PRINTED: 04/03/2006 FORM APPROVED OMB NO. 0938-0391

MILLARD COUNTY CARE CENTER    SIMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MIST BE PRECEEDED BY FULL TAGE (PACH DEFICIENCY)    F 281		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
MILLARD COUNTY CARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 281 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS SS-E  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:  Based on observations, staff interviews, and record review, it was determined that the facility did not ensure professional standards of quality were met. Specifically, facility nursing staff had not discarded insulin vials when indicated.  Additionally, one insulin vial was not dated to identify when it had been opened. The insulin vials belonged to Residents 12, 13, and 14.  Findings include:  On 3/21/06, beginning at 7:40 AM, the surveyor asked the south hall charge nurse (a registered nurse) if she had administered insulin to any residents that morning. The charge nurse stated she had administered both Regular and NPH insulin to Resident 12 and 70/30 insulin to Resident 12.  The surveyor asked to observe the insulin vials for Residents 12 and 13. The charge nurse obtained each of the vials from the mediation refrigerator located at the South Hall nursing station. The Regular insulin vials of Resident 12 bad at stanged label with a date of 2 AMAGE.			465157	B. WING		03/23/2006
F 281 SS=E The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:  Based on observations, staff interviews, and record review, it was determined that the facility did not ensure professional standards of quality were met. Specifically, facility nursing staff had not discarded insulin vials when indicated. Additionally, one insulin vial was not dated to identify when it had been opened. The insulin vials belonged to Residents 12, 13, and 14.  Findings include:  On 3/21/06, beginning at 7:40 AM, the surveyor asked the south hall charge nurse (a registered nurse) if she had administered insulin to any residents that morning. The charge nurse stated she had administered both Regular and NPH insulin to Resident 12 and 70/30 insulin to Residents 12 and 13. The charge nurse obtained each of the vials from the mediation refrigerator located at the South Hall nursing station. The Regular insulin vials for Residents 12 had a stronged label with a gate of 1.2 MAMS.				S	150 SOUTH WHITE SAGE AVEN	
The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by:  Based on observations, staff interviews, and record review, it was determined that the facility did not ensure professional standards of quality were met. Specifically, facility nursing staff had not discarded insulin vials when indicated.  Additionally, one insulin vial was not dated to identify when it had been opened. The insulin vials belonged to Residents 12, 13, and 14.  Findings include:  On 3/21/06, beginning at 7:40 AM, the surveyor asked the south hall charge nurse (a registered nurse) if she had administered insulin to any residents that morning. The charge nurse stated she had administered both Regular and NPH insulin to Resident 12 and 70/30 insulin to Resident 13.  The surveyor asked to observe the insulin vials for Residents 12 and 13. The charge nurse obtained each of the vials from the mediation refrigerator located at the South Hall nursing station. The Regular insulin vial for Resident 12 and a tensed label with a date of "20/0/06".	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE COMPLETE HE APPROPRIATE DATE
The NPH insulin vial for Resident 12 had no tapped label or date written on it. The 70/30 insulin vial for Resident 13 had a tapped label with a date of " 2/06/06".  On 3/22/06 at 7:10 AM, the surveyor asked the Certification and Resident Assess		The services provinust meet profes  This REQUIREMI by: Based on observate record review, it will did not ensure proview meet. Specific not discarded insidentify when it havials belonged to Findings include:  On 3/21/06, begind asked the south I nurse) if she had residents that make had administ insulin to Resident 13.  The surveyor ask for Residents 12 obtained each of refrigerator locate station. The Regulation at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date of "at the NPH insulin tapped label or dinsulin vial for Rewith a date o	cided or arranged by the facility sional standards of quality.  ENT is not met as evidenced ations, staff interviews, and was determined that the facility of essional standards of quality fically, facility nursing staff had ulin vials when indicated. Insulin vial was not dated to ad been opened. The insulin Residents 12, 13, and 14.  Inning at 7:40 AM, the surveyor hall charge nurse (a registered administered insulin to any orning. The charge nurse stated the tered both Regular and NPH int 12 and 70/30 insulin to seed to observe the insulin vials and 13. The charge nurse if the vials from the mediation ed at the South Hall nursing ular insulin vial for Resident 12 in with a date of "2/04/06". Vial for Resident 12 had no late written on it. The 70/30 esident 13 had a tapped label 2/06/06".	FOUNDER AND SOLONO	F-281 Insulin vials for res #12, 13, and 14 we and replaced on 3/new vials were date on the vial.  Staff will be educa "Use of Multidose also on the procede ing vials for outdat administration of n Training will be co 05/02/06.  Checking for outdat vials will be added charge nurse duties  DON will check al 04/19/06 for outdat monitor monthly th  DON will give ver report of complian QA meeting on 6/2 report at QA meetit thereafter.  Utah Depail	ted to policy Vials" and ure of check- es prior to medication. Impleted on  the son all open to weekly s schedule. I open vials on tes. DON will tereafter.  bal and written ce at quarterly 18/06. She will mg quarterly  I ment of Health  The Facility Licensing.
South Hall charge nurse if they could view all of  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE		South Hall charg	e nurse if they could view all of		Cermication a	(X8) DATE

