## Utah Department of Health TValls 5-2209

| DEFANI                   | MENT OF HEALTH   | AND HUMAN SERVICES  & MEDICAID SERVICES  |                      | MAR 2004<br># 402085 HD  | FORM A  | D: 3/4/2004<br>APPROVED<br>0938-0381 |
|--------------------------|--|--|----------------------|--|---|--------------------------------------|
| STATEMEN                 | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CHA (DENTIFICATION NUMBER   | A, BUILDING          |  | (X3) DATE SU<br>COMPLE  |                                      |
|                          |  | 465108   | e. wing              |  | 2/26/   | 2004                                 |
|                          | ROVIDER OR SUPPLIER  | NTER   | 370                  | TET ADDRESS, CITY, STATE, ZIP CODE<br>06 WEST 9000 SOUTH<br>EST JORDAN, UT 84088   |   |                                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DESIGIENCY   | NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAGY | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPE<br>DEFICIENCY)  | ULD BE  | (X5)<br>COMPLETION<br>DAVE           |
| F 226<br>SS=C            | RESIDENTS  | AFF TREATMENT OF   | F 226                | The information contained herein provided to the QA committee at regularly scheduled meeting.  | shall be<br>heir next   |                                      |
|                          | policies and proce<br>mistreatment, neg<br>and misappropriat<br>(Use F226 for defic  | evelop and implement written dures that prohibit lect, and abuse of residents ion of resident property.  Diencies concerning the ent and implementation of dures.)   | Carried Minister     | We do not agree with the deficient herein or the scope and severity of However, to remain in the Medicare/Medicaid programs we required to provide a plan of correct therefore submit the following.   | ited.<br>are  |                                      |
|                          | by: Based on review of procedures, review and interviews, it will did not develop a postate nurse aide to aide to provide directly failed to registry for 4 of 4 registry for 5 and 6 providing resident Findings include:  1. Anti-Abuse Policy address under the Hires" to call the Sallowing a nurse a care.  2. Facility Person  A. E1 was hired a | vas determined that the facility policy and procedure to call the egistry prior to allowing a nurse ect resident care. In addition, contact the State nurse aide nurse aides (Employee E1, E2, and the nurses aides had been care since their hire dates.  The procedures did not "Protocol for Screening New state nurse aide registry prior to ide to provide direct resident in the Files:  The procedures aide on 9/22/03. The | F226 P               | The Abuse Policy and Procedure been amended to include calling a nurse aide registry prior to allowing aide to provide direct resident can.  A new policy and procedure for a hires has been written to assign responsibilities for each step of the employment process and a check designed which must be certified and correct to the administrator will authorize active employment hire. A spread sheet has been detrack all required certifications are held by employees.  The Human Resources Assistant all new hires and current licenses business day of the month and readministrator for presentation to committee at their next meeting. | the State ing a nurse re.  Ill new the off sheet complete pefore he of any new esigned to ad licenses will review on the last port to the | 4/19/04                              |
|                          | personnel file of E  | 1 was reviewed on 2/24/04.   |                      |  |   |                                      |

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

The personnel file did not contain any

OHS OF PROTECTION OF THE PRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

|                          |  | WEDICAID SETTIOES   | T                  |             | CONCTRUCTION   | (X3) DATE S       |                            |
|--------------------------|--|---|--------------------|-------------|--|-------------------|----------------------------|
| STATEMEN<br>AND PLAN     | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:   | (X2) M             |             | CONSTRUCTION   | COWBIT            | ETED                       |
|                          |  | 465108  | B. WIN             | IG          |  | 2/20              | 6/2004                     |
|                          | ROVIDER OR SUPPLIER  |   | _                  | 3706        | ADDRESS, CITY, STATE, ZIP COD<br>WEST 9000 SOUTH<br>T JORDAN, UT 84088                           | E                 | ·                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PRÉFI<br>TAG |             | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE         | (X5)<br>COMPLETION<br>DATE |
| F 226                    | documentation to sought information registry regarding as a nurse aide.  B. E2 was hired as personnel file of E. The personnel file documentation to sought information registry regarding serve as a nurse at personnel file of E. The personnel file of E. The personnel file ocumentation to sought information registry regarding serve as a nurse at D. E4 was hired at The personnel file 2/24/04. The personnel file 2/24/04. The personnel file 2/24/04. The personnel file 2/24/04 at an urse aide.  3. Interviews:  On 2/24/04 at 2:4 stated that she had aide registry on an On 2/24/04 at 2:4 stated that she cashe had not called hired and she did | evidence that the facility had a from the State nurse aide E1 prior to allowing her to serve E2 was reviewed on 2/24/04. did not contain any evidence that the facility had a from the State nurse aide E2 prior to allowing him to aide. E3 a nurse aide on 2/11/04. The 3 was reviewed on 2/24/04. did not contain any evidence that the facility had a from the State nurse aide E3 prior to allowing him to aide. E3 prior to allowing him to aide. E4 was reviewed on sonnel file did not contain any evidence that the facility had a from the State nurse aide E4 prior to allowing her to serve  O PM, the Director of Nurses and not called the State nurse aide E4 prior to allowing her to serve  O PM, the facility receptionist alls the nurse aide registry but don E3 because he was just not call on E1, E2 or E4 | F 226              |             |  |                   |                            |
|                          | because they well  | re hired prior to her being  DIS Obsolete Event ID: APX61   | 11 F               | acility ID: | UT0080 h   | f continuation sh | eet Page 2 of 5            |

| STATEMEN                 | T OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) N            | MULT | IPLE CONSTRUCTION   | (X3) DATE SU<br>COMPLE   |                            |
|--------------------------|--|---|-------------------|------|---|--|----------------------------|
| AND PLAN (               | OF CORRECTION  | IDENTIFICATION NUMBER:  | A BU<br>B. WI     |      | VG  | 2/26   | /2004                      |
|                          |  | 465108  |                   | _    | OTATE ZID CODE  |  |                            |
|                          | ROVIDER OR SUPPLIER  | NTER  |                   | 3    | REET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC |      | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY)  | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 226                    | Continued From pag<br>assigned the job d   | ł.  | F 226             | 3    |   |  |                            |
| F 241<br>SS=D            | The facility must p manner and in an enhances each refull recognition of I This REQUIREME by: Based on observation determined the facts ampled and four dining environmer of diminished self-(resident identifier)  Findings include:  1. Observation of 2/23/04, 2/24/04 at and 2/25/04 durin  Resident 27, 41 at by staff during the lap buddy on their meal time. Resident and the end of her ground. Resident and her clothing, table next to her the meal tray hawater, a cup of old. | romote care for residents in a environment that maintains or sident's dignity and respect in his or her individuality.  ENT is not met as evidenced tions and interview, it was cility did not provide, one additional residents, a dignified at; thus, placing residents at risk esteem and self-worth is 16, 27, 30, 41, 63).  Tresident's 27,30, 41 and 63 on and 2/25/04 during the breakfast githe noon meal are as follows:  Ind 63 was observed being feed a wheelchair during the entire ent 30 was observed to feed tance and also had a lap buddy during the entire meal time.  7:40 AM, resident 16 was laying bed with her feet touching the tance and also had a lap buddy during the entire meal time.  7:40 AM, resident 16 was laying bed with her feet touching the tance to the feet which had a meal tray on it. It is a glass of milk, a glass of range juice, a cup of medpass, of yellowish milk, bowl of green |                   |      | All residents with lap buddies we them removed from their wheeld the chairs positioned close to the wheels locked or transferred to rechairs to provide a more dignifies secure eating experience. All nurshave been in-serviced on the nect this procedure. The DON or regwill monitor the procedure week weeks and keep a record of result logbook, to ensure compliance, monitoring will be done at least with documentation. Results ship presented to the QA committee a meeting. Resident 16 will have amended to reflect that she will extra hour to eat, and will be off the meal is not consumed during time. The tray will then be removed in an effort to comfort a sensitive snack and beverage with on a tray, to resident when the removed in an effort to comfort assuage anxiety, which develops food tray is taken from her. | hairs and table with egular d and rsing staff essity of presentative ly for 8 lts in a POC Thereafter, monthly, all be at their next her care plan be given an ered help if the normal ved from the cts, in order ime ll be offered, meal tray is resident and | 4/19/04                    |
|                          |  | Proc Obsolute Event ID: APX6  |                   | Faci | ility ID: UT0080 If o   | continuation she   | et Page 3 of               |

| NAME OF PROVIDER OR SUPPLER  SOUTH VALLEY HEALTH CENTER  SUMMAY STATEBURY OF DEPOCIABLES  (PAR) D  PROVIDERS PLAN OF CORRECTION  RECONSTRUCTION ON INSTRUCTION  RECONSTRUCTION ON INSTRUCTION  RECONSTRUCTION ON INSTRUCTION  RECONSTRUCTION  RECONSTRUCTION | STATEMENT | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) M<br>A. BU<br>B. WI | ILDI |   | (X3) DATE S<br>COMPL | ETED       |
|--|-----------|---|--|--------------------------|------|---|----------------------|------------|
| SOUTH VALLEY HEALTH CENTER  CALL DESCRIPTION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL FREGUATORY OR LECTORY OR NOT BE APPROPRIATE DEFICIENCY  F241  Continued From page 3 (each or the food was dry and crusty. There were drops of lood on the floor at the resident from and some of the food was dry and crusty. There were drops of lood on the floor at the resident's text and around the bedside table.  On 2/26/04 at 7:50 AM, the facility's Assistant Director of Nurses stated that resident 16 will not let the nurse aides pick up the meal trays and that the resident 16's from and pick the meal tray up.  On 2/26/04 at 7:55 AM, the facility night nurse stated that resident 16's room and pick the meal tray up.  On 2/26/04 at 7:55 AM, the facility night nurse stated that resident twould not tell the. When the night nurse was asked if she tried to replace the old tray with a new tray the facility night nurse stated that she did not offer another tray to resident 16.  F 279  SS-B  F 279  483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as  |           |   | 465108   |                          |      |   | 1 212                | 6/2004     |
| PREFIX TAG  F 241  Continued From page 3 jello, a slice of wheat bread, puree meat, vegetables and mashed potatoes with gravy on it. The meal tray appeared to be being eaten from and some of the food was dry and crusty. There were drops of food on the floor at the resident's feet and around the bedside table.  On 2/26/04 at 7:50 AM, the facility's Assistant Director of Nurses stated that resident 16 will not let the nurse aides pick up the meal tray and that the resident 16's ac care plan to replace the old trays with new trays. The ADON proceeded to go into resident 16's tray was from dinner the night before and that she tried on four different occasions to pick the tray up and the resident would not let her. When the night nurse stated that resident 16.  F 279  SS-B  The facility must develop a comprehensive care plan for each resident thin includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as   |           |   | NTER   |                          | 1    | 3706 WEST 9000 SOUTH WEST JORDAN, UT 84088                    |                      | -          |
| jello, a slice of wheat bread, puree meat, vegetables and mashed potatoes with gravy on it. The meal tray appeared to be being eaten from and some of the food was dry and crusty. There were drops of food on the floor at the resident's feet and around the bedside table.  On 2/26/04 at 7:50 AM, the facility's Assistant Director of Nurses stated that resident 16 will not let the nurse aides pick up the meal trays and that the resident has a care plan to replace the old trays with new trays. The ADON proceeded to go into resident 16's room and pick the meal tray up.  On 2/26/04 at 7:55 AM, the facility night nurse stated that resident 16's tray was from dinner the night before and that she tried on four different occasions to pick the tray up and the resident would not let her. When the night nurse was asked if she fried to replace the old tray with a new tray the facility night nurse stated that she did not offer another tray to resident 16.  F 2/9  483.20(k) RESIDENT ASSESSMENT  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mertal, and psychosocial well-being as   | PREFIX    | /EACH DEFICIENCY  | MUST BE PRECEEDED BY FULL  | PREF                     | ΊX   | (EACH CORRECTIVE ACTION SHOOLS OF CROSS-REFERENCED TO THE APP | OULDBE               | COMPLETION |
| The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as   | F 241     | jello, a slice of whe vegetables and ma The meal tray appeared and some of the fowere drops of food feet and around the On 2/26/04 at 7:50 Director of Nurses let the nurse aides the resident has a trays with new tray into resident 16's round on 2/26/04 at 7:55 stated that resider night before and the occasions to pick would not let her asked if she tried new tray the facility. | ast bread, puree meat, ashed potatoes with gravy on it. eared to be being eaten from hod was dry and crusty. There on the floor at the resident's e bedside table.  AM, the facility's Assistant stated that resident 16 will not pick up the meal trays and that care plan to replace the old so oom and pick the meal tray up.  AM, the facility night nurse at 16's tray was from dinner the nat she tried on four different the tray up and the resident When the night nurse was to replace the old tray with a y night nurse stated that she did |                          | 1    |   |                      |            |
| Any services that would otherwise be required  |           | The facility must of plan for each residual plan for each residual plan for each residual plan for each that are ideassessment.  The care plan must be serviced that maintain the residual physical, mental, required under se  | develop a comprehensive care dent that includes measurable tetables to meet a resident's and mental and psychosocial entified in the comprehensive are to be furnished to attain or dent's highest practicable and psychosocial well-being as 183.25; and  |                          | 9    |   |                      |            |

| CENTE                    | 35 FOR WEDICALL  | T WEDIOTHE GETTINGES   |                    |   |  | IO ICV                     |
|--------------------------|--|--|--------------------|---|--|----------------------------|
| STATEMEN<br>AND PLAN     | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BUI             | ULTIPLE CONSTRUCTION  LDING   |  |                            |
|                          |  | 465108   | B. WIN             | NG  | 2/26   | /2004                      |
| •                        | ROVIDER OR SUPPLIER  | NTER   |                    | STREET ADDRESS, CITY, STA<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84   |  | -                          |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | X (EACH CORRECTE<br>CROSS-REFERENCE   | AN OF CORRECTION  IVE ACTION SHOULD BE  ED TO THE APPROPRIATE  FICIENCY)   | (X5)<br>COMPLETION<br>DATE |
| F 279                    | resident's exercise including the right to s483.10(b)(4).  This REQUIREME by: Based on medical was determined the (Residents 9, 11, 1) the facility did not oplans for each resineeds identified by Findings include:  1. Resident 11 was 9/14/03, with diagred diabetes mellitus the renal insufficiency, disease.  An admission MDS assessment, dated resident 11 needed dressing, extensive extensive assistant frequent bladder in mellitus and an incentional/rehability incontinence and inc | are not provided due to the of rights under s483.10, o refuse treatment under  NT is not met as evidenced record review and interview, it at for 9 of 15 sample residents 2, 16, 22, 34, 39, 46 and 47), develop comprehensive care dent based on their individual | F 279              | All MDS's will be of with care plans and if found the offending rewritten to reflect the assessment of reside needs.  A temporary plan of within 4 hours of addicharge nurse and car will be completed we admission. The care within the 14 day pethe RAPS are completed we are completed we admission. The care within the 14 day pethe RAPS are completed when a charge nurse orders, they will be the care plan, and signations required by been, or are being assign the order. Copplaced in the DON/areview for action and All licensed nursing serviced on the appetite of the DON will keep and will check daily MDS's are being of prescribed time per responsible to ensure review is completed. | ne most accurate ints and best meet their ints and best meet their interest and inte | 4/19/04                    |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A BU  | ILDIN(   | PLE CONSTRUCTION  G   |                 | ATE SUE | ED                         |
|--------------------------|--|---|-------|--|---|-----------------|---------|----------------------------|
|                          |  | 465108  | B. WI |  |   |                 | 2/26/   | 2004                       |
|                          | ROVIDER OR SUPPLIER  | NTER  |       | 37   | EET ADDRESS, CITY, STATE, ZIP C<br>706 WEST 9000 SOUTH<br>/EST JORDAN, UT 84088 |                 |         |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)  |       | ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY) |   |                 | E       | (X5)<br>COMPLETION<br>DATE |
| F 279                    | that an indwelling mellitus, urinary trause had not been care.  2. Resident 34 was 12/2003, with the curinary tract infect.  A 30 day MDS assistance with transsistance with transistance with easistance with easistance with easistance with hy incontinent of bow history of falls, and A review of reside that ADL's, incontinot been incorport.  3. Resident 47 was 1/4/04, with the dill Lymphoma, reflux failure, neuropath.  Review of resident revealed that the was "adjustment to documented in reshe had an indwellab draws, chronic wedge, antibiotics restraints.  4. Resident 12 was 12/12/03, with dia | ent 11's plan of care revealed catheter, ADL's, diabetes act infections, falls and oxygen incorporated into his plan of as re-admitted to the facility diagnoses including Alzheimers, ions (UTI), and backache.  Sessment dated 1/13/04, resident 34 needed extensive ansfers, does not walk, needs not with dressing, needs limited ating, needs extensive religione, was frequently rel, incontinent of bladder, | F 279 |  |   |                 |         |                            |
| EORM Chap :              | 2567/02-99) Previous Versio  | ons Obsolete Event ID: APX61  | 1     | Facility   | / ID. UT0080  | If continuation | n shee  | t Page 6 of 5              |

