NO ... L. R. int 2000 4801

PRINTED: 03/23/2006 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SOUTH VALLEY HEALTH CENTER  SUMMAY STATEMENT OF DEPICIENCES THE GEACH OFFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FRESULATORY OR LSC IDENTIFYING INFORMATION  FRESULATORY OR LS		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION	(X3) DATE S	
SOUTH VALLEY HEALTH CENTER  REGULTION MIST SE PRECEDED BY FULL REGULTION MIST SE PRECEDED BY FULL REGULTION OF MIST SEPACE OF MIST S			465108			i i	
FREETY TAG  FREQUENTRY OR LSC IDENTIFYING INFORMATION  FREST  F 225  483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate uniftness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident.  An in-service will be given to Staff regarding facility Policy & Procedureson Abuse and neglect was a wellas reporting abuse/bruises educated by:			NTER		3706 WEST 9000 SOUTH		
The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (folluding to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is not met as evidenced by:  The facility must not employ in facility will report all Injuries of unknown origin.  Abuse to the proper state Agencies in accordance to State law along with an Investigation report within 5 days of the incident.  Licensed nurses will complete and property dentify abuse/injuries of unknown origin. Licensed nurses will complete and reports to to assist in the investigation process of injuries of unknown origin.  Resident 2,4,5 & 6 Incident Reports to the properts at the property dentify policy & Procedureson Abuse and neglect will be given to Staff regarding facility Policy & Procedure	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREFI	IX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
OIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X8) DATE  3/24/9/6	SS=H	The facility must no been found guilty of mistreating resident had a finding entereregistry concerning of residents or misa and report any know court of law against indicate unfitness foother facility staff to or licensing authorit.  The facility must en involving mistreatmincluding injuries of misappropriation of immediately to the atoother officials in a through established State survey and certifications are thoroup revent further pote investigation is in proposition of the administrator representative and the with State law (inclucentification agency) incident, and if the appropriate correction.  This REQUIREMENT by:	at employ individuals who have a fabusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a fan employee, which would be reservice as a nurse aide or the State nurse aide registry ies.  Sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the entification agency).  We evidence that all alleged aighly investigated, and must intial abuse while the ogress.  We estigations must be reported or his designated to other officials in accordance ding to the State survey and within 5 working days of the alleged violation is verified we action must be taken.  IT is not met as evidenced	Solo Charles Car Dall Brown L	The facility will report all Injuries of unknown origin/ Abuse to the proper state Agencies in accordance to State law along with an Investigation report within 5 days of the incident.  Licensed nurses will complemore detailed information of the incident reports and nurses describing how the injuries, etc occurred so as to properly identify abuse/injure of unknown origin. License nurses will complete a Resident Incident Follow-up Report on all Incidents report to assist in the investigation process of injuries of unknown origin  Resident 2,4,5 & 6 Incident Reports, nurses notes were Reviewed and an Investigating Report completed and report to the proper state agency clarifying the incidents.  An in-service will be given to Staff regarding facility Policia & Procedureson Abuse and reas wellas reporting abuse/bruand that an incident report is be completed on bruises, skiil	bete in sees curies of the sees of the see	
	•	DIRECTOR'S OR PROVIDE	ERISUPPLIER REPRESENTATIVE'S SIGN	IATURE	Colm	3/	24/2/2

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

Previous Versions Obsolete

Event ID: 7JA711

Facility ID: UT0080

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE S COMPL	
		465108	B. WIN			03/2	C 20/2006*
•	PROVIDER OR SUPPLIER	NTER		37	EET ADDRESS, CITY, STATE, ZIP CODE 706 WEST 9000 SOUTH /EST JORDAN, UT 84088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	Based on medical review and interview of 6 sampled reside that all alleged viola unknown source we State survey and ce alleged injuries of u investigated to prev Specifically, resident bruising of unknowr the body. These brunor reported to the Stindings include:  A. On 3/20/06 the final procedures for prohing the "Investigation a portion of the policy"  1. Any person that or misappropriation occurred, will immediation to the facility advocacy agencies.  2. Administration will of unknown origin, since it is property in residents, abuse, and resident's property in reported to the Stindings by interview.	ecord review, incident report wit was determined that for 4 ents the facility did not ensure ations involving injuries of the present of the entification agency or that the entification and further potential abuse.  It is 2, 4, 5, and 6 aquired or entification and investigated states are not investigated. State survey agency.  It is policies and investigated and investigated and reporting procedures states the following:  It is suspects that abuse, neglect, of property may have diately report the alleged by administration and or entification.  It immediately notify Injuries ignificant incidence between and misappropriation of	F 2	225	Director of Nursing will review all incident rep daily during the work week assure that abuse/injuries o unknown origin are investigand reported to the proper agencies according to state and report to the Adm/Qual Assurance Committee daily the next 30 days then week thereafter.	to f gated state law ity	