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.

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	PLE CONSTRUCTION  3	(X3) DATE SU COMPLE	
	465157	B, WIN	IG		03/23	/2006
NAME OF PROVIDER OR SUPPLIER  MILLARD COUNTY CARE CE	NTER	•	15	EET ADDRESS, CITY, STATE, ZIP CODE 60 SOUTH WHITE SAGE AVENUE ELTA, UT 84624		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
South Hall medica observed Residen insulin vials. The label with a date or vial had no tapped surveyor observed vial. The 70/30 ins a date of "2/06/06 On 3/22/06 at 7:15 South Hall charge on the insulin vials stated the date on insulin vials were of the charge nurse with know. The charge could only be used opened.  On 3/21/06 at 7:55 North Hall charge nurse) if she had a residents that more she had administed 14. The surveyor insulin vial for Residents that more she had administed 14. The insulin vial for Residents that more she had administed 15 obtained the insulin refrigerator located station. The insulin vial charge the insulin vials of "2/03/06 at 8:00 North Hall charge the insulin vials of Hall medication reposerved Resider	rrently being stored in the tion refrigerator. The surveyor to 12's Regular and NPH Regular insulin vial had tapped if "2/04/06". The NPH insuling tabel with a date. The Resident 13's 70/30 insuling sulin vial had tapped label with 3".  AM, the surveyor asked the nurse what the tapped labels indicated. The charge nurse the labels identified when the opened. The surveyor asked why that date was necessary to enurse replied that the insuling of for three months after being the formulation of the charge nurse stated administered insuling to any ming. The charge nurse stated ared Regular insuling to Resident asked to observe the Regular sident 14. The charge nurse in from the mediation dat the North Hall nursing in vial had a tapped label with a	F	281	4/18/06 Per Tele To DON Falility Internum QA mo- pur to compula and tags of 5/ Busenba	15/06	1 pm

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING COMP		DATE SURVEY COMPLETED			
		465157	B. WIN	G			03/23/2006	Ì
	PROVIDER OR SUPPLIER  D COUNTY CARE CE			150	T ADDRESS, CTY, STATE, ZIP SOUTH WHITE SAGE AVENU TA, UT 84624			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD B HE APPROPRIA	E COMPLETIO	<b>N</b>
F 281	North Hall charge ron the insulin vials stated the date on insulin vials were of the charge nurse with the charge nurse with the charge nurse with the charge nurse with the charge could only be used opened.  On 3/22/06 at 3:30 from the Administration of the policy regarding the including insulin. On the county of the form the copy of the form the copy of the co	AM, the surveyor asked the nurse what the tapped labels indicated. The charge nurse the labels identified when the pened. The surveyor asked thy that date was necessary to nurse replied that the insulin for three months after being  PM, the surveyor requested ator a copy of the facility 's a use of multi-dose vials, on 3/23/06 at 8:30 AM, the (DON) provided the surveyors acility 's policy titled, " Multi-ose Vials." The policy d, " Multi-dose vials may ays. Multi-dose vials need to ned."  rmacy Society of Wisconsin, as 2 Insulin Storage and ed that potency loss may be of insulin had been in use a month. Specifically, Regular, sulin is stable if used within 28 was punctured, whether they are at room temperature.  Product/insulin gives general the storage of insulin products. Insulin storage for Regular, sulin is 28 days. This	F2	281				