|                          | T OF DEFICIENCIES<br>DE CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A. BU             | ILDI1 | IPLE CONSTRUCTION  | (X3) DATE SU<br>COMPLET |                            |  |
|--------------------------|--|--|-------------------|-------|--|-------------------------|----------------------------|--|
|                          |  | 465108   | B. WI             | NG _  |  | 2/26/                   | 2004                       |  |
|                          | ROVIDER OR SUPPLIER  | ITER   | _                 | 3     | REET ADDRESS, CITY, STATE, ZIP CODE<br>8706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088                   |                         |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORRE-<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                 | (X5)<br>COMPLETION<br>DATE |  |
| F 279                    | Continued From page  | 9 6  | F 279             | )     |  |                         |                            |  |
|                          | that she had an ind<br>psychotropic medic<br>A review of residen<br>that an indwelling c   | t 12's plan of care revealed atheter and psychotropic  |                   |       |  |                         |                            |  |
|                          | medications had no<br>plan of care.  | ot been incorporated into her  |                   |       |  |                         |                            |  |
|                          | 7/12/03, with diagnates Huntington's chore   | s re-admitted to the facility on<br>osis which included<br>a, constipation, chronic back<br>tis and depression.  |                   |       |  | ,                       |                            |  |
|                          | the end of her bed ground. Resident and her clothing. Feather to her feather the meal tray had water, a cup of oracup of coffee, cup of jello, a slice of whe vegetables and matched meal tray appeared some of the fowere drops of food feet and around the | AM, resident 16 was laying at with her feet touching the 16 had dried food on her chin desident 16 had a bedside et which had a meal tray on it. a glass of milk, a glass of nge juice, a cup of medpass, of yellowish milk, bowl of green at bread, puree meat, shed potatoes with gravy on it. eared to be being eaten from od was dry and crusty. There on the floor at the resident's e bedside table.  AM, the facility's Assistant |                   |       |  |                         |                            |  |
|                          | Director of Nurses<br>let the nurse aides<br>the resident has a<br>trays with new tray   | stated that resident 16 will not pick up the meal trays and that care plan to replace the old s. The ADON proceeded to go oom and pick the meal tray up.   |                   |       |  |                         |                            |  |
|                          | stated that that res   | AM, the facility night nurse ident 16's tray was from dinner d that she tried on four  |                   |       |  |                         |                            |  |

| STATEMEN<br>AND PLAN     | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BU             | IILDI |   | (X3) DATE SURVEY COMPLETED |                            |  |
|--------------------------|---|--|-------------------|-------|---|----------------------------|----------------------------|--|
|                          |   | 4 <del>6</del> 5108  | B. WI             | ING   |   | 2/20                       | 5/2004                     |  |
|                          | ROVIDER OR SUPPLIER   | NTER   |                   |       | TREET ADDRESS, CITY, STATE, ZIP COU<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088          |                            |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENCY  | NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | FIX   | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE /<br>DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |  |
| F 279                    | resident would not was asked if she tranew tray the facil did not offer another. A review of resider care plan which ad resident 38 refused meals. Facility state resident would fashion, that there her room, that the shift and no food of documented that the care to meet the recare to meet the recare to meet the recare to meet the recare to meet the resident 22 was facility on 12/17/03 obesity, hypertens anemia, osteoarth and constipation.  Review of resident she had obesity, hand a low albumin.  An admission MDS as status and the facindicating that the planning.  A review of resident status and the facindicating that the planning. | to pick the tray up and the let her. When the night nurse led to replace the old tray with ity night nurse stated that she er tray to resident 16.  It 38's plan of care revealed a dressed under problem that do let staff take her tray after ff documented under goals that eat her meals in a timely would be no left over food in resident would be clean every in the floor. The facility staff ney would review this care plan was no documented evidence viewed or updated this plan of esident needs.  Is originally admitted to the symbol with diagnosis which included ion, diabetes, sleep apnea, ritis, edema, muscle spasms |                   | P .   |   |                            |                            |  |

| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER.   | A. BU             | ILDING |   | (X3) DATE SU<br>COMPLE | TED                        |
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|                          |  | 465108  | B. WI             | NG _   |   |                        | /2004                      |
|                          | ROVIDER OR SUPPLIER  | NTER  |                   | 37     | EET ADDRESS, CITY, STATE, ZIP CODE<br>706 WEST 9000 SOUTH<br>PEST JORDAN, UT 84088            |                        | ·                          |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC | :      | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AIDEFICIENCY) | HOULD BE               | (X5)<br>COMPLETION<br>DATE |
| F 279                    | On 2/11/04, a physical bladder retraining. clamp the indwelling hours, then every 2/4 hours for 24 hours for 200 and 2/2 observed to still has place.  There was no physical record to 6 catheter after the bladder record to 6 catheter after the bladder record incorporated into 6/8/02, with diagnostical osteoarthritical physical costeoarthritical physical | The order was written for The order was written to a catheter every hour for 24 hours for 24 hours for 24 hours, then every and then to discontinue.  24/04, resident 22 was ave an indwelling catheter in scician order in resident 22's continue with the indwelling pladder retraining.  |                   |        |   |                        |                            |
|                          | chronic obstructive Review of resident completed on 2/24 documented on ref 4/27/03, under Se b. 1, the resident is continent of bladd 1/5/04 documents that resident 9 is of the current care place in an interview with that resident 9 was any problems. Do  | e pulmonary disease.  It 9's medical record was It 9's medical record was It 9's quarterly MDS dated ction H. Continence; a., O and s continent of bowel and usually er. The quarterly MDS dated it, Continence; a., 2 and b., 2, becasionally incontinent.  It bowel and bladder. It staff member E5, he stated its continent and never really had uring the course of the survey, It, no episodes of incontinence |                   |        |   |                        |                            |

| STATEMENT                | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BU             | NLD | LTIPLE CONSTRUCTION DING   | (X3) DATE S<br>COMPLI |                            |
|--------------------------|---|---|-------------------|-----|--|-----------------------|----------------------------|
|                          |   | 465108  |                   | 1   | OTTY STATE 719 CODE  |                       | 0,200.                     |
|                          | ROVIDER OR SUPPLIER ALLEY HEALTH CE   | NTER  |                   | S   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088                |                       |                            |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STA   | ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC | EIX | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE               | (X5)<br>COMPLETION<br>DATE |
| F 279                    | Continued From pag  | e 9   | F 279             | 9   |  |                       |                            |
|                          | 12/12/03, with diag<br>disease, chronic re<br>hyperglycemia and<br>Beview of resident | aspiration pneumonia. 39's medical record was   |                   |     |  |                       |                            |
|                          | documented on re  | /04. The following was sident 39's admission MDS admission MDS ader Section C. 2. earing aide present and used.                                   |                   | ٠   |  |                       |                            |
|                          | The current care p<br>39's use of hearing   | lan did not address resident<br>g aides.  |                   |     |  |                       |                            |
|                          | diagnoses that inc  | as admitted on 12/26/03, with<br>luded asthma, chronic back<br>d chronic obstructive pulmonary  |                   |     |  |                       |                            |
|                          | documented on 2/26  | t 46's medical record was<br>5/04. The following was<br>esident 46's admission MDS<br>ender Section P. Special<br>procedures, g., oxygen therapy. |                   |     |  |                       |                            |
|                          | The current care p<br>46's use or need t  | olan did not address resident<br>or oxygen.   |                   |     |  |                       |                            |
| F 286<br>SS=B            |   | nt Assessment   | F 28              | 6   |  |                       |                            |
| 00-0                     | A facility must ma completed within resident's active r This REQUIREM by:             | ENT is not met as evidenced   |                   |     |  |                       |                            |
|                          | Based on record maintain Minimur  | review, the facility did not<br>n Data Set (MDS) assessments  |                   |     |  |                       |                            |

| CTATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BU             | ILDIN | IPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |                            |
|--------------------------|--|--|-------------------|-------|---|--|----------------------------|
|                          |  | 465108   | . D. VV           |       |   | 2/26   | /2004                      |
|                          | ROVIDER OR SUPPLIER  | NTER   |                   | 3     | REET ADDRESS, CITY, STATE, ZIP CODE<br>1706 WEST 9000 SOUTH<br>VEST JORDAN, UT 84088  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREI<br>TAG | ΊX    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | DULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 286                    | completed within the resident's active residents.  Resident identifier: Findings include:  1. Resident 34 was 12/12/03, with the Alzheimers, urinare backache.  Resident 34 had a completed on 12/9 anticipated."  There were no ME active medical recompleted on 12/9 anticipated on 12/9 articipated. There were no ME active medical recompleted on 12/9 articipated on 12/ | ne previous 15 months in the secord for 4 of 15 sample  22, 34, 47 and 59,  as re-admitted to the facility diagnoses including y tract infections (UTI), and  discharge tracking form 9/03, which documented "return of assessments in resident 34's ford before 12/18/03.  as re-admitted to the facility on agnoses of non-Hodgkin anemia, osteoporosis, renally and hypertension.  a discharge tracking form 19/03, which documented d."  OS assessments in resident 47's cord.  as admitted to the facility on liagnoses including chronic pain theart, pneumonia and hip  DS assessments in resident 59's |                   |       | All medical charts will be audited they contain the required MDS's. DON will do a random audit of 2: ensure MDS compliance and shall names on the charts in the POC lo Quarterly, the DON, or representareview all charts which have had creviews for adequate MDS's and shoument the review in the POC I Results shall be reported to the Qa committee at it's next regular meeting. | The 5 chart's to note the g book. tive, shall quarterly shall og book. A ting. | 4/19/04                    |

| CENTER                   | IS FOR MEDICARE   | & MEDICAID SETTIOES  |               |   | (X3) DATE SU                 | DVEV               |
|--------------------------|---|--|---------------|---|------------------------------|--------------------|
| STATEMENT<br>AND PLAN C  | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BUILE      |   | COMPLE                       | red                |
|                          |   | 465108   |               | G   |                              | /2004              |
|                          | ROVIDER OR SUPPLIER   | NTER   | S             | STREET ADDRESS, CITY, STATE, ZIP C<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088 | ODE                          |                    |
| 3001111                  |   |  | ID ID         | PROVIDER'S PLAN OF CO   | ORRECTION                    | (X5)               |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG | CAOU CODDECTIVE ACTIC   | N SHOULD BE<br>E APPROPRIATE | COMPLETION<br>DATE |
| F 286                    | urinary tract infectionsteoarthritis, eder anemia.  A complete review   | with diagnoses which included on, hypertension, reflux, ma, muscle spasms and of resident 22's active medical n 2/24/04. The medical record  | F 286         |   |                              |                    |
| F 309<br>S=G             | Each resident must provide the necessor maintain the nigmental, and psych   | OF CARE st receive and the facility must sary care and services to attain shest practicable physical, osocial well-being, in the comprehensive assessment  | F 309         |   |                              |                    |
|                          | This REQUIREMS by: Based on observative record review, it will did not provide new of 15 sampled researched with sign complications. Researched with sign complications. Reservices when he retraining and discept the services when he retraining and residuals. | ation, interviews and medical vas determined that the facility essary care and services for 4 sidents. Specifically, resident ve prompt services when she cans of Coumadin therapy esident 16 did not receive a n as ordered by her physician, lent 22 did not receive prompt r physician ordered bladder continuation of her indwelling dent 47 did not receive prompt or physician ordered her |               |   |                              |                    |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BU             | iLDIN |   | (X3) DATE SU<br>COMPLE   |                            |  |
|---|--|-------------------|-------|---|--|----------------------------|--|
|   | 465108   | B. WII            | NG    |   | 2/26   | /2004                      |  |
| NAME OF PROVIDER OR SUPPLIER  SOUTH VALLEY HEALTH CEN   | NTER   |                   | 37    | EET ADDRESS, CITY, STATE, ZIP CODE<br>706 WEST 9000 SOUTH<br>VEST JORDAN, UT 84088  |  |                            |  |
| PREFIX (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED FICIENCY)   | ULD BE   | (X5)<br>COMPLETION<br>DATE |  |
| and prevent clotting dose that both avoidachieves therapeut monitoring through prothrombin time (Findividual, (Referent Suddarth's textbook 8th edition 1996 Lip.  The International Night another laboratory prothrombin time in doses of anticoagul administered. (Reference 53 Economics Compation 1. Resident CL2 with 12/22/03 with diagrance fracture, congularly hypokalemia, hyper Resident CL2's me 2/26/04.  A review of admissing revealed the following every day for Draw PT/INR on Mireriday.  Resident CL2's, January Resident CL2's, January PT/INR on Mireriday. | all anticoagulant used to control of disorders. Prescribing the disorders. Prescribing the disorders and ic range clotting times requires laboratory tests. The PT) is a laboratory test used for office office office office. Brunner and office office office. Brunner and office office office office office. Brunner and office | F 309             |       | All licensed staff have been in-serve the new policy and procedures for handling of Telephone Orders (TC All TO originals will be reviewed to the DON or representative before to transferred to medical records. The pwill check all charts for resider experiencing a change of condition generate TO's, to ensure policy recare being met. These checks shall daily for 8 weeks, then shall be doweekly for 8 weeks, then shall be doweekly for 8 weeks and weekly the The DON shall document the chart by name and date in the POC log be All licensed staff have been in-serve new policy and procedures for the of lab orders and use of the Lab Log The DON or representative shall contain the Lab Log Book daily for compliance period of 8 weeks and weekly them The person checking the Lab Log shall initial and date the book each checked.  Resident 16 is on a puree diet and encouraged by staff members to tue sit up straight and take time to swar completely. The order for a swall evaluation was discontinued 2/27 physician order  Resident 22's bladder training proceompleted and catheter removed 2 per physician's order. The DON or representative will monitor the treat book daily for 8 weeks and then we thereafter, initialing and dating boottime it is checked.  When items are needed for resident request will immediately be placed central supply box which has been | the daily by being e DON or outs a likely to quirements be done as a times ereafter. It is checked book. Viced on treatment og Book. Heck the e for a eafter. Book time it is will be ck in chin, allow ow 1/04 per gram was 1/24/04 timent eekly ok each at care, the lin the | 4/19/04                    |  |

