STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations and record review, it was determined the facility did not provide services to accommodate resident needs for 2 of 15 sample residents. One resident was not prepared prior to leaving the facility for an appointment and one resident was not assisted to ensure she received oxygen as ordered. Resident identifiers: 4 and 13. Findings included: 1. Resident 4 was admitted to the facility September 2005. Resident 4 was observed on 12/13/05 at 7:30 AM. Resident 4 was sitting in a geri chair in the main dining room, waiting for breakfast to be served. Resident 4 was wearing a plaid shirt and his pajama bottoms. The resident's feet were partially covered with soiled bandages that left his toes bare. Resident 4 had an order to keep his dressings clean and to keep his heels protected with specially designed lined boots, but he was not wearing the boots. Two nursing assistants were alerted that the resident had a physician's appointment and had to leave before breakfast. The resident was	F 246	F 246 Accommodation of Needs Resident 4 was discharged 12-16-05 Van Driver will post appointment schedule at nurse's stations and to all department heads. All staff will be inserviced on being more aware of resident's needs and having residents properly dressed for appointments, meals arranged to accommodate the appointments. Residents with orders for O2 will be highlighted on the nursing assistant's assignment sheet. Nursing assistants will check each resident with O2 every hour. A list of residents on O2 that eat in the dinning room for meals will be provided for the restorative aid. The restorative aid will monitor each resident from the list for proper use of O2 concentrators, tanks, and tubing during each meal. All CNA's and restorative aides will be Inservice 1/10/06 on the proper use of O2 equipment, the need to change the tubing when it touches the ground and being more of resident needs i.e. resident pulling concentrator by O2 cannula. DON will monitor resident appointments and residents on O2 q week for 2 months and randomly thereafter and report to regular scheduled QA meeting.	2/4/06

1/9/06 POC acceptable Completion date 2/4/06 Buesinger RN

Utah Department of Health
A55
JAN 0 9 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kathleen Johnson — Jan 9, 2006

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

MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ITH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

ID FIX G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
246	Continued From page 1 taken from the dining room to his bedroom, where he was transferred to a wheelchair. Resident 4 went to his appointment dressed in his pajama bottoms. The van driver located sock type foot coverings for resident 4. Then one of the nursing assistants located resident 4's boots and asked if they belonged to the resident and if they would help. Resident 4 required a special nutrition program. Due to his diagnoses of diabetes the resident needed no concentrated sweets. Due to the pressure sores on his feet, resident 4 needed high protein for healing. Resident 4 required nutritional supplements due to progressive weight loss. Resident 4 did not receive his breakfast or his diabetic supplement before he left the facility and no food or supplement was sent with him. The Medication Administration Record for resident 4 was documented by the nurse that the resident did not receive his morning medications because he was out of the facility. The resident's morning medications that were not administered included 16 units of insulin. The nurse also documented resident 4 did not have his blood sugar checked at 11:00 AM for his sliding scale insulin, because he was still out of the facility. There was no documentation that resident 4's blood sugar was checked or his morning medications were administered when the resident returned to the facility, prior to noon. 2. Resident 13 was admitted to the facility 12/1/05 with diagnoses that included congestive heart failure. Resident 13's comprehensive Minimum Data Set (MDS) assessment, dated 12/14/05, revealed the	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 2	F 246		

resident was receiving oxygen therapy. Resident 13's care plan included that the resident was to receive oxygen at 3 to 4 liters as ordered. A nurse's note, dated 12/4/05, revealed the resident demonstrated shortness of breath.

Resident 13 was observed during breakfast. on 12/13/05, to be receiving supplemental oxygen via a concentrator and nasal cannula. When the resident had finished eating. she attempted to leave the dining room without unplugging the concentrator. The concentrator was connected to an electrical outlet that was inside a cupboard. Resident 13 ran out of cord when she reached the dining room doorway. Resident 13 continued to tug on the concentrator until the plug pulled free from the outlet. Other residents were calling to resident 13 to get the concentrator unplugged, but no staff appeared to notice the problem.

On 12/13/05, after finishing lunch, resident 13 pulled the oxygen concentrator out of the dining room without unplugging it first. The electrical outlet was inside a cupboard and not easily accessible to the resident. Resident 13 pulled the concentrator until the plug came free.

On 12/14/05, resident 13 was observed during breakfast. Resident 13 was using a portable oxygen tank. The resident stated that she was told she could not take the tank out of the dining room without assistance. Resident 13 stated she was told the tank would explode if she tried to take it alone. Resident 13 stated she did not like to wait until someone had the time to take her back to her room, so the resident left without her oxygen.