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

Event ID: MOWK11

Facility ID: UT0093

If continuation sheet Page 3 of 15

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SU COMPLE		
		465157	B. WII	IG		03/2:	3/2006
·	ROVIDER OR SUPPLIER  COUNTY CARE CE	NTER		16	EET ADDRESS, CITY, STATE, ZIP CODE 50 SOUTH WHITE SAGE AVENUE ELTA, UT 84624		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERÊNCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 3	F	281			
F 333 SS=D	The facility must eany significant me  This REQUIREME by: Based on observate record review, it will did not ensure that selected for Medic resident was free Specifically, a faci provide guidance proper administration (MDI).  Findings include: Resident 15 was 3/01/04, his diagrobstructive pulmonary fibrosition on 3/21/06 at 7:2 was observed president MDI, receive two puffs Combivent MDI, receive two puffs Combivent MDI a succession, less Resident 15 was Combivent MDI,	tions, staff interviews, and ras determined that the facility at for 1 of 11 residents randomly cation Pass observation, the of significant medication errors. Ility registered nurse did not to Resident 15 with regard to tion of a Metered Dose Inhaler admitted to the facility on loses included: chronic anary disease, depression,		333	F-333 Resident # 15 will be en DON on Manufacturers tions for usage of MDI information by April 21 Resident will demonstrate verbalize correct self a tion to DON.  All licensed nursing streducated on correct us manufacturers specific April 27, 2006.  DON will observe admost MDI by nursing staverbal and written regiven by DON at quar meeting on 6/28/06 at the reafter.	especifica- per product 3, 2006. ate and dministra- aff will be e of MDI per ations on ministration ff monthly. cort will be terly QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Italy and the territoria MAN MOUNT CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
465157	B. WING		03/23/2006	
NAME OF PROVIDER OR SUPPLIER  MILLARD COUNTY CARE CENTER	15	EET ADDRESS, CITY, STATE, ZIP CODE 0 SOUTH WHITE SAGE AVENUE ELTA, UT 84624		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
guidance to Resident 15 with regard to the proper adminstration of the medication.  On 3/22/06 at 12:02 PM, the same facility registered nurse was observed preparing medications for Resident 15. The registered nurse handed resident 15 a Combivent MDI, for which the resident was to receive two puffs. The resident shook the Combivent MDI and took two puffs in rapid succession, less than five seconds apart. While Resident 15 was self administering the Combivent MDI, the registered nurse was at the bedside. The registered nurse provided no guidance to Resident 15 with regard to the proper administration of the medication.  On 3/22/06 at 4:00 PM, an interview was held with the Administrator and a different facility registered nurse. The surveyor requested a copy of the facility's policy regarding the administration of inhaled medications. The surveyor asked both the Administrator and the registered nurse if they were aware of any guidelines regarding the time interval between doses of inhaled respiratory medications such as Combivent MDI. Both the Administrator and the registered nurse were unaware of any such guidelines. The surveyor asked the registered nurse if she had ever been assigned to administer medications, including Combivent MDI to Resident 15. She replied that she had on several occasions and that Resident 15. The surveyor requested a copy of the manufacturer's product insert for Resident 15's Combivent MDI. The registered nurse retrieved this information for the surveyor and acknowledged she had not been aware that there must be a one-minute interval between doses of the Combivent MDI, as the	F 333			