PRINTED: 3/4/2004 FORM APPROVED OMB NO. 0938-0391

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BUI             | RULTIPLE CONSTRUCTION   | (X3) DATE S<br>COMPLE  |                            |
|--------------------------|---|---|--------------------|---|--|----------------------------|
|                          |   | 465108  | B. WI              | NG  | 2/26   | 5/2004                     |
|                          | PROVIDER OR SUPPLIER  | NTER  |                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088  | DDE  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | N SHOULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 309                    | re-certification order had a PT/INR on 12 12/29/03. There was resident CL2's med the PT/INR for 12/2 ordered.  On 12/31/03 at 10:00 documented the following of results - 10 12/31/03, the process of the PT/INR on 1/2/04. It documented on the notified of the results.  On 1/5/04 on the 7:1 facility nurse documented the following Care found on the floor a apparent injury"  On 1/7/04 at 10:00 documented the following Care Recorded and Pt has [zero (complaints of) SOI pains" | ession orders and January 2004 ars, resident CL2 should have 2/24/03, 12/26/03 and as no documentation in lical record to evidence that 19/03 had been performed as 200 AM, a facility nurse lowing in a nursing progress or PT/INR. Notify MD (medical to be drawn 1/02/04." anysician wrote an order for a The physician also order that he wanted to be ts.  mentation in resident CL2's vidence that the PT/INR was physician was notified of the 24 Record, "Res (resident) was about 0200 (2:00 AM). No | F 309              | at each nurse's station. If it is need, the central supply super called by telephone. If they available, the DON, ADON of Administrator shall be called needed supplies. If the need is emergency, the Central Supplies shall notify nursing of the explication that it is not in stock. Nurnotify the Doctor and DON is not arrive in time to meet require await further instructions. All appropriate staff members serviced on the new procedur. The DON will report to the Quegular meetings on the above procedures and how they are | visor shall be are not r to obtain s not an an aly Supervisor ected arrival of sing shall then the item will airements and a have been intes.  A committee at e policies and |                            |

Facility ID. UT0080

PRINTED: 3/4/2004 FORM APPROVED OMB NO. 0938-0391

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A BU              | ILD | TIPLE CONSTRUCTION  | (X3) DATE SU<br>COMPLE | TED                        |
|--------------------------|---|---|-------------------|-----|---|------------------------|----------------------------|
|                          |   | 465108  |                   |     |   | 2/26                   | /2004                      |
|                          | ROVIDER OR SUPPLIER<br>'ALLEY HEALTH CEN  | NTER  |                   |     | TREET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088                   | <del></del>            |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ULD BE                 | (X5)<br>COMPLETION<br>DATE |
| F 309                    | c/o (complaints of)<br>chest pain or dizzin<br>On 1/9/04 at 10:00<br>documented the fol<br>Nursing Care Reco<br>edema [and] [zero]                        | rd, "Pt (patient) has [zero] SOB(shortness of breath), ess."  AM, a facility nurse lowing on the "24 Hour rd, "Pt (patient) has [zero] c/o (complaints of) pain SOB   | F 309             | •   |   |                        |                            |
|                          | documented the fol<br>Nursing Care Reco<br>yelling. Zero urinar<br>1-9-04 to 2230 (10:<br>physician] informed<br>[unreadable] Sig (?<br>There was no docu | eveyard nurse for 1/9/04 slowing on the "24 Hour and,"Intermittent sleep [with] by output since 0500 (5:00 AM) 30 PM) 1-9-04. [resident 22's and of this by phonePT significant) oral bleeding." Intermediate and also informed the physician               |                   |     |   |                        |                            |
|                          | resident CL2's med  | mentation of an injury in<br>lical record that would have<br>ling from her mouth.   | -                 |     |   |                        |                            |
|                          | The January 2004<br>administration reco<br>CL2 received her C<br>5:30 PM.   | MAR (medication ord) documented that resident Coumadin 2.5 mg on 1/9/04 at  |                   |     |   |                        |                            |
|                          | from resident CL2, count), BMP (basic PT/INR. Resident count was 16.4. Thigh per the labora Resident CL2's PT her INR was 8.5 se                          | specimens were collected, for a CBC (complete blood metabolic panel) and a 22's WBC (white blood cell) he WBC count was deemed tory utilized by the facility. I level was 34.2 seconds and econds. These PT/INR results cally high per the laboratory, ity. |                   |     |   |                        |                            |

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

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BU             | IULTIPLE CON<br>LDING | NSTRUCTION   |              | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|--|-------------------|-----------------------|--|--------------|-------------------------------|----------------------------|
|                          |   | 465108   | 0. WI             | vu                    |  |              | 2/26                          | 5/2004                     |
|                          | ROVIDER OR SUPPLIER  /ALLEY HEALTH CEN  | ITER   |                   | 3706 WES              | DRESS, CITY, STATI<br>ST 9000 SOUTH<br>ORDAN, UT 840         |              |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | X (CR                 | PROVIDER'S PLA<br>EACH CORRECTIVE<br>OSS-REFERENCED<br>DEFIC | E ACTION SHO | ULD BE                        | (X5)<br>COMPLETION<br>DATE |
| F 309                    | Continued From page   | 15   | F 309             |                       |  |              |                               |                            |
|                          | On 1/10/04, a facility following in a nursing confusion WBC [indicalled to [resident 2] assistant] pt (patient po (by mouth) [even old dried blood compacturately assess appears to be gumes [resident 22's physic [with] above assess return ca!! yet" The evidence that the fact 22's physician of the The January 2004 NCL2 received her Compact to 1/11/04 Courading until furth vitamin K 10 mg sull the physician also of CL2's PT/INR on 1/11/04 at 10:00 documented the following the control of the couraging that the couraging t | y nurse documented the g progress note, "[increased] reased] 16.4 [and] results 2's physician and physician's t) started on Levaquin 250 mg y] day [times] 5 daysPt has ing from oral cavity, unable to ource of bleeding, but or sores on lipsCall into cian and physician's assistant] ment; left message [and] no here was no documentation to cility nurse informed resident or critically high PT/INR.  MAR documented that resident ournadin 2.5 mg on 1/10/04 at boratory test values, facility sician telephone order the to hold resident CL2's her notice and to administer ocutaneous times one now. Ordered to recheck resident 12/04 and 1/14/04.  On 1/11/04. Due to her death, thable to recheck the PT/INR 1/04.  AM, a facility nurse owing in a nursing progress |                   |                       |  |              |                               |                            |
|                          | labs see T.O. (telept<br>order) family notified   | (medical doctor) abnormal hone order) for N.O. (nursing f. Res (resident) condition th) intake unresponsive to request hospice"  |                   |                       |  |              |                               |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BU             | ILDII |   | (X3) DATE SU<br>COMPLE |                            |
|--------------------------|--|---|-------------------|-------|---|------------------------|----------------------------|
|                          |  | 465108  | B. WII            | NG.   |   | 2/26                   | /2004                      |
|                          | ROVIDER OR SUPPLIER  | ITER  | -                 | ;     | REET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088                    | ·                      | ·                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                 | (X5)<br>COMPLETION<br>DATE |
| F 309                    | On 2/26/04 at 2:45 caring for resident of found the laborators the critical PT/INR substituting further stated that the physician had been on 1/10/04, so he corder to hold the Covitamin K. The factoresident CL2 had substituting to On 2/26/04 at 3:15 worked for the laborator facility, was intervies stated the laborator facility staff member CL2's high critical value 1/10/04. She further collected a PT/INR 12/26/03 and 1/10/04 assistant was intervited intercranial hemorrholeeding from the named Coumadin therapy, Resident CL2's phend informed of any ora 2. Resident 16 was 7/12/03 with diagnost the control of the control of the control of the control of the course of th | PM, the facility nurse who was CL2 on 1/11/04, stated that he y results dated 1/10/04, with sitting on the nurse's desk. Henere was no evidence that the notified of the critical PT/INR alled the physician and got the burnadin and administer the difficult nurse further stated that borne bleeding coming from her igh INR and that could have the bleeding.  PM, a representative that ratory service, utilized by the wed over the phone. She y had documented that a rewas informed of resident values of the PT/INR on the stated that the lab had for resident CL2 on 12/24/03, 04.  PM, resident CL2's physician's viewed. He stated that the lab had for resident CL2 on 12/24/03, 04.  PM, resident CL2's physician's viewed. He stated that the lab had inal bleeding as well as naging. When asked if nouth was a complication of the stated it could be yesician's assistant stated that ing informed of the PT/INR or could he recall being at bleeding. | F 309             |       |   |                        |                            |

|                          | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BU             | ILDING |   | -                  | (X3) DATE SI<br>COMPLE |                            |
|--------------------------|--|---|-------------------|--------|---|--------------------|------------------------|----------------------------|
|                          |  | 465108  | B. Wil            | NG     |   |                    |                        |                            |
|                          | ROVIDER OR SUPPLIER  | NTER  |                   | 37     | EET ADDRESS, CITY, STATE, ZIP 1<br>706 WEST 9000 SOUTH<br>VEST JORDAN, UT 84088       | CODE               |                        | ·                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | 1      | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOU<br>HE APPR | JLD BE                 | (X5)<br>COMPLETION<br>DATE |
| F 309                    |  | e 17<br>t 16's admission orders, dated<br>ne following: Speech swallow  | F 309             |        |   |                    |                        |                            |
|                          | due to a fall which r<br>The re-admission o  | nt 16 was seen at a hospital esulted in a left rib fracture. rders, revealed the following: ald benefit from chin tuck.   |                   |        | ·   |                    | ÷                      | -                          |
|                          | following order, "sw   | nt 16's physician wrote the allowing evaluation ondary to difficulties while  |                   |        |   | <i>,</i>           |                        |                            |
|                          |  | mentation in resident 16's swallow evaluation being   |                   |        | ·   |                    |                        |                            |
|                          | the facility was inter   | AM, a physical therapist at viewed. He stated he had not sident 16 needed a swallow   |                   |        | :   | •                  |                        |                            |
|                          | nurses) stated that<br>resident 16's medic<br>speech evaluation.<br>that she contacted the<br>speech therapist did | 5 AM, the DON (director of she had looked through al record and could not find a At 12:15 PM, the DON stated the speech therapist and the d not have any documented allow evaluation had been ent 16. |                   |        |   |                    |                        |                            |
|                          | facility on 12/17/03 obesity, hypertensic  | s originally admitted to the with diagnosis which included on, diabetes, sleep apnea, tis, edema, muscle spasms   |                   |        |   |                    |                        |                            |
|                          |  | t 22's physician wrote the<br>Start bladder training-   |                   |        |   |                    |                        |                            |

| NAME OF PROVIDER OR SUPPLIER  SOUTH VALLEY HEALTH CENTER  SUMMY STATELENT OF DESIGNOUS PRIERTX TAG  CASH D SUMMY STATELENT OF DESIGNOUS PRIERTX TAG  CONTINUED FOR THE PROVIDER SUMMY STATELENT OF DESIGNOUS PRIERTX TAG  CONTINUED FOR THE PROVIDER FLANOF CORRECTION (EACH OD RECTIVE ACTIONS SHOULD BE clamp/unclamp catheter [every] hr (hour) [times] 24, then [every] 2 [hours times] 24 [hours] [then [every] 4 [hours] - then dc (discontinues).  Based on the 2/11/04 physician's order, resident 22 should have had her indivelling catheter discontinued on 2/14/04.  Fresident 22 was observed by a nurse surveyor on 2/23/04 and 2/24/04, with her indivelling catheter still in place.  On 2/24/04 at 1:00 PM, resident 22 was interviewed. He stated that he don know resident 22 was to begin a bladder retraining on 2/11/04. He further stated that he would call resident 22 stated that facility staff members have come at different times and clamped the indivelling catheter and then come back and unclamp it. Resident 22 further stated that she did not know when the indivelling catheter would be discontinued.  On 2/24/04 at 1:30 PM, the DON stated that she worked on 2/20/04 and found the order for resident 22's bladder retraining on 2/11/04. The DON further stated that she could not find any documentation that the bladder retraining was done so she initiated the schedule of clamping and un-clamping the indivelling catheter on 2/20/04 gl days after the physician wrote the order). When the DON was asked why the indivelling catheter was not discontinued on 2/20/04 the DON replied that she did not know and now the retraining would have to start all over again.  |        | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BU | MULTIPLE CONSTRUCTION ILDING                  | (X3) DATE S<br>COMPL              |            |
|--|--------|--|--|-------|---|-----------------------------------|------------|
| SOUTH VALLEY HEALTH CENTER    CACH DE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   DEFICIENCY MUST BE PRECEDED BY FULL TAG   TAG   CROSS-REFERENCE TO THE APPROPRIATE   |        |  | 465108   | B. Wi | NG  | 2/20                              | 5/2004     |
| Final Tag  REGULATORY OR USC IDENTIFYING INFORMATION)  F 309  Continued From page 18  clamp/unclamp catheter [every] hr (hour) [times] 24, then [every] 2 [hours] then de (discontinue).  Based on the 2/11/04 physician's order, resident 22 should have had her indivelling catheter discontinued on 2/14/04.  Resident 22 was observed by a nurse surveyor on 2/23/04 and 2/24/04, with her indivelling catheter still in place.  On 2/24/04 at 12:55 PM, the RN (registered nurse) caring for resident 22 was interviewed. He stated that he did not know resident 22's physician to find out what to do next.  On 2/24/04 at 1:00 PM, resident 22 stated that facility staff members have come at different times and clamped the indivelling catheter and then come back and unclamp it. Resident 22 further stated that she did not know when the indivelling catheter would be discontinued.  On 2/24/04 at 1:30 PM, the DON stated that she worked on 2/20/04 and found the order for resident 22's bladder retraining on 2/11/04. The DON further stated that she did not flow or so she initiated the schedule of clamping and un-clamping the indivelling catheter on 2/20/04 (aday attert the physician wrote the order). When the DON replied that she did not know was asked why the indivelling catheter was not discontinued to a 2/23/04, the DON replied that she did not know and now the retraining would all resident asked with the indivelling catheter was not discontinued to a 2/23/04, the DON replied that she did not know and now the retraining would be discontinued to a 2/23/04, the DON replied that she did not know and now the retraining would all residuant and un-clamping the indivelling catheter was not discontinued to a 2/23/04, the DON replied that she did not know and now the retraining would have to start all over |        |  | ITER   |       | 3706 WEST 9000 SOUTH                          | CODE                              |            |
| clamp/unclamp catheter [every] Ir (hour) [times] 24, then [every] 2 [hours times] 24 [hours] then [every] 4 [hours] - then do (discontinue) "  Based on the 2/11/04 physician's order, resident 22 should have had her indwelling catheter discontinued on 2/14/04.  Resident 22 was observed by a nurse surveyor on 2/23/04 and 2/24/04, with her indwelling catheter still in place.  On 2/24/04 at 12:55 PM, the RN (registered nurse) caring for resident 22 was interviewed. He stated that he did not know resident 22 was to begin a bladder retraining on 2/11/04. He further stated that he would call resident 22's physician to find out what to do next.  On 2/24/04 at 1:00 PM, resident 22 stated that facility staff members have come at different times and clamped the indwelling catheter and then come back and unclamp it. Resident 22 further stated that she did not know when the indwelling catheter would be discontinued.  On 2/24/04 at 1:30 PM, the DON stated that she worked on 2/20/04 and found the order for resident 22's bladder retraining on 2/11/04. The DON further stated that she could not find any documentation that the bladder retaining was done so she initiated the schedule of clamping and un-clamping the indwelling catheter on 2/20/04 (9 days after the physician wrote the order). When the DON was asked why the indwelling catheter was not discontinued on 2/23/04, the DON replied that she did not know and now the retraining would have to start all over  | PREFIX | (EACH DEFICIENCY   | MUST BE PRECEEDED BY FULL  | PREF  | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1 | TION SHOULD BE<br>THE APPROPRIATE | COMPLETION |
|  | F 309  | clamp/unclamp cath 24, then [every] 2 [h [every] 4 [hours] - th Based on the 2/11/6 22 should have had discontinued on 2/1 Resident 22 was obon 2/23/04 and 2/24 catheter still in place On 2/24/04 at 12:55 nurse) caring for resistated that he did no begin a bladder retristated that he would to find out what to do On 2/24/04 at 1:00 facility staff member times and clamped then come back and further stated that slindwelling catheter worked on 2/20/04 at 1:30 fworked on 2/20/04 aresident 22's bladded DON further stated documentation that done so she initiated and un-clamping the 2/20/04 (9 days after order). When the Doindwelling catheter would now the retraining and now the retraining the 2/23/04, the DON reand now the retraining the 2/23/04 the 2/23/04, the 2/23/04 th | neter [every] hr (hour) [times] hours times] 24 [hours] then hen dc (discontinue)."  24 physician's order, resident her indwelling catheter 4/04.  served by a nurse surveyor 4/04, with her indwelling e.  25 PM, the RN (registered sident 22 was interviewed. He of know resident 22 was to aining on 2/11/04. He further I call resident 22's physician or next.  26 PM, resident 22 stated that its have come at different the indwelling catheter and if unclamp it. Resident 22 he did not know when the evold be discontinued.  27 PM, the DON stated that she and found the order for it retraining on 2/11/04. The that she could not find any the bladder retaining was did the schedule of clamping indwelling catheter on it the physician wrote the ON was asked why the was not discontinued on plied that she did not know | F 309 |   |                                   |            |