On 12/15/05 at 3:30 PM, resident 13 was

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

4) ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
246	Continued From page 3 observed in the day room. The resident ambulated into the room, pulling her oxygen concentrator with her. The oxygen tubing, including the nasal cannula, was dragging along behind the concentrator. When resident 13 sat down to talk, she left the tubing on the floor beside her and did not use her oxygen. On 12/19/05 at 7:45 AM, resident 13 was observed to be ambulating to the dining room with stand-by assist of staff. Resident 13 did not have oxygen on. On 12/19/05 at 2:00 PM, resident 13 was observed to be in a wheelchair in the hallway. A nursing assistant was assisting resident 13 back to her room. The nursing assistant left resident 13 in the doorway to her room. The oxygen concentrator inside resident 13's room. It was running at 3 liters per minute and the nasal cannula was laying on the floor. The nursing assistant left without changing the cannula or assisting resident 13 to put her oxygen on.	F 246		
253 S=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, from 12/12/05 through 12/19/05, it was determined that the facility did not provide maintenance services to maintain a sanitary and comfortable interior.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 Findings included: Observations of the facility revealed the following: The bathroom, located in room 319, had a light fixture over the sink that had no covering. A bare florescent bulb was exposed. Compression spring covers were missing from the entry doors of rooms 315, 317, and 318. An electrical plug cover was missing from a wall socket in the hallway across from room 319. In the closed unit dining room on the south wall, approximately 6 feet from the floor, a hole in the wall approximately 6 inches in diameter with electrical wires exposed was observed. There was a partial covering over the hole. Observations of the closed unit shower room revealed the following: areas of peeling paint,a tile missing from the 4 foot wall on the east side of the shower room and two containers with soiled linen. Observations of the east shower room revealed the following: 4 broken tiles on the inside of the 4 foot wall, a 3 foot by 1 foot area of peeling paint near the bottom of the north wall, the door jam hinge side at floor level was rusting out, a tile was missing north of the door jam, and there were two containers with soiled linen. Observations of the west shower room revealed the following: an open electrical box with exposed wires on the west wall behind the bathtub, just under the electrical box was a 2 foot by 1 foot	F 253	F 253 Housekeeping/Maintenance **By 12-19-05** The light fixture in the bathroom in room 319 was covered. The electrical plug across the hall from 319 was covered. The cover was replaced on the hole on the wall in the closed unit dining room. The electrical box in west shower room has been covered. **By date of elided compliance of 2-4-06.** On rooms 315, 317, and 318 the cover for the springs on the door closures will be purchased and replaced by maintenance. The eastside, unit and the west side shower rooms will be painted and new tiles will be replaced by maintenance. The rusted door frame in the east side shower room will be sanded and painted. The dirty linen containers have been replaced in the large shower rooms on the west side and the unit. The linen and garbage containers in the eastside shower room have been removed and placed in the eastside soiled utility room. Resident 16's armrests on his wheelchair have been replaced. All staff will be inserviced 1-10-06 on -- Reporting maintenance issues and location of maintenance logs. Nightshift CNA's checking wheelchairs, while cleaning them for maintenance issues. Maintenance will do weekly maintenance rounds to check for any possible deficiencies for the first 2 months and then monthly thereafter and report any deficiencies to the next scheduled QA meeting.	2/4/06

EMENT OF DEFICIENCIES 'LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

) ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
253	Continued From page 5 area of peeling paint. In the toilet room the light fixture covering was partially unattached. The shower in the east side had 4 chipped and/or missing tiles on the end of the 4 foot wall. The shower on the east side had 4 chipped and partially missing tiles on the 4 foot high wall. There were two containers with soiled linen in the shower room. On 12/19/05 at 8:20 AM a housekeeping person was interviewed. She was observed in the west shower room collecting the dirty linens from the containers. She stated that soiled linen for the 200 hall are kept in the west shower room. Resident 16 required a wheelchair for locomotion. The arm rests on resident 16's wheelchair were observed on 12/13/05, 12/14/05, and 12/19/05, to have multiple cracks along the length of the arm rests. The arm rests could not be cleaned and sanitized and they posed a risk for scratching resident 16's skin.	F 253		
278 =E	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 6 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility did not ensure that the Minimum Data Set (MDS) assessments accurately reflected residents' status for 11 of 15 sample residents. (Resident identifiers: 1, 2, 3, 4, 5, 6,7, 8, 10, 12, 13) Findings Included: 1. Resident 3 was an 84-year-old female admitted to the facility in April of 2005 with diagnoses that included deep vein thrombosis and hypertension. Resident 3's admission MDS dated 4/28/05 was reviewed. The MDS did not have dates entered by the signatures of the facility staff completing	F 278	F 278 **Resident Assessment** Resident 2, 3, 1, 4, 10, 12, 5, Have hired new MDS coordinator with experience who will check and monitor the resident assessments for accuracy, signatures, dates, raps are completed and include proceed to care plan is checked, dated and signed prior to filing in chart. Medical records will monitor resident assessments for signatures, dates, completion and report finding to quality assurance committee. Resident 7: 08/12/05 MDS correction done removing DD/MR from assessment. Completed 01/05/06. Resident 8: 07/14/05 MDS correction done removing DD/MR from assessment. Completed 01/05/06. Resident8: 09/04/05 MDS correction done removing DD/MR from assessment. Completed 01/05/06. Resident 10: 10/27/05 MDS correction done to "return anticipated". Completed 01/05/06. Resident 2: 08/06/05 & 11/04/05 MDS correction done to include side rails used daily. Completed 01/05/06. Resident 10: 11/10/05 MDS correction done to include therapeutic diet. Completed 01/05/06. Resident 13: 12/14/05 MDS correction done to include correct diagnosis. Completed 01/03/06. Medical Records will audit MDS in all charts for completion, signatures and care planning.	2/4/06