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FORM APPROVED
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	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI		OING (X3) DATE SUR			
		465157	B. WII	4G_			03/23	/2006
	ROVIDER OR SUPPLIER  COUNTY CARE CE	NTER		10		S, CITY, STATE, ZIP CODE /HITE SAGE AVENUE 84624		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEEDED BY FULL  SC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				ULD BE	(XS) COMPLETION DATE
F 333 F 371 SS=E	product insert instr On 3/22/06 at appr Director of Nursing facility's policy reg medications includ manufacturer's sp the Combivent MD doses.  On 3/22/06 at 4:30 had been observed Resident 15 on 3/2 the surveyor and s something about C nurse stated she h doses of Combiver administered, there between doses. S had known about t  A review of the ma regarding the prep Combivent MDI inc Combivent Inhale one minute and Sh each inhalation pre  483.35(h)(2) SANI PREP & SERVICE The facility must si	oximately 4:30 PM, the informed the surveyor that the parding inhaled respiratory ed guidance to follow the pecifications, and in the case of I to wait one minute between  PM, the registered nurse, who dispreparing medications for 21/06 and 3/22/06, approached tated she had just learned combivent MDI. The registered ad learned that if multiple int MDI were being a must be at least two minutes the stated she was the first she this guidance.  Inufacture 's specifications aration and administration of cluded the following: I package insert, "6. Wait HAKE the inhaler again for escribed by your physician."  TARY CONDITIONS - FOOD		333	F-371	(a) Dietary personnel weducated on appropriate of food on 04/20/06.	handling	
		anitary conditions.  NT is not met as evidenced				Dietary employees will contact exposed, ready food with their hands. Sutensils such as spatular other dispensing equipm utilized.	to eat Suitable s, tongs and	