|                          | T OF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER.   | A. BU             | ILDI |   | (X3) DATE S<br>COMPLE |                            |
|--------------------------|--|---|-------------------|------|---|-----------------------|----------------------------|
|                          |  | 465108  | B. Wi             | NG _ |   | 2/20                  | 5/2004                     |
|                          | ROVIDER OR SUPPLIER  | ITER  |                   | 3    | REET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088              |                       | -                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE              | (X5)<br>COMPLETION<br>DATE |
| F 309                    | 1/4/04, with the diagosteoporosis, renal  A physician order for documented, "[char [change] foley to Ba [change] Q (every) of the commented of | radmitted to the facility on gnoses of reflux, neuropathy, failure, and hypothyroidism.  or resident 47, dated 1/21/04 age] foley today, within 1 week ard Silver Impregnated,  | F 309             |      |   |                       |                            |
|                          | [change] Q month."  A treatment sheet for  | or resident 47, dated 1/04<br>catheter change was   |                   |      |   |                       |                            |
|                          | 2004, documented a completed on 2/4/04 Based on the physic resident 47 should h  | or resident 47, dated February a foley catheter change was 4. sian order dated 1/21/04, have had her indwelling the Bard Silver Impregnated   | e e               |      |   |                       |                            |
|                          | catheter by 1/28/04.   | There was no documented 47's medical record that the  |                   |      |   |                       |                            |
|                          | director of nurses) a manager were inten Bard Silver Catheter. The central supply resurveyors the invoice catheter was ordered the physician ordered (the same day). The stated that the median  | AM, the ADON (assistant and the central supply viewed. They stated that the rewas ordered on 1/29/04. In an ager brought the e which documented that the don 1/29/04 (10 days after ed it) and shipped on 1/29/04 e central supply manager also cal supply company used, theter would arrive in 3-4 |                   |      |   |                       |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | A BU              | AULTIPLE CONSTRUCTION   |                        | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|---|-------------------|---|------------------------|-------------------------------|----------------------------|
|  |  | 465108  | B. WI             | NG  | -                      | 2/26                          | 5/2004                     |
|  | PROVIDER OR SUPPLIER   | NTER  |                   | STREET ADDRESS, CITY, STATE, Z<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088 |                        |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |   | CTION SHOU<br>THE APPR | JLD BE                        | (X5)<br>COMPLETION<br>DATE |
| F 309  | working days. Mak  | ing the delivery date of the 04 or 2/3/04. The catheter   | F 309             |   |                        |                               |                            |
|  | dated 2/4/04 docum   | none order for resident 47<br>nented, "UA/C&S (urinary<br>e and sensitivity) to rule out<br>fection)."  |                   |   |                        |                               |                            |
|  |  | esident 47, dated 2/4/04, prior<br>being inserted, documented<br>S to rule out UTI."  |                   |   |                        |                               | ÷.                         |
|  |  | mented that the lab was at 2:00 PM and was faxed to ian.  |                   |   |                        |                               |                            |
|  | dated 2/5/04, docum<br>(milligrams) PO (by<br>(times) 10 days for (intravenously) QD | one order for resident 47,<br>nented "Macrobid 100 mg<br>mouth) BID (twice a day) X<br>UTI, Vancomycin 1 gram iV<br>(every day) X 3 days for UTI,<br>00 mg IV Q (every) 8 [hours] X |                   |   |                        |                               |                            |
|  | 6:00 PM documente<br>Macrobid 100 mg P<br>Vancomycin 1 gram                          | sident 47, dated 2/5/04 at<br>ed "[physician] ordered<br>O BID X 10 days for UTI,<br>IV QD X 3 days for UTI, et<br>Q 8 [hours] X 10 days for  |                   |   |                        | · ,                           |                            |
| F 326<br>SS=D  |  | 's comprehensive<br>fility must ensure that a<br>therapeutic diet when there is   | F 326             |   |                        | ·                             |                            |

| STATEMEN<br>AND PLAN     | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | A. BU             | (X2) MULTIPLE CONSTRUCTION (X3) DATE ST COMPLE A. BUILDING |   |   |                    |  |
|--------------------------|--|---|-------------------|--|---|---|--------------------|--|
|                          |  | 465108  | B. WI             | ING  |   | 2/26  | /2004              |  |
|                          | PROVIDER OR SUPPLIER   | NTER  |                   |  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088<br>PROVIDER'S PLAN OF CORRE   | CTION   | (X5)               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | FIX  | (EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)  | OULD BE   | COMPLETION<br>DATE |  |
| F 326                    | This REQUIREMED by:  Based on observate record review, it was a neutrition of the resident receives the resident receives the resident 22 expensed a low albuminant did not receive the facility's regist.  Findings include:  1. Resident 22 was facility on 12/17/0 on 2/5/04 with dia hypertension, dial osteoarthritis, edeconstipation.  Resident 22 was wound that was in resistant staphylo (vancomycin resident 24/12/04 shound indicator of mainural albumin level of 3 visceral protein decomposition of Clinical Association, 6the constipation.  There were no decomposition of the resident 22's medietary physician. | tion, interviews and medical as determined that for 1 of 15 the facility did not ensure that wed a therapeutic diet when onal problem as evidenced by: rienced a significant weight loss, level and an abdominal wound e a diet as recommended by ered dietitian.  as originally admitted to the 3 and re-admitted to the facility gnosis which included obesity, betes, sleep apnea, anemia, ema, muscle spasms and admitted with an abdominal admitted with MRSA (methicillin coccus aureus) and VRE stant enterococcus).  value taken at the facility and by the facility and cowed an albumin (a protein utrition) level of 3.3 g/dl. An albumin (a protein utrition) level of 3.3 g/dl. | F 326             |  | The person responsible for weigh residents and recording their weight received discipline for failure to record the weight of all residents. The Dietary Manager has receive for failure to communicate neces information to the Registered Die Policy and procedures have been a weekly meeting to communicate the nursing dept, dietary dept, and dept. This meeting is to identify residents who are nutritionally at communicate their additional received from each department, both to the department and to the Registered Consultant.  Minutes of the meeting shall be the DON, and Administrator as participants.  Results of the meetings shall be the QA committee at their regulations. | ghts has weigh and as required. d discipline sary etitian. n written for e between d therapy those risk, and juirements e I Dietitian provided to well as the | 4/19/04            |  |

| STATEMEN<br>AND PLAN     | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BU             | HEDI |   | (X3) DATE S<br>COMPLI |                            |
|--------------------------|--|---|-------------------|------|---|-----------------------|----------------------------|
|                          |  | 465108  | B. W              |      |   |                       | 6/2004                     |
|                          | PROVIDER OR SUPPLIER   | NTER  |                   | :    | REET ADDRESS, CITY. STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088              |                       |                            |
| (X4) ID<br>PREFIX<br>TAG | ALVOR DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREI<br>TAG | FIX  | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE              | (X5)<br>COMPLETION<br>DATE |
| F 326                    | calorie diet.  On 2/24/04 at 11:0 dietitian) stated that albumin of 3 3 g/dl asked about reside that on the 12/18/0 the weight of 384 l stay that resident? When the RD was resident 22, the RRD further stated recorded on the "Comeet resident 22's the decreased alb wound she would intake.  On 2/24/04 at 12:1 obtained resident (This represented 2 month period, where the following: Kcal needs = 261 maintenance. Protein needs = 1 and repletion.  An SNP (special soft, NAS (no add concentrated swedlass of milk three.) | e 22 esident 22 was on a 1500  O AM, the RD (registered at she was not aware of the on 2/12/04. When the RD was ent 22's weight, the RD stated 3 assessment she obtained bs (pounds) from a hospital 22 had in December of 2003. asked for a current weight on D was unable to find one. The that the 1500 calorie diet Change of Diet" slip would not a protein needs and that due to umin and infected abdominal not restrict resident 22's caloric 30 PM, the RD reported that she 22's weight and it was 339 lbs. a 45 lb (11.7%) weight loss in a which was significant).  atted that due to the low albuminal wound and weight loss, she dations and handed the nurse sees of paper, which documented 0 calories per day for 31 grams per day for healing nutritional program) mechanicated salt) and NCS (no sets) diet with an 8 oz (ounce) e times a day with meals. |                   | 6    |   |                       |                            |

PRINTED: 3/4/2004 FORM APPROVED OMB NO. 0938-0391

| CENTER            | RS FOR MEDICARE  | & MEDICAID SETTIOES   |                    |       | <u> </u>   | T.,,              | CHDVEV                     |
|-------------------|--|---|--------------------|-------|--|-------------------|----------------------------|
|                   | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A, BUII            | LDING | CONSTRUCTION   | (X3) DATE<br>COMP |                            |
|                   |  | 465108  | B. WIN             |       |  |                   | 26/2004                    |
|                   | ROVIDER OR SUPPLIER  | NTER  |                    | 3706  | - ADDRESS, CITY, STATE, ZIP COI<br>West 9000 South<br>It Jordan, UT 84088    | DE                |                            |
| (X4) ID<br>PREFIX | SUMMARY STA  | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG | ıx    | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE | SHOULD BE         | (X5)<br>COMPLETION<br>DATE |
| TAG               | REGULATORY ON E  | SO IDENTIA TWO  |                    |       | DEFICIENCY)  | ·_                |                            |
| F 326             | Diet* slip dated 2/5, calorie diet, that the resident 22 with the The RD documente her meals and rece of protein per day. resident 22 require to promote would hon 2/25/04 at 8:05 observed to receive a SNP dimeals. Resident 2 water, coffee, creat piece of wheat to  | even though the "Change of 704, documented a 1500 of facility had been providing a SNP, NCS, NAS diet. The RD calculated that d 131 grams of protein per day realing and repletion.  AM, resident 22 was a her breakfast tray. A dietary are tray indicated that she was retained a glass of milk with her 2's meal consisted of juice, m of wheat, 1 hard boiled egg, ast and an orange slice. | F 326              |       |  |                   |                            |
|                   | stated that anyone<br>have received supe<br>protein milk) on the<br>Besident 22 was n  | AM, the DM (dietary manager) on an NCS - SNP diet would er cereal (oatmeal with high eir breakfast tray.  |                    |       |  |                   |                            |
|                   | the super cereal will 2/25/04.   | ith her breakfast tray on   |                    |       |  |                   |                            |
|                   | On 2/25/04 at 8:40 stated that residen because she does  | AM, a facility nursing assistant<br>t 22 never eats the hot cereal<br>not like it.  |                    |       |  |                   |                            |
|                   | observed to receive meal consisted of a pears, rice, meat with the milk of wheat bread with the milk of the milk o | 5 PM, resident 22 was e her lunch tray. Resident 22's milk, water, juice, green jello, vith gravy, carrots and a piece h butter. Resident 22 drank water and juice. Resident 22 en jello, 10% of the rice, 10% of   |                    |       |  |                   |                            |

Event ID: APX611

|                          | ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |   |                                 | ITE SURVEY<br>IMPLETED     |
|--------------------------|--|--|---|---|---|---------------------------------|----------------------------|
|                          |  | 465108   | B. WII                                  | NG  |   |                                 | 2/26/2004                  |
|                          | ROVIDER OR SUPPLIER  | NTER   |   | STREET ADDRESS, CITY, STATE, ZIP COI<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088 |   | CODE                            | ·                          |
| (X4) iD<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                       |   | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | TON SHOULD BE<br>THE APPROPRIAT | (X5)<br>COMPLETION<br>DATE |
| F 326                    | of the pears.  On 2/25/04 at 12:15 lunch residents on received SNP pudd milk and sugar free trays.  Resident 22 was no pudding with her luid During the meal ob 22 was not observed was not observed to breakfast meal and | 7, 10% of the carrots and none 5 PM, the DM stated that for a NCS - SNP diet would have ling (sugar free pudding, whole instant breakfast) on their of observed to receive the SNP | F 326                                   |   |   |                                 |                            |
| F 354<br>SS=C            | resident 22 had bee DM further stated the resident 22's nutritions and not let the Frefusing the SNP d mind."  483.30(b)(1)-(3) NUExcept when waive this section, the face   | ed under paragraph (c) or (d) of<br>cility must use the services of a<br>r at least 8 consecutive hours  | F 354                                   | ·   |   |                                 |                            |
|                          | this section, the fac<br>registered nurse to<br>nursing on a full tin  | ed under paragraph (c) or (d) of cility must designate a serve as the director of the basis.   |   |   |   |                                 |                            |