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

I) ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
278	Continued From page 7 the assessment under section AA9b, and c. In addition section V, the "Location and Date of RAP Assessment Documentation" column was blank. 2. Resident 7 was a 76-year-old male resident admitted to the facility on 6/03/04 with diagnoses that included Depressive Disorder, Dementia, Hyperlipidemia, Anxiety, malnutrition and pain. Residnt 7's annual MDS dated 8/12/05 was reviewed. It documented on the MDS in section AB10f that resident 7 was diagnosed with MR/DD. The Preadmission Screening and Resident Review (PASARR) dated 07/29/05 documents that resident 7's level I assessment determined no DD/MR related conditions. In section V, the "Care Planning Decision" column was blank. 3. Client 8 was an 85-year-old female resident admitted to the facility on 6/24/05 with diagnoses that included Hypertension, Dementia, Insomnia, Osteoporosis, Hypothyroidism, and Incontinence. On 9/04/05, an admission MDS was completed by the facility staff as in section R2b. The date of 7/14/05 was documented by the staff members completing the form in section AA9c, and d.. It was also documented on the MDS in section AB10f that resident 8 was diagnosed with MR/DD. The Preadmission Screening and Resident Review (PASARR) dated 06/24/05 documents that resident 8's level I assessment determined no DD/MR related conditions. 4. Resident 1 was admitted to the facility July 1998. Resident 1's active medical record included an annual MDS assessment dated 8/13/04, an	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 annual MDS assessment dated 11/1/04, and a quarterly MDS assessment dated 11/3/04. Resident 1's annual MDS assessment, dated 8/13/05, did not included section V, Resident Assessment Protocol Summary (RAPs). Resident 1's annual MDS assessment, dated 11/1/05, included section V. Section VB 2 was dated 11/2/04. Section VB 4 was dated 11/2/04. The Locations and Dates of RAP assessment Documentation referred to social service notes, physician orders, and nursing documentation and assessment that were all dated August 2004. Section R2b had been dated 8/30/04 but was written over to read 11/1/04. Section AA9 a was dated 11/11/04. after both the original and the corrected R2 b dates. Although the MDS was signed and in the resident's medical record, it had not been transmitted to the State. Resident 1's medical record included a comprehensive MDS assessment dated 7/31/05. The MDS was signed as completed by one of the team members, in section AA9, on 7/3/05, before the the assessment began. 5. Resident 2 was admitted to the facility January 2005. Resident 2's quarterly MDS was documented by the facility interdisciplinary team (IDT) that the resident did not have restraints. Resident 2 was observed to have full side rails up whenever the resident was in bed. It was documented in the MDS assessment that the resident used the side rails to assist with turning and positioning. It was also documented in the resident's restraint assessments dated 7/8/05 and 11/4/05, that the	F 278		

MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ITH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