	OF CORRECTION	IDENTIFICATION NUMBER:	' '	ULTIPLE LDING	E CONSTRUCTION	(X3) DATE	LETED
		465108	B. WIN	IG	· · · · · · · · · · · · · · · · · · ·	03/	C * . 20/2006
	ROVIDER OR SUPPLIER	NTER		3706	T ADDRESS, CITY, STATE, ZIP COE WEST 9000 SOUTH ST JORDAN, UT 84088		20/2000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	investigation within	on will complete the the the next 5 days and will iews including the date, time,	F2	225			
	findings as to whet verified and report which were notified investigation. If the required that surve	document a summary of its her the alleged abuse was its findings to the agencies at the beginning of the nature of the incident y and certification was initially of the investigation must be					
	Coordinator was interest injury of unknown the facility will report all allegations of abstated that the staff any hint of abuse in Administration. He injury of unknown of allegation to the staff investigate. He furt they did an investigate and two aides put the facility considered.  2. On 3/20/06 3 fact Assistants) were interest in the facility considered.	50 PM the facility Abuse serviewed. He stated that sown origin is reported to the diately. He further stated that it first and investigate later with use. The Abuse Coordinator have been instructed to report inmediately to him or stated that if the abuse is an inigin the facility will report the te agency that day and then her stated that just recently ation due to a resident falling he resident back into bed urse examine the patient so					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII	CIPLE CONSTRUCTION NG	(X3) DATE : COMPL	
	465108	B. WING		03/:	C ". 20/2006
NAME OF PROVIDER OR SUPPLIER SOUTH VALLEY HEALTH CE	NTER		REET ADDRESS, CITY, STATE, ZIP C 3706 WEST 9000 SOUTH WEST JORDAN, UT 84088		
PRÉFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
nurse can go and of further stated that to inservice on abuse 3. On 3/20/06 3 far regarding abuse. A bruise is found on a from a CNA they go document it in the ostated that they do for a bruise unless occurring. The nurwitness the injury the incident report they to find out who first other nurse chart it nurses further state inservice on abuse report the abuse im C. Injuries of Unknown 1. Resident 2 was facility on 1/2/03 with Alzeheimers, anemical ulcer.  On 3/20/06 resident reviewed.  The following entries nurse's notes by face 2/23/06 "Res (resid to bed. Was found Bruising to L (left) eyes.	the bruise to the nurse, so the check it out. The CNA's the facility had just had an and who to report to.  cility nurses were interviewed all three nurses stated that if a resident or reported to them and check it out and then chart. The nurses further not fill out an incident report they witness the injury ses stated that if they don't nen they don't fill out an just talk with the other shifts observed it and why didn't the in the medical record. The dot that the facility just had an and they were instructed to mediately to Administration.  Town Origin:  originally admitted to the h diagnosis which included, italy pertension, and gastric exists afficiently attempted to transfer self lying upside down in bed.	F 225			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
		465108	B. WING	S	03/:	C * . 20/2006
	PROVIDER OR SUPPLIER  VALLEY HEALTH CEI	NTER	S	STREET ADDRESS, CITY, STATE, ZIF 3706 WEST 9000 SOUTH WEST JORDAN, UT 84088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	both eyes, L (left) e [with] dark purple by NOC (night) [with] [with] [with] [distress noted"  2/25/06 "pt. rested of (signs or symptoms [with] purplish bruish 2/26/06 "NOC. Restoruising to both eye Appears to be in [not Review of the facility revealed an incident staff on 2/23/06 regulation of incident and describing and commented, by a factorising and the "Resident Incided (certified nursing as to put Res (resident was already in bedinaticed bruising and eye brow area."  Review of the incide staff members wither sustained.  Review of state agent that the injury of unk to the State survey a did the agency received.	ye lid [with] slight swelling ruise, pt. slept well through no] c/o's (complaints) or well [with] [no] c/o's or s/s ) distress noted, both eye lids es"  cont. (continues) to have lids more so to the L lid. of pain or discomfort"  y incident reports on 3/20/06 treport filled out by facility arding resident 2. It was acility nurse, in the "Narrative cription of injuries" section of the Report" that, "CNA sistant) reported that he went of to bed and found that Res lying upside down. CNA also swelling to L (left) eye lid and ant report revealed that no essed the injury that resident 2 hocy documentation revealed nown origin was not reported and certification agency nor eye a final investigation report.	F 22	25		
		njury of unknown origin.  dmitted to the facility on				