| CENTER                   | S FOR MEDICARE   | & MEDICAID SERVICES  | <del>-</del>      |       |  | (X3) DATE SU   | IRVEY                      |
|--------------------------|--|--|-------------------|-------|--|--|----------------------------|
| STATEMENT                | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BU             | 1LDIN | IPLE CONSTRUCTION  | COMPLE   | TED                        |
|                          |  | 465108   | B. WI             |       |  | 2/26   | /2004                      |
|                          | ROVIDER OR SUPPLIER  | NTER   |                   | 3     | REET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENCY   | MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | X     | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | ULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 354                    | This REQUIREME by: Based on the revie February of 2004, interview with the I was determined the a charge nurse to Findings include: Review of the nurse February documents scheduled to work 2/14/04, 2/15/04, On 2/24/04 at 1:30 that she worked of 2/20/04. On 2/25/04.  | e facility has an average daily fewer residents.  NT is not met as evidenced who of the Staffing Schedule for the census of 64 and an Director Of Nursing (DON), it at the facility used the DON as work the floor.  Sing schedule for the month of the thor as a charge nurse on 2/21/04 and 2/22/04.  OPM, the facility DON stated in the floor as the RN on 04 at 11:10 AM, The DON also been scheduled to work the | F 354             | 1     | The DON has been ordered to ce functioning as a charge nurse and employed staff is not adequate, to services of temporary nurses, unti staff can be recruited. The facilit currently attempting to recruit ade nurses, even though there is a known shortage of qualified nurses in the Results of the recruiting campaig amount of agency staff used shall reported to the QA committee by at regular meetings. | if obtain the il adequate y is ditional own e area. n and the be | 4/19/04                    |
| F 360<br>SS=D            | The facility must prourishing, palata meets the daily nuneeds of each research research for the second palata meets the daily nuneeds of each research for this REQUIREMID by:  Based on intervier observations, it will did not ensure research for the second palata f | provide each resident with a<br>ble, well-balanced diet that<br>utritional and special dietary   | F 36              | 00    |  |  |                            |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) N<br>A. BU   |      | TIPLE CONSTRUCTION   | (X3) DATE S<br>COMPLE   |                            |
|--------------------------|--|---|-------------------|------|--|---|----------------------------|
|                          |  | 465 <b>108</b>  | B. WI             | NG _ |  | 2/26  | 5/2004                     |
| NAME OF P                | ROVIDER OR SUPPLIER  |   | <u> </u>          | ł    | REET ADDRESS, CITY, STATE, ZIP CODE  | <u> </u>  |                            |
| SOUTH \                  | VALLEY HEALTH CE   | NTER  |                   | i    | 8706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHOT<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | ULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 360                    | malnutrition and an no documented die to ensure she recei nutritional needs.  Findings include:  1. Resident 22 was facility on 12/17/03 on 2/5/04 with diagrhypertension, diabe osteoarthritis, edem constipation.  Resident 22 was ac open abdominal wo MRSA (methicillin naureus) and VRE (venterococcus).  An initial nutritional was completed by the 12/18/03. The RD's an SNP (special nutadded salt) and NC diet. The RD docur 100% of her meals, resident 22's curren and that resident 22's curren and that resident 22's Kcal (ca) 3234 calories per da were 120 grams per There were no othe | open abdominal wound, with tary intervention implemented wed a diet that would meet her originally admitted to the and re-admitted to the facility nosis which included obesity, tes, sleep apnea, anemia, ia, muscle spasms and limitted and readmitted with an und that was infected with esistant staphylococcus rancomycin resistant assessment for resident 22 ne RD (registered dietitian) on a recommendations included tritional program), NAS (no S (no concentrated sweets) mented that resident 22 ate. The RD documented that tweight was 384 lbs (pounds) thad an abdominal wound E. The RD documented that calorie) needs were 2760 - ay and that her protein needs or day. | F 360             |      | Policy and procedures have been wa weekly meeting to communicate the nursing dept, dietary dept. and dept. This meeting is to identify the residents who are nutritionally at ricommunicate their additional requifrom each department, both to the department and the registered dieticonsultant.  Both the Dietary manager and the presponsible for weighing residents disciplined for failure to do their justification for the meeting shall be prothed DON and the Administrator as the participants.  Results of the meetings shall be prothed QA committee at their regular in the process. | between therapy hose isk and irements tian person have been obs and ovided to well as | 4/19/04                    |
| !                        | There were no docu<br>22 in her medical re   | mented weighs for resident cord.  |                   |      |  |   |                            |

| CENTER                   | S FOR MEDICANE   | & MEDICAID SERVICES  |                     | <del></del>   | (X3) DATE S | URVEY           |
|--------------------------|--|--|---------------------|---|-------------|-----------------|
| STATEMENT                | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | A. BUILDI           |   | COMPL       | ETED            |
|                          |  | 465108   | 1                   |   |             | 6/2004          |
| NAME OF P                | ROVIDER OR SUPPLIER  |  | ;                   | REET ADDRESS. CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH                                       | <u>:</u>    |                 |
| SOUTHV                   | ALLEY HEALTH CE  | NTER   |                     | WEST JORDAN, UT 84088   | CCTION      | (X5)            |
| (X4) ID<br>PREFIX<br>TAG | (TACH DEELCIENCY   | ATEMENT OF DEFICIENCIES  / MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOOLD RE    | COMPLETION DATE |
| F 360                    | Continued From pag   | je 27  | F 360               |   |             |                 |
| F 360                    | Resident 22's med dietary physician of dated 2/5/04, in redocumented that in calorie diet. The Fresident 22 required day. The diet provinceting the calorie on 12/18/03.  A lab (laboratory) dated 2/12/04 sho indicator of malnual bumin level of 3 visceral protein de Manual of Clinical Association, 6th e On 2/24/04 at 11: had not re-assess needs when she vafter a hospital stashe was not awar 2/12/04. When the 22's weight, the Fassessment she (pounds) from a hin December of 2 for a current weight unable to find one 1500 calorie diet Diet" slip would in needs and that dinfected abdomin resident 22's calorie calo | fical record did not contain a order. A "Change of Diet" slip, sident 22's medical record, resident 22 was on a 1500 RD calculated on 12/18/03, that ed 2760 to 3234 calories per vided to resident 22 was not re needs the RD had calculated en albumin (a protein trition) level of 3.3 g/dl. An .0- 3.5 g/dl is considered a mild eficit. (Reference guidance: Dietetics, American Dietetic edition, 200, page 22).  On AM, the RD stated that she sed resident 22's nutritional was re-admitted to the facility ay. The RD further stated that re of the albumin of 3.3 g/dl on the RD was asked about resident RD stated that on the 12/18/03 obtained the weight of 384 lbs mospital stay that resident 22 had get on resident 22, the RD was en. The RD further stated that the recorded on the "Change of the recorded on the "Change of the resident 22's protein we to the decreased albumin and all wound she would not restrict oric intake. The RD also stated fected abdominal wound she | d  <br>e  <br>d     |   |             |                 |
|                          | would recommer<br>and vitamin C.   | nd that resident 22 receive zinc   |                     |   |             |                 |

| STATEMEN                 | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BUI            | LDING |   | (X3) DATE SU<br>COMPLE       | TED                        |
|--------------------------|--|--|-------------------|-------|---|------------------------------|----------------------------|
|                          |  | 465108   | B. WII            | VG    |   |                              | /2004                      |
|                          | ROVIDER OR SUPPLIER  | NTER   |                   | 370   | ET ADDRESS, CITY, STATE, ZIP CO<br>06 WEST 9000 SOUTH<br>EST JORDAN, UT 84088             | ODE                          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)  | 1D<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 360                    | obtained resident 2 (This represented 2 month period, where The RD further state infected abdominated made recommend surveyor four pieces the following:  Kcal needs = 2610 maintenance.  Protein needs = 13 and repletion.  An SNP mechanican 8 oz (ounce) glywith meals. | e 28 0 PM, the RD reported that she 22's weight and it was 339 lbs. a 45 lb (11.7%) weight loss in a nich was significant).  Ited that due to the low albumin, I wound and weight loss, she ations and handed the nurse es of paper, which documented 0 calories per day for 31 grams per day for healing cal soft, NAS and NCS diet with ass of milk three times a day a to include a protein snack and | F 360             |       |   |                              |                            |
|                          | Diet" slip dated 2/5 calorie diet, that the resident 22 with the The RD document her meals and recoff protein per day resident 22 requires to promote would  | at even though the "Change of 5/04, documented a 1500 ne facility had been providing ne SNP, NCS, NAS diet.  Ited that resident 22 ate 100% of beived approximately 130 grams.  The RD calculated that need 131 grams of protein per day healing and repletion.  |                   |       |   |                              |                            |
|                          | observed to receive a SNP meals. Resident water, coffee, cre   | ve her breakfast tray. A dietary 22's tray indicated that she was diet and a glass of milk with her 22's meal consisted of juice, am of wheat, 1 hard boiled egg, toast and an orange slice.   |                   |       |   |                              |                            |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A, BU   | ILDIN |  | <del></del> - | (X3) DATE<br>COMP | SURVEY<br>LETED            |  |
|--------------------------|--|---|---|-------|--|---------------|-------------------|----------------------------|--|
|                          |  | 465108  | B. WII  | NG _  |  | - — —         | 2/:               | 26/2004                    |  |
|                          | ROVIDER OR SUPPLIER  /ALLEY HEALTH CEN   | NTER  | STREET ADDRESS, CITY, STATE, ZIP COD<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088 |       |  |               | E                 |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG   |       | PROVIDER'S PLA<br>(EACH CORRECTIV<br>CROSS-REFERENCE<br>DEFI | 'E ACTION SHO | DULD BE           | (X5)<br>COMPLETION<br>DATE |  |
| F 360                    | Continued From page  | 29  | F 360   | )     |  |               |                   |                            |  |
|                          | stated that anyone   | AM, the DM (dietary manager)<br>on an NCS - SNP diet would<br>or cereal (oatmeal with high<br>ir breakfast tray.  |   |       |  |               |                   |                            |  |
| ·                        |  | ot observed to receive milk or<br>h her breakfast tray on   |   |       |  |               |                   |                            |  |
|                          |  | AM, a facility nursing assistant<br>22 never eats the hot cereal<br>not like it.  |   |       |  |               | -                 |                            |  |
|                          | observed to receive<br>meal consisted of m<br>pears, rice, meat wi<br>of wheat bread with<br>100% of the milk, w<br>ate 100 of the green | 5 PM, resident 22 was her lunch tray. Resident 22's hilk, water, juice, green jello, th gravy, carrots and a piece butter. Resident 22 drank rater and juice. Resident 22 higello, 10% of the rice, 10% of the carrots and none | -   |       |  |               | <br>              |                            |  |
|                          | lunch residents on a received SNP pudd   | 5 PM, the DM stated that for<br>a NCS - SNP diet would have<br>ing (sugar free pudding, whole<br>instant breakfast) cn their  |   |       |  |               |                   |                            |  |
|                          | Resident 22 was no pudding with her lur  | ot observed to receive the SNP och tray on 2/25/04.   |   |       |  |               |                   |                            |  |
|                          | 22 was not observe<br>was not observed to<br>breakfast meal and  | servations on 2/25/04, resident<br>d to receive the SNP diet, she<br>o receive 8 oz of milk with her<br>she was not observed to<br>f either of the meals.   |   |       |  |               |                   |                            |  |
|                          | On 2/25/04 at 12:25  | 5 PM, the DM stated that  |   |       |  |               |                   |                            |  |

Event ID: APX611

| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A. BU             | NULTIPLE CONSTRUCTION REDING  | (X3) DATE SU<br>COMPLET   | RVEY<br>FED                |
|--------------------------|--|--|-------------------|---|---|----------------------------|
|                          |  | 465108   | B. WI             | NG  |   | 2004                       |
|                          | ROVIDER OR SUPPLIER  | NTER   |                   | STREET ADDRESS, CITY, STATE, Z<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088   |   | ·                          |
| (X4) ID<br>PREFIX<br>TAG | TEACH DESIGNENCY   | ATEMENT OF DEFICIENCIES  / MUST BE PRECEEDED BY FULL  LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC | i opoge betebencen it   | OTION SHOULD BE<br>OTHE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE |
| F 360                    | resident 22 had be<br>DM further stated the<br>resident 22's nutritions and did not let the  | ge 30 seen refusing the SNP diet. The sthat she and the RD discussed ional status on 2/24/04, but that RD know resident 22 was diet because "it slipped my   | F 360             |   |   |                            |
| F 364<br>SS=E            | Each resident rece food prepared by value, flavor, and palatable, attractive temperature.  This REQUIREMED by: Based on observation interviews, a conferesidents and temperature food that we temperature.  Findings Include: On 2/23/04 at 7:0 was done with an When asked about the resident state and many times to the residents. When its was done with an work of the resident state and many times to the residents. When its was done with an work of the residents. | O AM, a confidential interview alert and oriented resident. In the temperature of the food, and that the food is not the best the food was cold.  O PM, a confidential group ne with alert and oriented asked about the temperature of of nine residents stated that the |                   | The Dietary Manager weach day in the morning meeting of temperatures of the trays served the pequal number of temper each meal and the tempon the tray. Temperative weekend shall be report Administrator shall ove temperatures for at least week. Daily temperatifor 4 weeks, and from week thereafter, with the from various times of dietary and temperatures of food se reports of temperatures Administrator with the available for inspection management.  The Dietary Manager st temperature samplings at regularly scheduled | s management is taken of 10 per cent previous day with an eratures taken from the eratures of each item tures taken during the ted on Monday. The ersee the taking of the tree meals per tures shall be taken at least 7 meals per the samples coming ay. The lomly sample the erved. Weekly written shall be made to the daily log book at any time by thall report on to the QA committee | 4/19/04                    |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A BU              | MULTIPLE CONSTRUCTION  ILDING  | (X3) DATE S<br>COMPL   |                            |
|--------------------------|--|---|-------------------|--|--|----------------------------|
|                          |  | 465108  | B. WI             | NG   | 2/2  | 6/2004                     |
|                          | PROVIDER OR SUPPLIER   | NTER  |                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |  | HOULD BE   | (X5)<br>COMPLETION<br>DATE |
| F 364                    | was obtained. The kitchen at 12:15 PM taken of the food ar tray. The gravy was the meat was 124.5 rice was 113.5 degrees. The test-12:20 PM. The test-12:20 PM. The temfood and beverage spinach was 106 dewas 101.3 degrees degrees Fahrenheit d | the lunch meal, a test tray test tray was taken from the funchmeage items on the test is 105.8 degrees Fahrenheit, and the rees Fahrenheit.  The lunch meal, a test tray was was taken from the kitchen at aperatures were taken of the items on the test tray. The regrees Fahrenheit, the squash Fahrenheit, the gravy was 106, and the meat was 119.3  RY SERVICES  Te, prepare, distribute, and | F 364             | The Dietary Manager has been indestroy any foods which are out ounlabelled, or unfit for use. Kitchave been in-serviced that person  | f date,<br>then staff<br>al foods are  |                            |
|                          | Based on observation determined that the distribute, serve and conditions as evident beverages which we tabeled and/or dated kitchen and the pant improper sanitizer coused by kitchen staff kitchen.  Findings include:   | on and staff interview, it was facility did not store, prepare food under sanitary iced by: multiple foods and ore either expired and not in the refrigerators in the rry and observation of oncentrations in the solutions in to sanitize and clean the  | ·                 | to be kept in the refrigerator in the room and placing personal items kitchen will result in disciplinary. The Administrator will tour the kit areas and storage areas weekly, for and monthly thereafter to observe | e break in the action. itchen, cool or 8 weeks if sanitary Dietary so observe on the olutions. y the urveys. | 4/19/04                    |