ID FIX G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
278	Continued From page 9 resident was a "priority candidate for restraint" and that side rails were used to prevent the resident from falling. 6. Resident 4 was admitted to the facility September 2005. A comprehensive MDS assessment was completed by the IDT for resident 4, on 9/21/05. Section AD of the Background information was not signed or dated. The RAPs care plan decision making, in section V, was not completed for resident 4. 7. Resident 10 was admitted to the facility September 2003. Resident 10's medical record was reviewed 12/15/05. Resident 10's comprehensive MDS assessment, dated 11/10/05, had been documented by the IDT that the resident did not have a therapeutic diet. The resident's change of diet communication, dated 10/28/05, revealed the resident was on a low fat, low cholesterol, diabetic diet. A Discharge Tracking MDS, dated 10/27/05, revealed the resident was going to a hospital. The resident was having a short stay surgical procedure and returned to the facility the following day. The Director of Nursing (DON) stated, on 12/10/05, that the resident was expected to return to the facility following the procedure. The Discharge Tracking MDS was documented as "Return not anticipated". A comprehensive assessment was signed as completed for resident 10 on 7/11/05. The MDS did not have section V, the RAP Care Planning decision making, completed.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11 On 11/21/05 a significant change MDS was completed by the facility staff. In section V, the "Location and Date of RAP Assessment Documentation" column was blank.	F 278		
F 372 SS=E	483.35(h)(3) SANITARY CONDITIONS - GARBAGE DISPOSAL The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the dumpster did not have the lid closed to cover garbage as required and additional refuse was observed on the ground around the dumpster. Findings included: On 12/14/05 at 10:55 AM, the dumpster was observed uncovered. On 12/14/04 at 12:20 PM, the dumpster was observed again uncovered. A plastic fork, 1/2 of a paper plate, a bottle cap, a large white piece of cardboard and a pile of clear plastic were observed on the ground around the dumpster. In addition, there were two large uncovered plastic trash receptacles on wheels next to the dumpster. One of the trash containers was 1/4th filled with paper products. On 12/14/05 the Administrator stated that the facility had been having problems continuously with the dumpster overflowing with trash. On 12/19/05 at 7:35 AM the dumpster was	F 372	F 372 **Sanitary Conditions-Garbage Disposal** The facility has gone to a 6 day a week garbage pickup. The housekeeping supervisor, dietary supervisor, and the two maintenance men (or designee) will monitor the dumpster lid and for garbage on the ground, twice a day for the first month, and daily for the next month and randomly thereafter to make sure the lid is being kept closed. The housekeeping supervisor will report to the scheduled QA meeting.	2/4/06

EMENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

) ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
278	Continued From page 10 8. Resident 13 was admitted to the facility 12/1/05 with diagnoses that included Congestive heart failure, hypertension, and hypokalemia. Resident 12's MDS assessment should have been completed and in the resident's medical record on 12/14/05. On 12/18/05 at 3:30 PM, the completed MDS assessment was located by the MDS coordinator in her filing. The MDS assessment did not include all identified diagnoses for resident 13. 9. Resident 12 was admitted to the facility in October of 2004 with diagnoses that included cerebral vascular accident, hypotension and depression. On 6/23/05, an admission MDS was completed by the facility staff. In section V, the "Location and Date of RAP Assessment Documentation" column and the "Signature of Person Completeing Care Planning Decision" were blank . 10. Resident 5 was admitted to the facility in May of 2003 with diagnoses that included Huntington Chorea, dementia and depression. On 3/17/05, a significant change MDS was filled out by facility staff. Section R2, "Signature of the Person Coordinating the Assessment" was not signed, signifiying that the MDS was not completed. 11. Resident 6 was admitted to the facility in November of 2004 with diagnoses that included hypertension, Alzhiemer's disease, and depression.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 12 observed to be overflowing with trash. The dumpster had full trash bags stacked above the rim of the dumpster, and the right hand side lid of the dumpster was unable to close with the excess amount of trash bags. There were 4 more clear plastic garbage bags sealed and stacked on the ground in front of the dumpster.	F 372		
F 431 SS=D	483.60(d) LABELING OF DRUGS AND BIOLOGICALS Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. This REQUIREMENT is not met as evidenced by: Based on observation of medication pass and interview, it was determined that the facility was dispensing a drug that was not labeled in accordance with currently accepted professional principles for 1 supplemental resident. (Resident identifier: 14) Findings included: Resident 14 was admitted to the facility in December of 2004 with diagnoses that included dementia and diabetes. On 12/13/05 resident 14's medical records were reviewed. A review of resident 14's physician's recertification orders, dated 11/29/05, revealed that resident 14 was to be administered Lasix 20	F 431	F 431 **Labeling of Drugs and Biological** Each medication cart in the facility was gone through and checked for bottled medications by a Registered Nurse. Each bottled medication label was assessed for expiration date, dosage, type, form, and quantity with the medication in each bottle. All family members wishing to bring medications from home will be ask to sign a statement declaring that this is the original medication in the original bottle from the pharmacy, any refills will be in the original sack from the pharmacy. The nurse will check in all medications. A Q_{A} and policy was completed which was in serviced on and signed by each licensed nurse. The facility pharmacy has been asked and has agreed to provide additional in servicing. A monthly audit of all bottled medications at the end of the month with the new MARs will be completed utilizing the same procedure as above. All results of audit will be reported to scheduled QA meeting.	2/4/06

MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

ID FIX G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
431	Continued From page 13 mg QOD (every other day). On 12/13/05 at approximately 7:10 AM, a facility LPN (licensed practical nurse) administered 1/2 of a round tablet to resident 14 that the nurse stated was a 20 mg (milligram) dose of Lasix. The label on the bottle that the medication was taken from read "Lasix 20 mg tablets", had an expiration date of 3/16/06 and documented that there were 45 tablets in the container. The Surveyor then asked the LPN, if she was sure that the 1/2 tablet was equal to 20 mg and not 10 mg. The LPN stated that she was sure that the half tablet was equal to 20 mg. She stated that resident 14's wife brought the pills in for the resident and that resident 14's wife got his pills from a local hospital. On 12/13/05 at 11:30 AM, the LPN emptied the bottle of above mentioned medication onto a pharmacy counting tray. Two hundred and seventy seven half round pills and 6 whole oval shaped pills were counted (Lasix 20 mg tablets are oval shaped). There were 2 different shapes of pills found in the medication bottle. It was documented on the label of the medication container that there were orginally 45 tablets in the container, when it had been filled 9/13/05. On 12/13/05 at 11:35 AM, a pharmacist from the local hospital that was named on the labeled bottle of the above medication was interviewed. The pharmacist stated that it is against their policy to dispense pills that are cut in half. On 12/19/05 a review of the facility's "Admission Agreement" was completed. It is documented in the "Medication" section that "No prescription or over-the-counter drugs may be brought into the	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 facility or dispensed unless the medication is ordered by the physician, is properly labeled with the date and dosage and is in a sealed container."	F 431		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility did not ensure that timely laboratory services were provided, as ordered by physicians, for 1 of 15 sample residents. Resident identifier: 12 Findings included: Resident 12 was admitted to the facility in October of 2004 with diagnoses that included cerebral vascular accident, hypotension and depression. On 11/14/05 a Lipid panel (to determine cholesterol levels) was ordered by resident 12's physician. No lipid panel was found in the resident's chart. On 12/19/05 at 9:30 AM a facility RN (registered nurse) was interviewed. The RN stated that around the time that this laboratory test was ordered for resident 12 there were approximately 40 other laboratory tests ordered for other	F 502	F 502 Laboratory Services Policy was reviewed with each licensed nurse on timely and proper implementation of lab procedures, with a copy of the policy and procedure at each nurses station to refer to. A weekly audit will be done by Medical Records for the first month and randomly thereafter. All results will be reported to the scheduled QA meeting.	2/4/06

TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

IE OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

1) ID EFIX AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
502	Continued From page 15 residents. She stated that she was unable to find the results for resident 12 and was unable to determine if the test was done.	F 502		
514 =E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview it was determined that the facility did not maintain complete and accurate medical records for 5 of 15 sample residents. Resident identifiers: 1, 5, 6, 9 and CL 2. Findings included: 1. Resident 5 was admitted to the facility in May of 2003 with diagnoses that included Huntington's Chorea, dementia and depression. Resident 5's medical record was reviewed on 12/13/05. The recertification of physician's orders, dated 11/28/05, included documentation that resident 5 had no known allergies.	F 514	F 514 Clinical Records Resident 1,5,6,9 Recertification Physician Orders have been corrected to reflect the correct allergies. All current inpatient records have been reviewed to assure that the allergies are correct onthe Physician Recertification Orders. Medical Records will assure that all new residents Physician Recertification orders list the correct allergies. Medical Records will monitor Q month and report to the Quality Assurance Committee. CL2 MDS was completed and transmitted To the State 6/14/05. The MDS was Reprinted and placed in the closed chart. Medical Records will review and monitor all records at the time of discharge to assure that all the proper MDS's are filed in the closed chart and report to the Quality Assurance Committee.	2/4/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 16 On the inside cover of resident 5's active medical record, a hand written note revealed that the resident was allergic to penicillin, erythromycin ethylsuccinate, and haldol. No other documentation was located in resident 5's medical record to indicate that the resident had a drug allergy. 2. Resident 6 was admitted to the facility in November of 2004 with diagnoses that included hypertension, Alzheimer's disease, and depression. The recertification of physician's orders, dated 11/28/05, included documentation that resident 6 had no known allergies. On the inside cover of resident 6's active medical record, a hand written note revealed that the resident was allergic to Biaxin. No other documentation was located in resident 6's medical record to indicate that the resident had a drug allergy. 3. Resident 9 was admitted to the facility in February of 2005 with diagnoses that included hypertension and Alzheimer's disease. The recertification of physician's orders, dated 11/28/05, included documentation that resident 9 had no known allergies. On the inside cover of resident 9's active medical record, a hand written note revealed that the resident was allergic to Codeine. No other documentation was located in resident 9's medical record to indicate that the resident had a drug allergy.	F 514		