Summer of Provider or Supplier   South Valley Health Center   South Valley Health Center		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPI ILDING	LE CONSTRUCTION		(X3) DATE : COMPL		
SOUTH VALLEY HEALTH CENTER  (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)  F 225  Continued From page 6 show that the facility on 11/11/03 with diagnosis which included, Alzeheimers, Hypothyroidism and incontinence.  On 3/20/06 resident 5's medical record was reviewed.  The following entries were documented in the nurse's notes by facility staff:  3/6/06 "A report was received from NOC (night) shift nurse that a large bruise on L (left) side of neck of pt (patient) was noted pt assess and ask How did the bruise happen pt. unable to verbalize! pt c/o (complains of) pain @ (at) touch"  3/8/06 "1600 (4:00 PM) - Bruise noted on L neck area in healing process. Getting smaller [with] yellow [and] greenish colors, Res. (resident) denies pain but is alert to bruise. Cannot verbalize knowledge of how happened."			465108	ŀ				03 <i>/</i> °	•	
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 225  Continued From page 6 show that the facility administration conducted an investigation of the injury of unknown origin.  3. Resident 5 was admitted to the facility on 11/11/103 with diagnosis which included, Alzeheimers, Hypothyroidism and incontinence.  On 3/20/06 resident 5's medical record was reviewed.  The following entries were documented in the nurse's notes by facility staff:  3/6/06 "A report was received from NOC (night) shift nurse that a large bruise on L (left) side of neck of pt (patient) was noted pt assess and ask How did the bruise happen pt. unable to verbalize! pt c/o (complains of) pain @ (at) touch"  3/8/06 "1600 (4:00 PM) - Bruise noted on L neck area in healing process. Getting smaller [with] yellow [and] greenish colors. Res. (resident) denies pain but is alert to bruise. Cannot verbalize knowledge of how happened."		•••	NTER		370	06 WEST 9000 SOUTH	DDE	001	20/2000	
show that the facility adminstration conducted an investigation of the injury of unknown origin.  3. Resident 5 was admitted to the facility on 11/11/03 with diagnosis which included, Alzeheimers, Hypothyroidism and incontinence.  On 3/20/06 resident 5's medical record was reviewed.  The following entries were documented in the nurse's notes by facility staff:  3/6/06 "A report was received from NOC (night) shift nurse that a large bruise on L (left) side of neck of pt (patient) was noted pt assess and ask How did the bruise happen pt. unable to verbalize! pt c/o (complains of) pain @ (at) touch"  3/8/06 "1600 (4:00 PM) - Bruise noted on L neck area in healing process. Getting smaller [with] yellow [and] greenish colors. Res. (resident) denies pain but is alert to bruise. Cannot verbalize knowledge of how happened."	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOU	LD BE	COMPLETIO	N
3/9/06 "1200 (12:00 PM)Bruise on L neck and throat area getting smaller Dark purple, yellow [and] greenish colored."  Review of facility incident reports on 3/20/06 revealed an incident report completed by facility staff on 3/5/06 regarding resident 5. It was documented, by a facility nurse, in the "Narrative of incident and description of injuries" section of the "Resident Incident Report" that " 1930 (7:30 PM) resident noticed to have large New Bruise on L (left) side of front part of neck - Also she has a small cut in L hand that looks like a claw mark -		show that the facility investigation of the 3. Resident 5 was a 11/11/03 with diagnary Alzeheimers, Hypother Teviewed.  The following entries nurse's notes by factor of the following entries have been shift nurse that a large neck of pt (patient) whow did the bruise here had been shift nurse that a large neck of pt (patient) who did the bruise here had been shift nurse that a large neck of pt (patient) who will be the following process of the facility incident and throat area getting yellow [and] greenish revealed an incident staff on 3/5/06 regard documented, by a factor of incident and describe "Resident Incident PM) resident noticed L (left) side of front pt	y adminstration conducted an injury of unknown origin.  