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

Event ID: MOWK11 Facility ID: UT0093

If continuation sheet Page 6 of 15

NAME OF PROVIDER OR SUPPUER  MILLARD COUNTY CARE CENTER  MILLARD COUNTY CARE CENTER  DOD 10 SUMMARY STATEMENT OF DETICIENCIES TARK EACH DEFICIENCY MUST BE PRECEDED BY TRUL. REGULATORY OR LSC IDENTIFYING INFORMATION)  FRETEX TAGE  F 371 Continued From page 6  Based on observations of breakfast being served and a kitchen inspection, it was determined that the facility staff did not consistently store and distribute food under sanitary conditions.  Findings included:  1. On 3/21/05 at 7.45 AM, in the North Hall dining area, breakfast was observed being served from a portable serving cart. The food server was observed to lace the sane tray repeatedly to deliver resident meals. Staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed buse the same tray repeatedly to deliver resident meals. Staff were observed buse the same tray repeatedly to deliver resident meals. Staff were observed buse the same tray repeatedly to deliver resident meals. Staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed buse the same tray repeatedly to deliver resident meals. Staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed placing French toast on the plates that were to be served to the residents willhout using a kitchen utensit to handle the food. The food server was observed placing French toast on the plates that were to be served to the residents. She was then observed to repositioned the toast on plates that were to be served to the residents. She was then observed to repositioned the toast on the plates that were to be served to the residents. She was then observed to repositioned the toast on the plates. The plate of the residents were to be served to the residents. S		F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING  B. WING			COMPLETED	
MILLARD COUNTY CARE CENTER    TOTAL   Continued From page 6			465157	B. WI	, NO _		03/2	3/2006
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FINATE  F371  Continued From page 6  Based on observations of breakfast being served and a kitchen inspection, it was determined that the facility staff did not consistently store and distribute food under sanklary conditions.  Findings included:  1. On 3/21/06 at 7:45 AM, in the North Hall dining area, breakfast was observed being served from a portable serving cart. The food server was observed to place biscuits and bacon on to the plates that were to be served to the residents. The food server was not using a kitchen utensit to handle the food. The food server was and return the tray to the food server for the next resident's meal.  2. On 3/22/06 at 7:50 AM, in the North Hall dining area, breakfast was observed being served from a portable serving cart. The food server was not custing a kitchen utensit to handle the food the bandle the food the bandle the food server was and return the tray to the food server for the next resident's meal.  2. On 3/22/06 at 7:50 AM, in the North Hall dining area, breakfast was observed being served from a portable serving cart. The food server was observed to the residents without using a kitchen utensit to handle the food. The food server was observed and attent were to be served to the residents without using a kitchen utensit to handle the food. The food server was observed placing French toast on the plates that were to be served to open a conditionally, staff were observed at the serving of the food server was observed to the residents without using a kitchen utensit to handle the food. The food server was observed to a resident use the same scissors.  3. On 3/22/06 at 8:15 AM, in the South Hall dining area, the food server was observed to use a spatula to place French toast on plates that were to be served to the residents. She was then			NTER	-	1	50 SOUTH WHITE SAGE AVENUE		
Based on observations of breakfast being served and a kitchen inspection, it was determined that the facility staff did not consistently store and distribute food under sanitary conditions.  Findings included:  1. On 3/21/06 at 7:45 AM, in the North Hall dining area, breakfast was observed being served from a portable serving cart. The food server was observed to place biscuits and bacon on to the plates that were to be served to the residents. The food server was not using a kitchen utensit to handle the food. The food server was also observed to touch the diet tray cards, condiments, milk cartons, and yogurt cartons. Additionally, staff were observed to use the same tray repeatedly to deliver resident meals. Staff were observed to set the tray on dining tables and return the tray to the food server was observed form a portable serving cart. The food server was observed to be the same tray resident's meal.  2. On 3/22/06 at 7:50 AM, in the North Hall dining area, breakfast was observed being served from a portable serving cart. The food server was observed being served from a portable serving cart. The food server was observed being served from a portable serving cart. The food server was observed being served from a portable serving cart. The food server was observed to the residents without using a kitchen utensit to handle the food. The food server also touched the tray cards and used a pair of scissors to open a condiment. This occurred after another staff member had assisted a resident use the same escisors.  3. On 3/22/06 at 8:15 AM, in the South Hall dining area, the food server was observed to use a spatula to place French toast on plates that were to be served to the residents. She was then	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	QULD BE	COMPLETION
	F 371	Based on observal and a kitchen insp the facility staff did distribute food und findings included:  1. On 3/21/06 at 7 area, breakfast was a portable serving observed to place plates that were to The food server whandle the food. Tobserved to touch milk cartons, and staff were observed repeatedly to delivobserved to set the return the tray to tresident's meal.  2. On 3/22/06 at 7 area, breakfast was a portable serving observed placing were to be served kitchen utensil to I server also touche pair of scissors to occurred after and a resident use the 3. On 3/22/06 at 6 dining area, the foa spatula to place were to be served were to be served were to be served were to be served were to be served.	tions of breakfast being served ection, it was determined that not consistently store and ler sanitary conditions.  2:45 AM, in the North Hall dining is observed being served from cart. The food server was biscuits and bacon on to the be served to the residents. as not using a kitchen utensil to he food server was also the diet tray cards, condiments, yogurt cartons. Additionally, and to use the same tray fer resident meals. Staff were e tray on dining tables and the food server for the next.  2:50 AM, in the North Hall dining as observed being served from cart. The food server was French toast on the plates that to the residents without using a mandle the food. The food ed the tray cards and used a open a condiment. This other staff member had assisted same scissors.  3:15 AM, in the South Hall od server was observed to use French toast on plates that to the residents. She was then	F	371	meal serving on each neighbor By 04/28/06. Manager will co To monitor monthly thereafter  Verbal and written report of ce will be given at quarterly QA 06/28/06 by dietary manager. will report quarterly to QA co meeting thereafter.  (b) Jello/Pudding in walk in ce was covered and dated with pe date on 03/20/06.  Dietary personnel will be educappropriate covering and mar- prepared food items on 04/20.  Dietary Manager will do chece walk-in cooler weekly to mon correct storage and marking of food items.  Verbal and written report of ce will be given at quarterly QA 06/28/06 by dietary manager. will report quarterly to QA co	ompliance meeting on Manager minitee cooler reparation cated on king of 606.  ks of itor for f prepared compliance meeting on Manager	

