.m. to include RD, Dietary manager, QA, to assess weight loss that is identified. QA will review above process 4th Friday at 2 p.m. of each month.

#### F-326

Resident's identified as 35 and 42-Dr. was notified of incidents. The licensed staff was inserviced on missed blood-sugars on 2-6-02. If blood-sugars are not being done then the process of weekly audits per medical records, the nurses identified will be called in by the DON and counseled-the nurse involved will then call the MD, and an incident report will be written out nurses will notify residents Dr. other than Dr. for sliding scale orders as warranted. QA will review above process 4th Friday of each month. The RD is currently reviewing assessments-and is completing annual assessment as scheduled per MDS and/or c.o.c. The RD will monitor resident diets to ensure they are as ordered weekly-The dietary manager will monitor 5 times a week-The cooks will monitor daily. QA will review above process 4th Friday of each month.

#### F-328

Resident 15 was seen by Dr. 1-8-02 for podiatry care. Medical records will maintain current podiatry list so that all residents are seen every 60 days. Medical records will audit every month for compliance. QA will review above process 4th Friday of each month.

#### F-329

Residents identified 4, 15, 24, 76-Dr. was informed of incidents-standard sliding scale was generated for all of his residents. If blood-sugars are not being done then the process of weekly audits per medical records, the nurses identified will be called in by the DON and counseled-the nurse involved will then call the MD, and an incident report will be written out nurses will notify residents Dr. other than house MD for sliding scale orders as warranted. QA will review above process 4th Friday of each month.

#### F-360 and F-361

QA is involved in the NIT committee weekly and has been ensuring that the conditions of the Directed Plan of Correction. for tags F-325, F-360, F-361, f-326, F-363, F-364, and F-371. The RD is conducting the dietary in-service weekly and report are submitted to the department of Health as required.

#### F-363

The dietary manager and RD have initiated a daily form to ensure that menus are followed daily-if any substitutions are to be used-the cook will notify either the dietary manager and / or RD for instruction- substitution availability list was provided by RD. Substitutions will be listed on the daily form if altered. Dietary staff was in-serviced 2-26-02 regarding appropriate serving sizes-appropriate utensils were bought to ensure correct serving sizes. QA will review above process 4th Friday of each month.

#### F-371

Florescent kitchen lights have been covered and filters cleaned by 2-26-02. The RD is monitoring sanitation weekly and copy sent to the Health Department-QA is involved in NIT committee weekly to ensure that sanitation check list is completed. fridg on the unit was removed. QA will review above issues monthly.

#### F-387

Residents identified 74, 61, 10, 86, 70, 67, 35, 83, 16, 50, 34, 11, 15, C2. Dr. was notified of last physician visits of each resident Dr. is working with medical records to ensure that residents are seen as required after admissions and periodically during their stay (at least once every 30 day for the first 90 days of admission, and at least once every 60 days there after) Medical records have scheduled appointments. for the other residents that are not house No -again according to regulations. Medical records is on the QA committee and review will be done monthly.

Residents identified 76, 4, 15, 24. Dr. was informed of missed blood sugars and sliding scale not followed as ordered -refer to F-329

#### F-490

The QA committee will monitor that administration is effective on a monthly basis. Facility issues will be brought up immediately to the administration for immediate resolution and QA will review for compliance.

#### F-495

The DON and CNA scheduler will ensure that all NA's are certified within 4 months of hire. They will monitor status monthly and review with QA monthly.

#### F-496

The CNA scheduler will call registry prior to interview with potential applicant. The DON will meet with potential employee and CNA scheduler to ensure that registry was called DON will monitor this process weekly QA will review monthly.

#### F-502

Medical records will audit labs on a monthly basis to ensure that they were done as ordered. QA will review monthly.

#### F-521

The facility administrator has made some changes in the nursing administration and has appointed an RN for QA as it was obvious that the previous QA system was inefficient.

It has been deemed necessary by the administration that QA meet monthly (4th Friday of each month) rather than quarterly to identify issues with respect to which QA activities are necessary; and develop and implement appropriate plans of action to correct identified quality deficiencies and issues and to ensure that the facility is administered in a manner to enable it to use its resources efficiently/effectively to ensure residents are provided the opportunity to attain and maintain their highest practicable well being. (F-490) Since the survey the Dietary manager has successfully completed the serve safe program.

New RD has been hired as the RD for consultant. The NIT committee is meeting weekly and required-reports are being submitted as required to the Dept. of Health for review.

Systems are currently in place to ensure that residents needs are being met and that necessary nutritional services are being met and that necessary nutritional services are being provided and residents nutritional needs are being met. (F-325)

The current RD is providing services, support and supervision, through assessment, monitoring and recommendations to meet each residents nutritional needs to prevent significant weight loss. (F-360)