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. BUILDING _____ B. WING _____	12/19/2005

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JTH VALLEY HEALTH CENTER	3706 WEST 9000 SOUTH WEST JORDAN, UT 84088

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
514	Continued From page 17 4. CL 2 was reviewed on 12/19/05. CL 2 was admitted to the facility in June of 2005 and dicharged from the facility in July of 2005. CL 2 was in the facility for 35 days. No admissions MDS (minimum data set) could be found on the closed chart. On 12/19/05 the medical records person was interviewed. She stated that she was unable to locate an MDS for CL 2. 4. Resident 1 was admitted to the facility with diagnoses that included schizophrenia. Resident 2's medical record was reviewed on 12/13/05. The recertification of physician's orders, dated 11/28/05, included documentation that resident 1 had no known allergies. On the inside cover of resident 1's active medical record, a hand written note revealed that the resident was allergic to the antipsychotic medication Stelazine. No other documentation was located in resident 1's medical record to indicate that the resident had a drug allergy.	F 514		

SVHC O2 Compliance Rounds

Date_____

Resident	Correct lters	Tubing dated	Humidifier H20 & date	Nasal Canula off floor Y/N	Resident has O2 on Y/N
Ronald Admson					
Keith Anderson					
Marie Borg					
Fay Brinkerhoff					
Vera Bruno					
Diane Clarkson					
Stanley Davis					
Herman McCune					
Wava Nielsen					
Lyla Shaffer					
Ina Twitchell					
Wylda Wagner					
Nathan Young					