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OF DEFICIENCIES F CORRECTION	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER:  A. BUILDING (X3) DATE SURVEY COMPLETED					
	465157	B. WI	1G		03/23	3/2006
COUNTY CARE CE	NTER		15	0 SOUTH WHITE SAGE AVENUE		
(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL			(EACH CORRECTIVE ACTION SHO	OULD BE	(XS) COMPLETION DATE
with the same glov touch menu cards. observed to place resident's plate wit then observed to retoast from the plate the warming containand that were use serving containers straws and serving 4. During the initia at 2:30 PM, it was refrigerator that a term of the touch the term of t	red hand that was used to A second food server was bacon on an individual h a gloved hand. She was emove the bacon and French e and placed them back into iners with the same gloved ed to touch milk cartons, juice glasses, unwrapped trays.  Il tour of the kitchen on 3/20/06 observed in the walkin tray of jello/pudding was not	F	371			
The drug regimen reviewed at least of pharmacist.  This REQUIREME by: Based on staff interwas determined the that the drug regiment reviewed at least of pharmacist. This residents. (Residents.)  Findings include: Resident 1 was additional reviewed at least of pharmacist.	of each resident must be once a month by a licensed.  ENT is not met as evidenced erviews and record review, it hat facility staff failed to ensure hen of each resident was once a month by a licensed occurred for 10 of 11 sampled ents 1, 2, 3, 4, 5, 6, 7, 8, 9, and limitted to the facility on 8/1/05	F	428			
	COUNTY CARE CE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR IT  Continued From particular the same glow touch menu cards observed to place resident's plate with then observed to resident's plate with the warming containers straws and serving 4. During the initia at 2:30 PM, it was refrigerator that a transport to the drug regimen reviewed at least of pharmacist.  This REQUIREME by:  Based on staff interviewed at least of pharmacist.  This requirement that the drug regimen reviewed at least of pharmacist.  This requirement into the transport of the trug regimen reviewed at least of pharmacist.  This requirement into the trug regiment of the trug regimen reviewed at least of pharmacist.  This requirement into the trug regiment of the tru	COUNTY CARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  with the same gloved hand that was used to touch menu cards. A second food server was observed to place bacon on an individual resident's plate with a gloved hand. She was then observed to remove the bacon and French toast from the plate and placed them back into the warming containers with the same gloved hand that were used to touch milk cartons, serving containers, juice glasses, unwrapped straws and serving trays.  4. During the initial tour of the kitchen on 3/20/06 at 2:30 PM, it was observed in the walkin refrigerator that a tray of jello/pudding was not covered and it did not have a preparation date.  483.60(c)(1) DRUG REGIMEN REVIEW  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  This REQUIREMENT is not met as evidenced by:  Based on staff interviews and record review, it was determined that facility staff failed to ensure that the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist. This occurred for 10 of 11 sampled residents. (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.)	A BUILD RESIDENT BOYLONG THE BUILD REGULATORY OR LSC IDENTIFICATION NUMBER:  A BUILD REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  with the same gloved hand that was used to touch menu cards. A second food server was observed to place bacon on an individual resident's plate with a gloved hand. She was then observed to remove the bacon and French toast from the plate and placed them back into the warming containers with the same gloved hand that were used to touch milk cartons, serving containers, juice glasses, unwrapped straws and serving trays.  4. During the initial tour of the kitchen on 3/20/06 at 2:30 PM, it was observed in the walkin refrigerator that a tray of jello/pudding was not covered and it did not have a preparation date.  483.60(c)(1) DRUG REGIMEN REVIEW  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  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Findings include:  Resident 1 was admitted to the facility on 8/1/05	A BUILDING  465157  STREET ADDRESS, CITY, STATE, 2IP CODE 180 SOUTH WHITE SAGE AVENUE DELTA, UT 84624  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  With the same gloved hand that was used to touch menu cards. A second food server was observed to place bacon on an individual resident's plate with a gloved hand. She was then observed to remove the bacon and French toast from the plate and placed them back into the warming containers with the same gloved hand that were used to touch milk cartons, serving containers, juice glasses, unwrapped straws and serving trays.  4. During the initial tour of the kitchen on 3/20/06 at 2:30 PM, it was observed in the walkin refrigerator that a tray of jello/pudding was not covered and it did not have a preparation date.  483.60(c)(1) DRUG REGIMEN REVIEW  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  This REQUIREMENT is not met as evidenced by:  Based on staff interviews and record review, it was determined that facility staff failed to ensure that the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist. This occurred for 10 of 11 sampled residents. (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.)  Findings include:  Resultation Resident to the facility on 8/1/05	COMPLET SUBJECT OF THE ABOUT OF DESCRIPTION NUMBER:  465157  STREET ADDRESS, CITY, STATE, ZIP CODE 150 SOUTH WHITE SAGE AVENUE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  with the same gloved hand that was used to touch menu cards. A second food server was observed to place bacon on an individual resident's plate with a gloved hand. She was then observed to remove the bacon and French toast from the plate and placed them back into the warming containers with the same gloved hand that were used to touch milk cartons, serving containers with the same gloved hand that was observed in the walkin refrigerator that a tray of jello/pudding was not covered and it did not have a preparation date.  483.60(c)(1) DRUG REGIMEN REVIEW  The drug regimen of each resident must be reviewed at teast once a month by a licensed pharmacist.  This REQUIREMENT is not met as evidenced by:  Based on staff interviews and record review, it was determined that facility staff failed to ensure that the drug regimen of each resident was reviewed at teast once a month by a licensed pharmacist. This occurred for 10 of 11 sampled residents. (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10.)  Findings include:  Resident 1 was admitted to the facility on 8/1/05