|                          | FOF DEFICIENCIES<br>DE CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | A BU              | ILDING  | · · · · · · · · · · · · · · · · · · ·   | (X3) DATE SU<br>COMPLE   |                            |
|--------------------------|---|---|-------------------|---------|---|--|----------------------------|
|                          |   | 465108  | B WI              | NG      |   | 2/26   | /2004                      |
|                          | ROVIDER OR SUPPLIER   | ITER  |                   | 37      | EET ADDRESS, CITY, STATE, ZIP COD<br>706 WEST 9000 SOUTH<br>PEST JORDAN, UT 84088   |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |         | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)  | SHOULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 37†                    | Continued From page the initial kitchen to 7:00 AM.  In the walk-in refrig a. There was a par which was not tabe b. There was one shad (a staff member. There was a conhad an open crack inches.  d. There was a smithat had a white sultabeled or dated. e. There were 2 pathat had meat in the dated. f. There was one phad "lunch Monday labeled. g. There was half of with the date 2/7 with the date 2/2 with the date 2/2. i. There was one copened and had a j. There was one hand dated 1/8. k. There was one hand dated 1/8. k. There was one base which was one | erator: In with 1/2 sandwiches in it, led or dated. Is mall container of salad, which ers name) on it. Intainer of peanut butter which in the rim approximately 3  all container with a cream lid betance in it, which was not ans, one small and one large erm, which were not labeled or an of meat dated 2/22 and written on it, which was not of one gallon of fat free milk eritten on the lid and Feb. 17 container. At 6:47 AM the er milk out of the refrigerator at 6:50 AM with some milk ainer of tomato juice opened, ontainer of cottage cheese printed date of 2/14. Itead of lettuce which were seen peppers which were container of chicken flavor tened and dated 8/11 and 8/22. | F 371             |         | solutions. The two open areas in the ceilidue to the maintenance departrand repairing the ceiling when occurred from roof leaks, which patched until the outside ambie temperature reached at least 40 Fahrenheit. The repairs were described as possible. The Dietary Manager has recedused iscipline. The Administrator shis surveys of the kitchen area committee at regular meetings. | nent removing e damage had h could not be ent d degrees completed as lived shall report on to the QA |                            |
|                          | n. There was one crusty white substa  | large white bucket that had a unce on the outside, just below   | 1 5               | acilibu | ID: UT0080 If c   | ontinuation sheet  | Page 33 of 52              |

| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BU             | ILDING        | CONSTRUCTION  |  | ATE SURVEY<br>OMPLETED  |         |
|--------------------------|---|--|-------------------|---------------|---|--|-------------------------|---------|
|                          |   | 465108   | B. WI             |               |   |  | 2/26/2004               |         |
|                          | ROVIDER OR SUPPLIER   | NTER   |                   | 3706          | ADDRESS, CITY, STA<br>WEST 9000 SOUTH<br>ST JORDAN, UT 84 | 4088   |                         |         |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | NTEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | ix            | (EACH CORRECTI<br>CROSS-REFERENCI                         | AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) | (X5)<br>COMPLET<br>DATE | TION    |
| F 371                    | o. There was one was opened and d in the dry storage: a. There was one chocolate chips, w b. There was one sauce and beets, in the walk-in free: a. There was one which was not labeled or dated. c. There was one opened, which was opened, which in the kitchen: a. On 2/23/04, the asked to check the solution in both burdes. At 6:32 work counters was both buckets, a te solution for appropriate supervisor taken from the solution. There was one late to the tray line by the ceiling just about the ceiling | not labeled or dated. container of beef base which ated 8/11 and 8/22.  container of semi-sweet hich was not labeled or dated. can of mushrooms, tomato which were dented.  zer: bag of meat that was opened, eled or dated. rown bags, which were not bag of cookie dough that was sont dated. large bag of breadsticks that h was not dated. large bag of breadsticks that h was not dated.  e food service supervisor was e concentration of the sanitizer ackets used to store cleaning, the bucket by the sink was AM the bucket by one of the schecked. During the check of est strip was submerged into the ximately 20 seconds by the food.  When the test strips were lution, they were over 200 ppm, which would indicate too much | i                 |               |   |  |                         |         |
|                          | the kitchen staff v   | why the buckets were there, the water leaking, because the   |                   |               |   |  | - short Dags (          | 74 of 5 |
|                          | 2567/02 00) Previous Versi  | ons Obsolete Event ID: APX   | 611               | . Facility IC | ): UT0080   | it continuation  | on sheet Page 3         | J4 UI 3 |

|                          | IT OF DEFICIENCIES<br>OF CORRECTION        | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                              | 1 ' '             |      | TIPLE CONSTRUCTION   |               | (X3) DATE S<br>COMPLE |                            |
|--------------------------|--|---|-------------------|------|--|---------------|-----------------------|----------------------------|
|                          |  | 405400  | A. BU<br>B. WI    |      | ING  |               | 2/20                  | 5/2004                     |
| NAME OF C                | PROVIDER OR SUPPLIER                       | 465108  |                   | T 63 | TREET ADDRESS, CITY, STAT                                    | TE ZID COOE   | 2/20                  | 72004                      |
| NAME OF F                | NOVIDEN ON SOLVEEL                         |   |                   | i .  | 3706 WEST 9000 SOUTH   | E, ZIF CODE   |                       | :                          |
| SOUTH                    | VALLEY HEALTH CE                           | NTER  |                   |      | WEST JORDAN, UT 84   | 088           |                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                           | ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG | IX   | PROVIDER'S PLA<br>(EACH CORRECTIV<br>CROSS-REFERENCE<br>DEFI | 'E ACTION SHO | ULD BE                | (X5)<br>COMPLETION<br>DATE |
| F 371                    | Continued From page                        | e 34  | F 371             |      |  |               |                       |                            |
|                          | snow is melting."                          |   |                   |      |  |               |                       |                            |
|                          | 2. The following of 2/24/04.               | oservations were made on  | 3                 |      | :  |               |                       |                            |
|                          | In the walk in refrie                      |   |                   |      |  |               |                       |                            |
|                          | In the walk-in refrig<br>a. There was one: | perator:<br>small container of salad half                                       |                   |      |  |               |                       |                            |
|                          | eaten, which had (a                        | a staff members name) on it.  |                   |      |  |               | •                     |                            |
|                          |  | ntainer of peanut butter which in the rim approximately                         |                   |      |  |               |                       |                            |
|                          | 3 inches.                                  |   |                   |      |  |               |                       |                            |
|                          |  | all container with a cream lid  |                   |      |  |               |                       |                            |
|                          | that had a white sul<br>labeled or dated.  | bstance in it, which was not  | <u> </u>          |      |  |               |                       |                            |
|                          | d. One 46 oz. cont                         | ainer of tomato juice opened,   |                   |      |  |               |                       |                            |
|                          | and dated 2/2. e. There was one of         | container of cottage cheese   | -                 |      | ·  |               |                       |                            |
|                          | opened and had a p                         | printed date of 2/14.   | <br> <br>         |      |  |               |                       |                            |
|                          |  | ds of lettuce which were  |                   |      |  |               |                       | ٠.                         |
| +                        | moldy.<br>g. There were 2 gr               | een peppers which were  | i                 |      |  |               |                       |                            |
|                          | moldy.                                     |   |                   |      |  |               |                       |                            |
|                          |  | container of chicken flavor<br>ened and dated 8/11 and 8/22.                    |                   |      |  |               |                       |                            |
|                          | i. There was one la                        | arge white bucket that had a  |                   |      | ·  | •             |                       |                            |
|                          | crusty white substa                        | nce on the outside, just below  |                   |      |  |               | •                     | ·                          |
|                          |  | not labeled or dated. ontainer of beef base which                               |                   |      |  |               |                       |                            |
|                          | was opened and da                          |   |                   |      |  |               |                       |                            |
|                          | In the dry storage:                        |   |                   |      |  |               |                       |                            |
|                          | a. There was one of                        | container of semi-sweet   |                   |      |  |               |                       |                            |
| ;<br>i                   |  | nich was not labeled or dated.  |                   |      |  |               |                       |                            |
|                          | tomato sauce, which                        |   |                   |      |  |               | -                     |                            |
| ļ                        | In the walk-in freeze                      | er:   |                   |      |  |               |                       |                            |
| į                        |  | pag of meat that was opened,  |                   |      |  |               |                       |                            |
|                          | which was not label                        | led or dated.<br>own bags, one opened, which                                    |                   |      |  |               |                       |                            |
|                          | b. There were 2 bit                        | bwn bags, one opened, willon  |                   |      |  |               |                       |                            |

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| STATEMEN                 | IT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) M            | IULTIP | LE CONSTRUCTION  | (X3) DATE SU<br>COMPLET   |                            |
|--------------------------|--|---|-------------------|--------|--|---|----------------------------|
| AND PLAN                 | OF CORRECTION  | IDENTIFICATION NUMBER:  | ł                 | ILDING |  |   |                            |
|                          |  | 465108  | B. WI             |        |  | 2/26/   | 2004                       |
|                          | PROVIDER OR SUPPLIER  VALLEY HEALTH CE   | NTER  | ,                 | 370    | ET ADDRESS, CITY, STATE, ZIP CODE<br>06 WEST 9000 SOUTH<br>EST JORDAN, UT 84088  |   |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |        | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOI<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | JLD BE  | (X5)<br>COMPLETION<br>DATE |
| F 371                    | opened, which wer  | dated. ags of cookie dough that were e not dated. large bag of breadsticks that   | F 371             |        |  |   |                            |
| F 426<br>SS=F            | A facility must prov (including procedu acquiring, receivin administering of all the needs of each.  This REQUIREME by:  Based on interview records and observas determined the pharmaceutical seadministration of desidents. Specificant receive an antitwo other sampled 48) with insulin dereceive the correct the sliding scale as Additionally, stock removed from lab placed in sterile ur Findings include:  1. Resident 48 was 1/2/04 with the diall, Hypothyroidism | ride pharmaceutical services res that assure the accurate g, dispensing, and I drugs and biologicals) to meet resident.  NT is not met as evidenced varion of medication pass, it at the facility did not provide rvices (including the accurate rugs) to meet the needs of its cally, one sampled resident did biotic as ordered (Resident 38), residents (Residents 11 and cendent diabetes did not amount of insulin based upon a ordered by the physician. medications had been eled pharmacy bottles and | F 426             |        | Nurses involved with the imprope administration of insulin and/or faicheck blood sugars as ordered recediscipline and medication error for completed. Licensed nurses were serviced on the proper use of the scale for insulin administration. It will monitor the blood sugar docur daily for all residents with Drs. On blood sugar checks for 4 weeks, ar weekly thereafter for three months the DON determines that random adequate.  All antibiotics will be given within hours of receipt of the Drs. order to unless otherwise specified by the p. Nursing staff has been informed the medications may be dispensed from than the factory labeled containers meds in improperly labeled containers med labeled labele | ilure to beived ms in- liding The DON mentation reders for ad then or until checks are four o do so, ohysician. aat no m other . All mers were eserviced conitoring es to the | 4/19/04                    |

Event ID: APX611

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) M            |   | IPLE CONSTRUCTION   |                   | (X3) DATE SU<br>COMPLE |                            |
|--------------------------|--|---|-------------------|---|---|-------------------|------------------------|----------------------------|
|                          |  | 465108  | i                 |   |   |                   | 2/26                   | /2004                      |
|                          | ROVIDER OR SUPPLIER  |   |                   | 3 | REET ADDRESS, CITY, STATE, ZIF<br>8706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088 | CODE              |                        |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)                                  | ID<br>PREF<br>TAG |   | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIENC  | TION SHOUTHE APPR | JLD BE                 | (X5)<br>COMPLETION<br>DATE |
| F 426                    | Upon admission to physician's order to on the results of results of results of results of the sliding scale of 151 - 200 = 2 U (ur 201 - 300 = 4 U 301 - 350 = 8 U | the facility, nurses had a provide regular insulin based sident 48's blood sugars (BS). dered was as follows: | F 426             |   |   |                   |                        |                            |
|                          | 48's blood sugars and 5:00 PM).  | facility were obtaining resident<br>(BS) twice a day (at 6:00 AM  | •                 |   |   |                   |                        |                            |
|                          | BS ct 178. Based   | O AM, facility staff recorded a conthe physician's orders, the received 2 units of regular received none.     |                   |   |   |                   | ·                      |                            |
|                          | BS of 193. Based   | O PM, facility staff recorded a con the physician's orders, the received 2 units of regular received none.    | .,                |   |   |                   |                        |                            |
|                          | BS of 151. Based   | O AM, facility staff recorded a conthe physician's orders, the received 2 units of regular received none.     |                   |   | ·   |                   |                        |                            |
|                          | BS of 179. Based   | O AM, facility staff recorded a con the physician's orders, the received 2 units of regular received none.    |                   |   |   |                   |                        |                            |
|                          | of 153. Based on t   | M, facility staff recorded a BS he physician's orders, the received 2 units of regular received none.         |                   |   |   |                   |                        |                            |

| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A. BU             | LDING | LE CONSTRUCTION  | (X3) DATE S<br>COMPL | ETED                       |  |
|--------------------------|--|--|-------------------|-------|--|----------------------|----------------------------|--|
|                          |  | 465108   |                   |       |  |                      | 6/2004                     |  |
|                          | ROVIDER OR SUPPLIER  | NTER   | İ                 | 370   | EET ADDRESS, CITY, STATE. ZIP COD<br>06 WEST 9000 SOUTH<br>EST JORDAN, UT 84088                  | 1                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | ıx    | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE            | (X5)<br>COMPLETION<br>DATE |  |
| F 426                    | of 175. Based on t   | AM, facility staff recorded a BS the physician's orders, the ve received 2 units of regular                                      | F 426             |       |  |                      |                            |  |
|                          | of 152. Based on t   | PM, facility staff recorded a BS the physician's orders, the ve received 2 units of regular received none.                       |                   |       |  |                      |                            |  |
|                          | BS of 194. Based   | AM, facility staff recorded a<br>on the physician's orders, the<br>ve received 2 units of regular<br>received none.              |                   |       |  |                      |                            |  |
|                          | BS of 180. Based   | AM, facility staff recorded a on the physician's orders, the ve received 2 units of regular received none.                       |                   |       | •  |                      |                            |  |
|                          | were obtained on<br>and 12/26/03 at 5:<br>1/3/04 and 1/4/04<br>AM. | umentation to evidence that BS<br>12/6/03 at 6:00 AM, 12/25/03<br>00 PM, 12/29/03 at 6:00 AM,<br>at 6:00 AM, and 1/10/04 at 6:00 |                   |       |  |                      |                            |  |
|                          | 2. Resident 38 wa  | as re-admitted to the facility on coses which included asia, coronary artery disease, prosepsis.                                 |                   |       |  |                      |                            |  |
|                          | A review of reside<br>MAR (medication<br>completed on 2/25         | nt 38"s medical record and administration record) was 5/04.  |                   |       |  |                      |                            |  |
|                          | dated 1/24/04, rev   | nitted orders from the hospital<br>realed a physician's order for<br>piotic) 250 mg (milligrams) for 5                           |                   |       |  |                      |                            |  |
| <u> </u>                 | Review of the Jan  | uary 2004 MAR revealed that  |                   |       |  |                      |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | A. BU   | LDINC             | PLE CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED<br>2/26/2004  |              |                            |  |  |
|---|--|---|-------------------|------------------|---|--------------|----------------------------|--|--|
|   |  | 465108  |                   | Γ                | EET ADDRESS, CITY, STATE, ZIP CODE  |              | 3/2004                     |  |  |
|   | ROVIDER OR SUPPLIER  | NTER  |                   | 37               | 06 WEST 9000 SOUTH  | <del>-</del> | ,                          |  |  |
| (X4) ID<br>PREFIX<br>TAG  | ! /EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAC | i                | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE     | (X5)<br>COMPLETION<br>DATE |  |  |
| F 426   | Continued From page the Levaquin was reafter the physician!  On 1/28/04 at 10:3 documented the formote, "Pt (patient) sordered on dischar brought in to facility.  On 2/25/04 at 10:4 (DON) stated that is the Levaquin to the was re-admitted. It medications were if the facility uses, the She further stated clarifying order from begin the Levaquin.  3. On 2/23/04 at a facility registered in dispense a white p | e 38 not started until 1/28/04, 4 days is order.  O AM, a facility nurse llowing in a nurse's progress started on Levaquin this AM. ge from hospital, wife just | F 426             |                  | DEFICIENCY  |              |                            |  |  |
|   | medication from w<br>sterile urine cups was<br>a. DSS/Colace was<br>was not written on<br>gel capsules in the<br>b. EC ASA was w<br>not written on the<br>well as while pills i<br>c. Iron was writter<br>written on the cup.<br>medium green as<br>cup.   | ritten on the lid, a dosage was cup. There were orange as   |                   |                  |   |              |                            |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | A. BUI   | IULTIPLE CONSTRUCTION | (X3) DATE SURVEY<br>COMPLETED   |          |                            |
|--|---|--|-----------------------|---|----------|----------------------------|
|  |   | 465108   | B. WII                | NG  | 2/2      | 6/2004                     |
|  | ROVIDER OR SUPPLIER<br>VALLEY HEALTH CEN  | ITER   |                       | STREET ADDRESS, CITY, STATE, ZIP COD<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088 | E        |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG     | i   | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 426  | were round as well f. Vit C was written written on the cup. in the cup. g. APAP 325 mg w round white pills in the cup. When the RN was a how she knew that lid of the sterile cup administering the R. She further stated the all stocked this way was not sure who to labeled pharmacy be the sterile urine cup. On 2/23/04 at 12:50 medication cart was sterile cups with medication cart was sterile cups with medication cart was sterile cups with medication cart was sterile cups were round as well cup. b. DSS Colace was was not written on the cup. d. Vit C was written written on the cup. d. Vit C was written written on the cup. e. Ca+ Vit D was we not written on the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. f. APAP 325 mg was rounded to the cup. | pills in the cup. As written on the lid. There as oblong pilis in the cups. On the lid, a dosage was not There were round white pills ritten on the lids. There were he cup. Asked by the nurse surveyor the medication written on the swas what she was N stated "I would not know." That the medication carts were she further stated that she work the medications out of the ottles and placed them into s.  PM, the second facility cobserved to have 6 different dications in them. The marked as follows: As written on the lid. There as oblong white pills in the swritten on the lid, a dosage was not the lid, a dosage was not the lid, a dosage was not there were light green round on the lid, a dosage was not there were white round pills ritten on the lid, a dosage was up. There were green oblong as written on the lid. There | F 426                 |   |          |                            |
|  | were round white pi   | ls in the cup.   |                       |   |          |                            |