admitted to the facility on osis which included, hyroidism and incontinence.  5's medical record was  s were documented in the illity staff:  s received from NOC (night) ge bruise on L (left) side of was noted pt assess and ask nappen pt. unable to implains of) pain @ (at)  PM) - Bruise noted on L neck ess. Getting smaller [with] in colors. Res. (resident) ert to bruise. Cannot of how happened."  PM) Bruise on L neck ing smaller Dark purple, in colored."  ident reports on 3/20/06 report completed by facility ding resident 5. It was cility nurse, in the "Narrative ription of injuries" section of int Report" that " 1930 (7:30 to have large New Bruise on art of neck - Also she has a	F2	225			1		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONS LDING	STRUCTION	(X3) DATE COME	SURVEY PLETED
		465108	B. WIN	G		_   03	C * . /20/2006
i	ROVIDER OR SUPPLIER	ITER		3706 WES1	RESS, CITY, STATE, ZII T 9000 SOUTH RDAN, UT 84088		2012000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (E.	PROVIDER'S PLAN OF ACH CORRECTIVE AC SS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	4/1/02 with diagnosis small bowel obstruction on 3/20/06 resident reviewed.  The following entry nurse's notes by fact entry. MD assess yet [no] orders given @ 2/14/06."  Review of the facility revealed an incident staff on 2/12/06 reg documented, by a fact of incident and describe "Resident Incident (resident) was being by her CNA (certified time when incident obruising to the pubic that no additional do on the incident report pubic area. The incident area. The incident staff members witnesstaff members witnesstaff members witnesstaff members witnesstaff members witnesstaff members witnesstaff the injury of unknown to the State survey as	is which included, Dementia, ition, and diabetes.  4's medical record was  was documented in the ility staff on 2/18/06. "Late ellowish bruise on pubic area this time assessment done  of incident reports on 3/20/06 report completed by facility arding resident 4. It was incitity nurse, in the "Narrative ription of injuries" section of int Report" that, "Restransferred from chair to bed incurred. There is also a slight area." It should be noted cumentation could be found to regarding bruising to the dent report was orginally tear that resident 4 transfer from the chair to the interport revealed that no issed the bruising injury that	F 2	25			
	No documentation co	ould be found in the facility to					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION IG	(X3) DATE :	
		465108	B. WII	1G _		03/:	C
	ROVIDER OR SUPPLIER	NTER		3	REET ADDRESS, CITY, STATE, ZIP CODE 1706 WEST 9000 SOUTH VEST JORDAN, UT 84088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Pt. denies pain - doc the bruise -"  Review of the incideresident 5 revealed bruise or injury of resident the injury of unkto the State survey add the agency received that the injury of unkto the State survey add the agency received.  No documentation of show that the facility investigation of the inve	es not recall how she obtained ent report completed for that no staff witnessed the esident 5.  Incy documentation revealed known origin was not reported and certification agency nor live a final investigation report could be found in the facility to adminstration conducted an injury of unknown origin.  Leadmitted to the facility on the eadmitted to the facility of the eadmitted to the facilit	F 2	225			
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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465108 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3706 WEST 9000 SOUTH

		465108	B. WII	NG		]	C ",
NAME OF F	PROVIDER OR SUPPLIER	700100				03	/20/2006
	VALLEY HEALTH CEN	TER		370	ET ADDRESS, CITY, STATE, ZIP CODE 06 WEST 9000 SOUTH EST JORDAN, UT 84088		
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	FEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	Continued From pag	ge 8 ncy documentation revealed	F 2	225			
	that the injury of unk to the State survey a	nown origin was not reported and certification agency nor ve a final investigation report					
	show that the facility	ould be found in the facility to adminstration conducted an njury of unknown origin.					
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