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET			
		465157	B. WIN	1G_		03/23	3/2006
	ROVIDER OR SUPPLIER  COUNTY CARE CE	NTER		15	EET ADDRESS, CITY, STATE, ZIP CODE 50 SOUTH WHITE SAGE AVENUE ELTA, UT 84624	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	regimen reviews resuggest the reside by a licensed phar December 2005.  Resident 2 was act and resided in the December 2005, regimen reviews resuggest the reside by a licensed phar December 2005.  Resident 3 was act and resided in the December 2005, regimen reviews resuggest the reside by a licensed phar December 2005.  Resident 4 was act 11/18/05 and resided to the december 2005.  Resident 5 was act and resided in the December 2005.  Resident 5 was act and resided in the December 2005.  Resident 5 was act and resided in the December 2005.  Resident 5 was act and resided in the December 2005.	A review of resident 1's drug evealed no documentation to ent's medications were reviewed macist for the month of draility throughout the month of A review of resident 2's drug evealed no documentation to ent's medications were reviewed macist for the month of A review of resident 3's drug evealed no documentation to ent's medications were reviewed revealed no documentation to ent's medications were reviewed revealed no documentation to ent's medications were reviewed revealed no documentation to ent's medications were reviewed reviews for the month of draility do do the facility throughout the ereviews revealed no suggest the resident's ereviewed by a licensed ereviewed by a licensed ereviewed to the facility on 8/4/04 facility throughout the month of A review of resident 5's drug revealed no documentation to ent's medications were reviewed armacist for the month of		428	Contracted Pharmacist was educated requirement of reviewing all residents 1,2,3,4,5,6,7,8,9 on 04/05/06.  Pharmacist will review all resident regimes by 04/28/06. Pharmacist continue to monitor monthly there DON will audit all charts before month end April, May, and June insure that pharmacist visit was to Pharmacist will be contacted and reminded if visit has not been maded if visit has not been maded by will audit random charts in thereafter.  Verbal and written report will be given by DON at quarterly QA meeting on 06/28/06. DON will report quarterly to QA committee thereafter.	dent's ag those and 10  at drug t will eafter.  to nade. ade. onthly	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/03/2006 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465157 03/23/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 150 SOUTH WHITE SAGE AVENUE MILLARD COUNTY CARE CENTER **DELTA, UT 84624** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 428 Continued From page 9 F 428 Resident 6 was admitted to the facility on 2/22/05 and resided in the facility throughout the month of December 2005. A review of resident 6's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 7 was admitted to the facility on 1/7/04 and resided in the facility throughout the month of December 2005. A review of resident 7's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005 Resident 8 was admitted to the facility on 6/9/03 and resided in the facility throughout the month of December 2005. A review of resident 8's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005. Resident 9 was admitted to the facility on 3/29/04 and resided in the facility throughout the month of December 2005. A review of resident 9's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed pharmacist for the month of December 2005