| STATEMENT                | IS FOR MEDICARE<br>TOF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A. BUI            | ILDING       | CONSTRUCTION  | (X3) DATE SU<br>COMPLE | TED                        |
|--------------------------|--|--|-------------------|--------------|---|------------------------|----------------------------|
|                          |  | 465108   | B. WII            |              |   |                        | 5/2004                     |
|                          | ROVIDER OR SUPPLIER  | NTER   |                   | 3706 V       | ADDRESS, CITY, STATE, ZIP CO<br>WEST 9000 SOUTH<br>F JORDAN, UT 84088                       |                        |                            |
| (X4) ID<br>PREFIX<br>TAG | (CACH DEDICIENCY   | ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |              | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOOFD RE              | (X5)<br>COMPLETION<br>DATE |
| F 426                    | Continued From pag   | e 40   | F 426             | 3            |   |                        |                            |
| F 426                    | On 2/23/04 at 1:00 interviewed. She swere put into the sconvenience while The facility DON wasterile urine cups of the sterile cups with many sterile cups with many sterile cups with many sterile cups was the sterile cups was sterile cups was estable cups was estable cups was written written on the cuppills in the cup.  In a color of the cup was written written on the cuppills in the cup.  In a color of the cup was written written on the cuppills in the cup.  In a color of the cup was written written on the cuppills in the cup.  A facility LPN (lick interviewed on 2/2) that the pills are cups for "staff constated that it is end the survey while | PM, the facility's DON was stated that the medications terile urine cups for staff administering medications. The state of the medication carts.  The property of the third facility as observed to have 8 different medications in them. There marked as follows:  The medication on the lid.  There were light green round may was written on the lid.  The pills in the cup.  The was written on the lid.  The cup.                     |              |   |                        |                            |
|                          | auministrator ca   | Function Appe  | 1.                | Facility ID: | UT0080  | If continuation she    | eet Page 41 of             |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) M            |    | TIPLE CONSTRUCTION   |                              | (X3) DATE SI<br>COMPLE |                            |  |
|--------------------------|--|---|-------------------|----|--|------------------------------|------------------------|----------------------------|--|
|                          |  | 465108  | B. WII            | NG |  |                              | 2/26                   | /2004                      |  |
|                          | ROVIDER OR SUPPLIER  | ITER  | •                 |    | TREET ADDRESS, CITY, ST<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 8 | <del>{</del>                 | DE.                    |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | ix | PROVIDER'S P<br>(EACH CORRECT<br>CROSS-REFERENC                      | LAN OF CORRECTIVE ACTION SHO | ULD BE                 | (X5)<br>COMPLETION<br>DATE |  |
| F 426                    | Pointing to the steri the pills in them.  4. Resident 11 was diagnoses of deme arthritis, congestive and renal insufficier.  The medical record on 2/24/04. During physician's order ar dated October 13, 2 finger stick qac/qhs night) for bs (blood ampule of dextrose 70-110 do nothing, 151-200 4 u insuling). | those bottles immediately." le urine specimen cups with s admitted 9/14/03 with the ntia, diabetes mellitus type 2, heart failure, hypertension ncy.  of resident 11 was reviewed this review, it was noted that a nd nursing care referral form 2003 documented to "check (every morning and every sugars) 0-50 give 1A D50 (1 50) 50-70 orange juice, 110-150 2 u (units) insulin, 201-250 6 u insulin, 251-399 10 u insulin, >351 12 u | F 426             |    |  |                              |                        |                            |  |
|                          | days, facility nurses when needed, did not the physician of a hotimes.  On 11/1/03, at 8:00 resident 11 was 188 have given 2 units conone.  On 11/2/03, at 8:00 resident 11 was 223  | hrough 26, 2003, a total of 26 either did not give insulin of check BS or did not notify igh BS, for resident 11 ten  PM, the blood sugar for 3. Facility nurses should of insulin, but instead gave  PM, the blood sugar for 3. Facility nurses should have alin, but instead gave none.   |                   |    |  |                              |                        |                            |  |
|                          | resident 11 was 28<br>given 6 units, but in  | AM, the blood sugar for  3. Facility nurses should have stead gave none.  PM, the blood sugar for   |                   |    |  |                              |                        |                            |  |

Event ID: APX611

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | A. BU             | ILDIN | IPLE CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |                            |  |
|---|--|--|-------------------|-------|---|----------------------------|----------------------------|--|
|   |  | 465108   | B. WII            | NG    |   | 2/26                       | /2004                      |  |
|   | ROVIDER OR SUPPLIER  | ITER   |                   | 3     | REET ADDRESS, CITY, STATE, ZIP COD<br>1706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088     | E                          | <u>-</u>                   |  |
| (X4) ID<br>PREFIX<br>TAG  | (FACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |  |
| F 426   | given 8 units, but in On 11/4/03 at 8:00                           | <ol><li>Facility nurses should have<br/>stead gave none.</li><li>PM, the blood sugar for</li></ol>   | F 426             |       |   |                            |                            |  |
|   | given 8 units, but in<br>On 11/9/03 at 8:00                        | PM, the blood sugar for<br>5. Facility nurses should have  |                   |       |   |                            |                            |  |
|   | On 11/12/03 at 8:00<br>suga: taken on resi                         | O PM, there was no blood dent 11.  |                   |       |   |                            |                            |  |
|   | resident 11 was 26   | O PM, the blood sugar for<br>1. Facility nurses should have<br>ulin, but instead gave none.  |                   |       | : .   |                            |                            |  |
|   | resident 11 was 21   | O PM, the blood sugar for<br>3. Facility nurses should have<br>ulin, but instead gave none.  |                   |       |   |                            |                            |  |
|   | On 11/26/03 at 6:00 sugar taken on res                             | D AM, there was no blood ident 11.   |                   |       |   |                            |                            |  |
|   | sugar change date<br>give 2 units reg. (re<br>units insulin, 251-3 | t order documented a blood d 11/24/03. For BS 150-200 egular) insulin, 201-250 give 4 00 give 6 units of insulin, as insulin, 351-400 give 10 r BS >351 call MD. |                   |       |   |                            |                            |  |
|   | 14 days, facility nul<br>when needed, did t                        | 4 through 27, 2003, a total of rees either did not give insuling not check BS or did not notify high BS, for resident 11 eight                                   |                   |       | :   |                            | ·                          |  |
|   | On 12/14/03 at 8:0 resident 11 was 29                              | 0 PM, the blood sugar for<br>4. Facility nurses should have  |                   |       |   |                            |                            |  |

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A. BUI            | ILDI | TIPLE CONSTRUCTION ING  |           | APLE | TEO                        |
|--------------------------|--|---|-------------------|------|---|-----------|------|----------------------------|
|                          |  | 465108  | B. WII            | NG   |   |           | 2/26 | /2004                      |
|                          | ROVIDER OR SUPPLIER  /ALLEY HEALTH CEN   | NTER  |                   | ļ    | TREET ADDRESS, CITY, STATE, ZIP CO<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088         | DE        |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE |      | (X5)<br>COMPLETION<br>DATE |
| F 426                    | given 6 units of insu On 12/15/03 at 8:00 resident 11 was 27 given 6 units of insu On 12/15/03 at 6:00 sugar taken on resi On 12/18/03 at 6:00 resident 11 was 27 given 6 units of insu On 12/24/03 at 8:00 resident 11 was 20 given 2 units of insu On 12/25/03 at 8:00 sugar taken on resi On 12/27/03 at 8:00 sugar taken on resi On 12/27/03 at 8:00 resident 11 was 36 notified the physicia There was no docu medical record of the From January 1 thr days, facility nurses when needed, did resident needed. | ulin, but instead gave none.  O PM, the blood sugar for  The Facility nurses should have ulin, but instead gave none.  O AM, there was no blood dent 11.  O AM, the blood sugar for  E Facility nurses should have ulin, but instead gave none.  O PM, the blood sugar for  O Facility nurses should have ulin, but instead gave none.  O PM, the blood sugar for  O Facility nurses should have ulin, but instead gave none. | F 426             |      | DEFICIENCY  |           |      |                            |
|                          |  | PM, there was no blood sugar<br>1.  |                   |      |   |           |      |                            |
|                          | On 1/4/04 at 6:00 A<br>taken on resident 1   | AM, there was no blood sugar<br>1.  | :<br>             |      |   |           |      | 1                          |
|                          | On 1/9/04 at 6:00 A<br>resident 11 was 20  | AM, the blood sugar for<br>5. Facility nurses should have   | :                 |      |   |           |      |                            |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | A. BU  | ILDIN             |      | (X3) DA  | (X3) DATE SURVEY<br>COMPLETED |      |                            |  |  |
|--|--|--|-------------------|------|--|-------------------------------|------|----------------------------|--|--|
|  |  | 465108   | B. WI             | NG _ |  |                               | 2/26 | /2004                      |  |  |
|  | ROVIDER OR SUPPLIER  | NTER   |                   | 3    | SEET ADDRESS, CITY, STATE, ZIP CO<br>706 WEST 9000 SOUTH<br>VEST JORDAN, UT 84088          | WEST 9000 SOUTH               |      |                            |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (FACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAC |      | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE                   | Ë    | (X5)<br>COMPLETION<br>DATE |  |  |
| F 426  | J  | ulin, but instead gave none.  PM, there was no blood sugar   | F 426             |      |  |                               |      |                            |  |  |
|  | On 1/10/04 at 6:00 resident 11 was 17                        | AM, the blood sugar for<br>9. Facility nurses should have<br>ulin, but instead gave none.  |                   |      |  |                               |      |                            |  |  |
|  | resident 11 was 38 notified the physicial There was no decu  | PM, the blood sugar for<br>0. Facility nurses should have<br>an of the high blood sugar.<br>Imentation in resident 11's<br>t the physician was notified. |                   |      |  |                               |      | :                          |  |  |
|  | resident 11 was 36 notified the physicial There was no docu  | G PM, the blood sugar for 8. Facility nurses should have an of the high blood sugar. Immentation in resident 11's the physician was notified.            |                   |      |  |                               |      |                            |  |  |
|  | On 1/14/04 at 8:00 taken on resident 1                       | PM, there was no blood sugar   |                   |      |  |                               |      |                            |  |  |
|  | On 1/22/04 at 8:00 taken on resident 1                       | PM, there was no blood sugar   |                   |      |  |                               |      |                            |  |  |
|  | On 1/23/04 at 8:00 taken on resident 1                       | PM, there was no blood sugar   |                   |      |  | ·                             |      | -                          |  |  |
|  | resident 11 was 37 notified the physici<br>There was no docu | PM, the blood sugar for '9. Facility nurses should have an of the high blood sugar. umentation in resident 11's the physician was notified.              |                   |      |  |                               |      |                            |  |  |
|  | On 1/26/04 at 6:00 taken on resident                         | AM, there was no blood sugar   |                   |      |  |                               |      |                            |  |  |
|  | On 1/28/04 at 6:00   | AM, the blood sugar for  |                   |      |  |                               |      |                            |  |  |