Observations/Concernes

_____

_____

_____

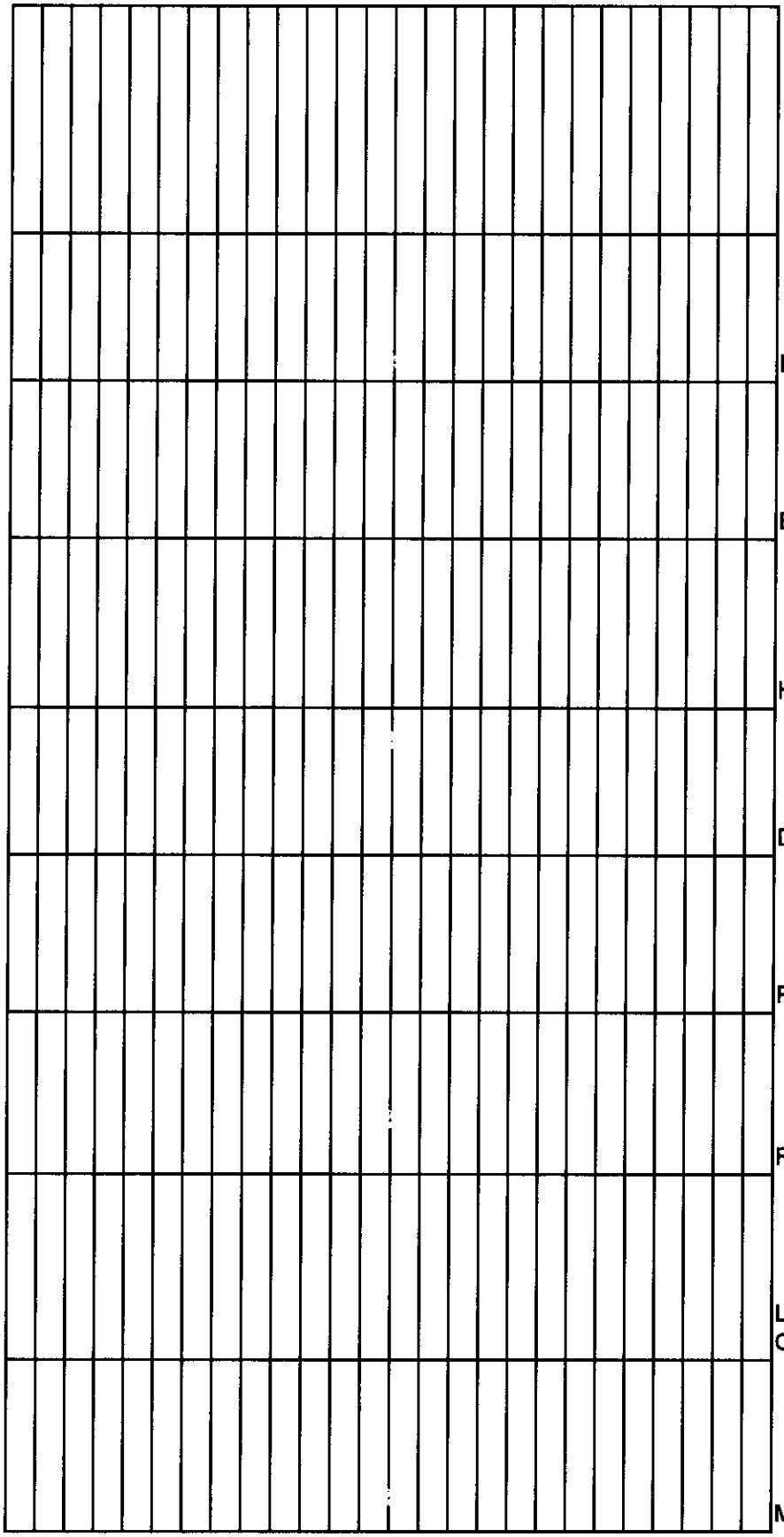
_____

Receiving Non-Facility Pharmacy Medication

The following medications have been dispensed by a licensed pharmacist and have not been tampered with, altered or added to.

Received by Nurse_____ Date _____

Resident or Resident Representative_____Date_____



MAINTENANCE/HOUSEKEEPING MONITORING

DUMPSTER LID MONITORING

TWICE A DAY MONITORING

9-Jan			
10-Jan			
11-Jan			
12-Jan			
13-Jan			
14-Jan			
15-Jan			
16-Jan			
17-Jan			
18-Jan			
19-Jan			
20-Jan			
21-Jan			
22-Jan			
23-Jan			
24-Jan			
25-Jan			
26-Jan			
27-Jan			
28-Jan			
29-Jan			
30-Jan			
31-Jan			
1-Feb			
2-Feb			
3-Feb			
4-Feb			
5-Feb			
6-Feb			
7-Feb			
8-Feb			
9-Feb			

DUMPSTER LID MONITORING

DAILY MONITORING

10-Feb			
11-Feb			
12-Feb			
13-Feb			
14-Feb			
15-Feb			
16-Feb			
17-Feb			
18-Feb			
19-Feb			
20-Feb			
21-Feb			
22-Feb			
23-Feb			
24-Feb			
25-Feb			
26-Feb			
27-Feb			
28-Feb			
1-Mar			
2-Mar			
3-Mar			
4-Mar			
5-Mar			
6-Mar			
7-Mar			
8-Mar			
9-Mar			
10-Mar			

Weekly LOA list Jan 9-13-06

Monday	Mary & Nathan 10-Am - 3.30pm
Tuesday	
Wednesday	Mary & Nathan 10Am - 3.30pm
Thursday	Barbara T 1.30pm
Friday	Nathan & Mary 10Am - 330pm
Sat/Sun	

LAB AUDIT

RESIDENT NAME	LAB	DATE	T.O	DR. NOTIFIED	NURSES NOTE	MISSING/COMMENT

QUALITY ASSURANCE - MDS AUDIT

RESIDENT NAME	ADMIT DATE	15 MO MDS	MDS TYPE	Rb2 Date	RN SIGNED					CP Ck	COMMENTS
					AA9	AD	Rb2	RAP	CP		

South Valley Health Center
Lab Order Procedure

1. Upon receiving an order for a lab make out the request form make sure to include appropriate ICD 9 codes
   Put the original in the Biolab canister
   Put the 2nd copy in the DON's box
   Put the 3rd copy in the Resident chart

2. Write the residents name, lab draw and date in the lab log
   The request form will be made out for the entire month if the order requires daily or weekly draws.
   The nurse doing the recerts will make out request form for the following month
   The request for monthly, semi-annual, or annual labs will be made out when the order is taken off and placed in the back of the lab log book under monthly labs

3. When lab results come in, inform the physician!
   Write the date and any new orders directly on the lab paper and initial
   Complete the lab log book filing in sections "Hard copy received" and "Charted"

4. Record order in the nursing notes

5. If a lab has not been drawn an "Incident Report" must be filled out or if a resident refuses to all blood to be drawn do "LAB ALERT"
   Inform DON of missed labs
   Call lab of any missed results for the day

I have read and understand the above Lab order procedure and the attached lab order form and log, and agree to implement them in my daily routine.