Facility ID: UT0080

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | A. BUI            | ILDIN |  |                           | (X3) DATE SURVEY<br>COMPLETED |                    |       |  |  |
|--|--|--|-------------------|-------|--|---------------------------|-------------------------------|--------------------|-------|--|--|
|  |  | 4651 <b>08</b>   | B. WI             | NG _  |  |                           | 2/26                          | 2004               |       |  |  |
|  | ROVIDER OR SUPPLIER  | NTER   |                   | з     | REET ADDRESS, CITY, STATE,<br>1706 WEST 9000 SOUTH<br>VEST JORDAN, UT 8408 |                           |                               |                    |       |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (FACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |       | PROVIDER'S PLAN<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED T<br>DEFICIE     | ACTION SHOU<br>O THE APPR | JLD BE                        | (XI<br>COMPL<br>DA | ETION |  |  |
| F 426  | given 4 units of inst  | e 45  1. Facility nurses should have ulin, but instead gave none.  AM, the blood sugar for   | F 426             | •     | :  |                           |                               |                    |       |  |  |
|  | resident 11 was 150<br>given 2 units of inst<br>On 1/30/04 at 3:00<br>resident 11 was 25 | O. Facility nurses should have ulin, but instead gave none.  PM, the blood sugar for 2. Facility nurses should have ulin, but instead gave none.     |                   |       |  |                           |                               |                    |       |  |  |
|  | On 1/31/04 at 6:00<br>resident 11 was 17<br>given 2 units of inst                        | AM, the blood sugar for<br>6. Facility nurses should have<br>ulin, but instead gave none.  |                   |       |  | -                         |                               | •                  | -     |  |  |
|  | days, facility nurses when needed, did r   | rough 25, 2004, a total of 22<br>seither did not give insulin<br>not check BS or did not notify<br>high BS, for resident 11                          |                   |       |  | · .                       |                               |                    |       |  |  |
|  | On 2/3/04 at 8:00 F<br>completed for resid   | PM, there was no blood sugar in lent 11.   | -                 |       |  |                           | ₽                             |                    | ·     |  |  |
|  | resident 11 was 15   | M, the blood sugar for 2. Facility nurses should have ulin, but instead gave none.   |                   |       |  |                           | :                             |                    |       |  |  |
|  | resident 11 was 36 notified the doctor   | PM, the blood sugar for<br>3. Facility nurses should have<br>of the high blood sugar. There<br>tion in resident 11's medical<br>sician was notified. |                   |       |  |                           |                               |                    |       |  |  |
|  | resident 11 was 18   | AM, the blood sugar for<br>6. Facility nurses should have<br>ulin, but instead gave none.  |                   |       |  |                           |                               |                    |       |  |  |
|  | On 2/13/04 at 8:00 completed for resid   | PM, there was no blood sugar<br>dent 11.   |                   |       |  |                           |                               |                    |       |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | A. BU  | ILDIN             | PLE CONSTRUCTION  G | (X3) DATE SURVEY COMPLETED   |          |                            |
|--|---|--|-------------------|---------------------|--|----------|----------------------------|
|  |   | 465108   | B. WI             |                     |  |          |                            |
|  | ROVIDER OR SUPPLIER  /ALLEY HEALTH CET                  | NTER   |                   | 37                  | REET ADDRESS, CITY, STATE, ZIP CODE<br>706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088                  |          | ·                          |
| (X4) ID<br>PREFIX<br>TAG   | /EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |                     | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SE<br>CROSS-REFERENCED TO THE API<br>DEFICIENCY) | IOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 426  | Continued From page                                     | e 46   | F 426             | 3                   |  |          | :                          |
|  | resident 11 was 38 notified the doctor                  | PM, the blood sugar for<br>8. Facility nurses should have<br>of the high blood sugar. There<br>tion in resident 11's medical<br>sician was notified. |                   |                     |  | ,        |                            |
|  | resident 11 was 16                                      | AM, the blood sugar for<br>3. Facility nurses should have<br>ulin, but instead gave none.  |                   |                     |  |          |                            |
|  | On 2/16/04 at 8:00 taken on resident 1                  | PM, there was no blood sugar 1.  |                   |                     |  |          |                            |
|  | resident 11 was 38 notified the doctor was no documenta | PM, the blood sugar for<br>4. Facility nurses should have<br>of the high blood sugar. There<br>tion in resident 11's medical<br>sician was notified. |                   |                     |  |          |                            |
|  | resident 11 was 23                                      | AM, the blood sugar for 0. Facility nurses should have ulin, but instead gave none.  |                   |                     |  |          |                            |
|  | On 2/20/04 at 8:00 taken on resident                    | PM, there was no blood sugar   |                   |                     |  | • .      |                            |
|  | resident 11 was 17                                      | AM, the blood sugar for 70. Facility nurses should have sulin, but instead gave none.  |                   |                     |  |          |                            |
|  | resident 11 was 16                                      | AM, the blood sugar for S2. Facility nurses should have sulin, but instead gave none.  |                   |                     |  |          |                            |
|  | resident 11 was 22                                      | AM, the blood sugar for 21. Facility nurses should have sulin, but instead gave none.  |                   |                     |  |          |                            |
|  | There was no doc  | umentation in nurses notes or  |                   |                     |  |          |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | A. BU             | ILDI     | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|---|-------------------|----------|--|-------------------------------|----------------------------|--|
|  |  | 465108  |                   |          |  | 2/26                          | /2004                      |  |
|  | ROVIDER OR SUPPLIER  | NTER  |                   |          | TREET ADDRESS, CITY, STATE, ZIP CODE<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088                |                               |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | ΊX       | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | (X5)<br>COMPLETION<br>DATE |  |
| E 426  | Continued From page  | e 47.   | F 426             | <br>}    |  |                               |                            |  |
| 1 420  | anywhere else in re  | esident 11's medical record<br>s given on the dates which   |                   |          |  |                               |                            |  |
|  | director of nurses)  | with the ADON (assistant<br>on 2/25/04, she stated that no<br>president 11 on the dates   |                   |          |  |                               |                            |  |
| F 502<br>S=G   | 483.75(j) ADMINIS  | TRATION   | F 502             | <u>?</u> |  |                               |                            |  |
| <b>3</b> -3  | services to meet th  | ovide or obtain laboratory<br>e needs of its residents. The<br>le for the quality and timeliness  |                   |          |  | •                             | !                          |  |
|  | This REQUIREME   | NT is not met as evidenced  | -                 |          |  |                               |                            |  |
|  | determined that the laboratory services  | r and record review, it was<br>e facility did not obtain<br>for 2 of 15 sample residents<br>i 16), as ordered by the  |                   |          |  |                               |                            |  |
|  | Findings include:  |   |                   |          |  |                               | 1                          |  |
|  | and prevent clotting dose that both avoing achieves therapeur monitoring through prothrombin time (monitoring blood clindividual. (Reference Suddarth's textbooks) | al anticoagulant used to control g disorders. Prescribing the ids bleeding complications and tic range clotting times requires a laboratory tests. The PT) is a laboratory test used for lotting time in a specific nce Guidance: Brunner and ok of Medical-Surgical Nursing ppincott pages 802-803). |                   |          |  |                               |                            |  |
|  | The International N  | Normalized Ratio (INR), is  |                   |          |  |                               |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION     |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | A. BU  | MULTIPLE CONSTRUCTION UILDING   |   | (X3) DATE SURVEY<br>COMPLETED         |  |
|---|--|--|--|---|---|---------------------------------------|--|
|   | 465108   |  | B. Wi  | ing   | 2/26  | 2/26/2004                             |  |
| 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<br>PREFIX<br>TAG                                | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID<br>PREF<br>TAC  | EIX (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   |                                       |  |
| F 502   | another laboratory to prothrombin time in doses of anticoagul administered. (Reference 53) Economics Compared. Resident CL2 with 2/22/03 with diagnineck fracture, conghypokalemia, hyper Resident CL2's med 2/26/04.  A review of admission revealed the following every day for 4 Draw PT/INR on Moriday.  Resident CL2's, Jancher CL2's, Janc | determining if therapeutic lant medication are being brence Guidance: Physician's Edition 1999 Medical my page 932).  as admitted to the facility on losis which included femurestive neart failure, tension and Alzheimers.  dical record was reviewed on on orders, dated 12/22/03, ang: Coumadin 2.5 milligrams weeks and then discontinue; anday, Wednesday and huary 2004, re-certification on 12/31/03 the Monday, iday PT/INR were sion orders and January 2004 rs, resident CL2 should have 2/24/03, 12/26/03 and as no documentation in ical record to evidence that 9/03 had been performed as | F 502  | •   | es for the s (TO's). Ewed daily by efore being s. The DON or charts for age of condition sure procedure. These checks ks, then shall be teks and weekly ocument the date in the POC in-serviced on or the treatment are Lab Log intative shall by for weeks and at the erson checking I and date the 2/26/04. | 4/19/04                               |  |
|   | PT/INR on 1/2/04.<br>documented on the<br>notified of the result<br>documentation in re  | order that he wanted to be   |  | The Administrator, or represensure compliance with this correction by monitoring that reports are made to the QA or | plan of<br>t all required   | • • • • • • • • • • • • • • • • • • • |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | A BU   | (X2) MULTIPLE CONSTRUCTION  A BUILDING |   |  | (X3) DATE SU<br>COMPLE | JRVEY<br>TED               |
|---|--|---|--|--|---|--|------------------------|----------------------------|
| 465108  |  | B. WING   |  |  | 2/26/2004   |  |                        |                            |
| 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<br>PREFIX<br>TAG                                | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREF<br>TAC  | 1X                                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  |                        | (X5)<br>COMPLETION<br>DATE |
| F 502   | the physician was reactive of the physician was reactive of the physician was reactive of the physician of t | loveyard nurse for 1/9/04 lowing on the "24 Hour rd, "Intermittent sleep [with] y output since 0500 (5:00 AM) 30 PM) 1-9-04. [resident 22's tof this by phonePT significant) oral bleeding." mentation to evidence that the red also informed the physician ad oral bleeding.  Specimens were collected, for a CBC (complete blood metabolic panel) and a 22's WBC (white blood cell) he WBC count was deemed tory utilized by the facility. I level was 34.2 seconds and econds. These PT/INR results rally high per the laboratory, ty.  Ity nurse documented the rig progress note, "[increased] creased] 16.4 [and] results 22's physician and physician's not) started on Levaquin 250 mg and grow oral cavity, unable to source of bleeding, but as or sores on lipsCall into there was no documentation to | )  |  |   |  |                        |                            |
| - William   | 22's physician of th   | acility nurse informed resident ne critically high PT/INR.  |  |  |   |  |                        |                            |
|   | Based on PT/INR  | laboratory test values, facility  |  |  | -   |  |                        |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | EFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA   |                     | TIPLE CONSTRUCTION  NG  | COMPLE                         | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|---------------------|---|--------------------------------|-------------------------------|--|
| 465108  |   |   | 2/20/200            |   |                                |                               |  |
|   | PROVIDER OR SUPPLIER  | NTER  |                     | REET ADDRESS, CITY, STATE, ZIP C<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088       | COUE                           | ·                             |  |
| (X4) iD<br>PREFIX<br>TAG                            | (FACH DEFICIENCY  | ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIVE<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>IE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 502   | next day on 1/11/0 Cournadin until fur Vitamin K 10 mg s The physician also CL2's PT/INR on 1 Resident CL2 died facility staff were non 1/12/04 and 1/1 On 2/26/04 at 2:45 caring for resident found the laborate the critical PT/INR further stated that physician had bee on 1/10/04, so he order to hold the C Vitamin K. The faresident CL2 had mouth, she had a been contributing On 2/26/04 at 3:15 worked for the lab facility, was intervistated the laborate facility staff memb CL2's high critical | ysician telephone order the 4 to hold resident CL2's ther notice and to administer ubcutaneous times one now. ordered to recheck resident /12/04 and 1/14/04.  I on 1/11/04. Due to her death, ot able to recheck the PT/INR 4/04.  I PM, the facility nurse who was CL2 on 1/11/04, stated that he ry results dated 1/10/04, with sitting on the nurse's desk. He there was no evidence that the n notified of the critical PT/INR called the physician and got the collity nurse further stated that some bleeding coming from her high INR and that could have | F 502               |   |                                |                               |  |
|   | collected a PT/INI 12/26/03 and 1/10 On 2/26/04 at 3:4 assistant was inte complications of a include gastrointe intercranial hemo   | R for resident CL2 on 12/24/03,   |                     |   |                                |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION      |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|---|---|-------------------------------|----------------------------|
| 465108   |   | B. Wi   | NG                                      | 2/26/2004   |                               |                            |
| NAME OF PROVIDER OR SUPPLIER  SOUTH VALLEY HEALTH CENTER |   |   |   | STREET ADDRESS, CITY, STATE, ZIP COD<br>3706 WEST 9000 SOUTH<br>WEST JORDAN, UT 84088 |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                                 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |   | ID<br>PREF<br>TAG                       |   | SHOULD BE                     | (X5)<br>COMPLETION<br>DATE |
| F 502  | Coumadin therapy,<br>Resident CL2's ph<br>he did not recall be  | he stated it could be.<br>ysician's assistant stated that<br>ing informed of the PT/INR<br>or could he recall being       | F 502                                   |   |                               |                            |
|  | 7/12/03 with diagno   | a, constipation, chronic back   |   |   |                               |                            |
|  | There was no decu   | ician ordered an Albumin.<br>mentation in the medical<br>16 to evidence that this lab<br>ordered.                         |   |   |                               |                            |
|  | director of nurses s on 1/7/04 had not b  | AM, the facility's assistant<br>tated that the Albumin ordered<br>een completed. She further<br>min would be drawn today. |   |   |                               |                            |
|  |   |   |   |   |                               |                            |
|  |   |   |   |   |                               |                            |
| )<br> <br>   |   |   |   |   |                               |                            |

F 279

Page 5, Line 12

Please replace "...14 day period required as soon as the RAPS are completed" with the following "...within the required seven days after the completion of the comprehensive assessment."

F 326

Please add to our current plan on page 22:

Resident 22 was counseled by the Dietary Manager. Resident 22 agreed to consume her planned diet, in order to promote healing. Resident 22 has been placed on weekly weighings in order to monitor her progress. The RD issued a new diet for Res. 22 and checked on her consumption 3/23/04. Consumption of meals was less than 100 percent, The RD therefore counseled Resident 22 on 3/23/04 and was rewarded with an agreement to also consume two extra diabetic supplements to increase protein intake. The supplements were offered daily, beginning 3/24/04.

The Dietary manager will record daily and submit weekly (Monday mornings) to the Administrator and DON all foods actually placed on Resident 22's trays and the percentage consumed. Ten other trays will be audited and reported on weekly. The DON and/or the Administrator shall randomly monitor the contents of the trays to ensure veracity of the reports. This shall be continued for a period of 4 weeks. Random tray samplings to ensure the correct diet for all residents shall continue for 6 months following. Reports of admissions, readmissions, and discharges shall be reported to the DON daily and shall be checked by the DON and marketing departments and then distributed to all departments to ensure cognizance of the need for plan changes due to change in census. It shall be the responsibility of the nursing dept to bring all such reports to the Nutritionally At Risk meeting weekly.

Results and reports shall be presented to the OA committee at regular meetings.

F 0360

Please add to our current plan on page 27:

Resident 22 was reviewed on 3/23/04 by the RD and since her meal consumption was less than 100 per cent, Res 22 was counseled by the RD and agreed to consume two extra diabetic dietary supplements daily to increase protein intake. Resident 22 has been placed on weekly weighings in order to monitor her progress. The supplements were offered daily beginning 3/24/04. The Dietary Manager will record daily and submit weekly (Monday mornings) to the Administrator and DON all foods actually place on Resident 22"s trays and the percentage consumed. Ten other trays will be audited and report weekly. The DON and/or the Administrator shall randomly monitor the contents of the trays to ensure veracity of the reports. This shall be continued for a period of 4 weeks. Random tray samplings to ensure the correct diet for all residents shall continue for 6 months following. Reports of admissions, re-admissions, and discharges shall be reported to the DON daily and shall be checked by the DON and Marketing department the then distributed to all departments to ensure cognizance of the need for plan changes due to change in census. It shall be the responsibility of the nursing dept. to bring all such reports to the Nutritionally At Risk meeting weekly. Results and reports shall be presented to the QA committee at regular meetings.

F 0426

Please add to our plan on page 36:

The DON will inspect med carts weekly to ensure all stock meds are in factory labeled containers. All licensed staff have been inserviced on the new policy and procedures for the handling of Telephone Orders (TO's). All original TO's will be reviewed daily by the DON or representative before

Milal Meller

03/24/2004 MED IT:24 [LX/KX NO 2041]

being transferred to medical records. The DON or rep will check all charts for residents experiencing a change of condition likely to generate TO's to ensure policy requirements are being met. The checks shall be done daily for 8 weeks, then shall be done 3 times weekly for 8 weeks and weekly thereafter. The DON shall document the charts checked by name and date in the POC log book.

The DON shall report results to the QA committee at regular meetings.

R Mun Mada D