Nurse_____ Date_____

Nurse Supervisor_____

QUALITY ASSURANCE SUMMARY AUDIT

AUDIT TOPIC: **Recieving medications for Residents from sources other than facility Pharmacy correctly and accurately**

DATE AUDIT PERIOD: 12/13/2005 TO 12/31/2005

Problems identified: Medication was given to a resident from a bottle with a lable that did not match the description of the actual tablet in the bottle.

Possible reasons for problems: 1. Nursing staff failure to follow facility policy and procedutre and accept medications in a manor that would ensure accurate and safe distribution of residents medications.

Goals: 1 Each nurse will follow facility protocal and accept all medications from family of residents or pharmacys to ensure accurate and safe disribution of medications.

Goals: 2 There will be no errors related to this polcy.

Action Plan:
1. Each nurse to review facility policy and procedure for accepting medications from family of residents and pharmacys.
2. The Policy and procedure instructions will be place in the Nurses Communication Book and a copy will be given to each nurse.
3. Each nurse will read and sign that they agree and understand the policy and procedure.
4. All discrepancies will be reported to the DON.

COMPLETED BY: Aaron H Hansen RN DON

Medications Receiving Policy

No prescription or over the counter drugs may be brought into the facility or dispensed unless the medication is ordered by the physician, is properly labeled with date and dosage, and is in a sealed container. The facility requires all pharmacies to comply with the facilities policies and procedures. Each nurse at time of receiving medications is responsible to utilize the following steps:

1. Check physician order against labels for dosage, time, frequency, and route.
2. Check expiration date.
3. Make sure medications are in a sealed container.
4. Sign any appropriate paper work (only after the above steps have been taken).
5. Distribute, organize, and secure in the med cart.

I have read understand and agree to implement the above policy

Name	Date

ROOM CHANGES

Room changes may be made at the facility's request or at the resident's request. All parties affected must be notified and agree to the change.

PERSONAL PROPERTY

The facility will not be responsible for damages to, or loss of resident's personal property while in the facility, except when the damage or loss is shown to be caused by members of the facility staff. We suggest that residents do not bring valuable items from home. Residents are encouraged to make their rooms as comfortable as possible. Pictures, a favorite bedspread, televisions and even small furniture help to make the environment home-like. Since most rooms are shared, personal items must be limited to what will fit in the resident's half of the room. Items that impose a safety hazard, such as extensive clutter, extension cords and unstable furniture are not allowed. Items cannot be placed on the overhead lights or above the closet. If you which to bring furniture, please notify Social Services so the facility furniture can be moved. Cloth covered chairs are discouraged because they present a real potential for order. Please provide a sturdy TV stand at an adequate height if you are bringing in a television.

All residents must have adequate clothing. This may include, but is not limited to, seven (7) complete changes of clothes, undergarments, sleepwear, etc.

Television and radio volumes must be considerate of other residents. If hearing is a problem, earphones are recommended. If a room change is made at the resident's request, the resident will be responsible for any associated fees; if the change is made at the facility's request, the facility will pay for any changes.

Residents may use the phone in the Social Services office if they need complete privacy. Long distance call charges are the responsibility of the person making the call (use phone cards, call collect, etc.)

MEDICATIONS

No prescription or over-the-counter drugs may be brought into the facility or dispensed unless the medication is ordered by the physician, is properly labeled with the date and dosage and is in a sealed container. The facility requires all pharmacies to comply with the facility's policies and procedures. Residents may self administer their medications if the Interdisciplinary Team determines that this practice is safe, and is part of the resident's care plan. The facility shall not require the resident to purchase drugs from any particular pharmacy, but the facility shall not be held liable for charges incurred for drugs the facility orders on behalf of the resident, when the resident representative does not supply the medications in a timely manner after being requested to do so.

VISITORS

Visiting hours are open. Family and friends are encouraged to visit so long as the visit is appropriate to the resident's physical and mental health. It is important to consider roommate needs when visiting. We invite you to use the foyer or days rooms, but ask that you pick up after yourself. Please keep small children with you at all times. Pets are welcome in the building, but must be kept on a leash, and have proof of up-to-date shots.

We will not tolerate any visitor becoming loud or abusive to staff or residents. It is the policy of this facility that no violence or threats of violence will be allowed on our property by visitors, residents or staff. Any behavior deemed unacceptable will be dealt with as follows:

1. You may be asked to leave the facility by a staff member.
2. The police may be called to escort you out of the building
3. Your visits may be limited to supervised visits with a Department Head present.
4. A restraining order may be obtained to keep you off the property.