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Resident 10 was admitted to the facility on 8/23/05 and resided in the facility throughout the month of December 2005. A review of resident

10's drug regimen reviews revealed no documentation to suggest the resident's medications were reviewed by a licensed

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465157	A. BUI B. WIN	LDING		COMPLI	
	ROVIDER OR SUPPLIER COUNTY CARE CE	NTER	STREET ADDRESS, CITY, STATE, ZIP 150 SOUTH WHITE SAGE AVEN DELTA, UT 84624				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 428	pharmacist for the An interview was h Nursing (DON) and at 2:15 PM. Both a stated that the facinot conduct a drug	month of December 2005.  Held with the facility's Director of the Administrator on 3/22/06 the DON and Administrator lity's contracted pharmacist did regimen review for any north of December 2005.	F	428	labs reco for reside	n orders were obtained for mmended by pharmacist ent # 4 on 04/13/06.	
F 429 SS=F	The pharmacist methe attending physical nursing.  This REQUIREMED by: Based on interview (DON) and record between April 200 failed to ensure the irregularities to the DON. Additionally facility staff did not recommendations 10.)  Findings include:  1. Resident 4 was to the facility on 1 osteoarthritis, and congestive heart to confusion.	ust report any irregularities to ician and the director of  ENT is not met as evidenced we with the Director of Nursing review, it was determined that 5 and March 2006, facility staff at the pharmacist reported any e attending physician and the 7, for 2 of 11 sampled residents, it act on the pharmacist's (Resident identifiers 4 and 1/18/05 with the diagnoses of iety due to smoking cessation, failure, hypertension and	F	429	Pharmaci facility ex report to and any r drug revi  Pharmaci April rev DON wil individua and recon  DON wil documen addressed  DON wil above pro  DON wil report of rnecting of	ist will deliver written repor- iew to DON by May 5, 2006 I review report and forward il physicians for review of commendations for their patier Il follow-up on June 5, 2006 It that recommendations were d by physician. Il continue to audit and follo ocedure monthly. Il give verbal and written compliance at quarterly QA on 06/28/06. DON will give uarterly to QA committee	hly md, hly t of to to to to to to to to ts ts. and e

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			(X3) DATE S		
		465157	B. Wil	NG		025	23/2006
MILLARI	PROVIDER OR SUPPLIER  D COUNTY CARE CE			15	EET ADDRESS, CITY, STATE, ZIP CODE TO SOUTH WHITE SAGE AVENUE ELTA, UT 84624	1 03/2	23/2006
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
	form located in his documented that the in November 2005 (patient) is on diure 2006, the Pharmacic consider checking is patient) on diuretic 4's clinical record deany lab results or plus be completed.  2. Resident 10 was admitted to the facilitiagnoses of osteodieatures and anxiety dementia.  During a review of microscopic features and anxiety dementia.  During a review of microscopic features and anxiety dementia.  During a review of microscopic features and anxiety dementia.  During a review of microscopic features and anxiety dementia.  During a review of microscopic features and anxiety dementia.  During a review of microscopic features and anxiety dementia.  During a review of microscopic features and anxiety dementia.  During a review of microscopic features and anxiety dementia.  During a review of microscopic features and anxiety dementia.	clinical record, it was a Pharmacist recommended to "Consider checking labs as tic therapy." Also, in January ist recommended, "May abs - no record in chart (and therapy." A review of resident etermined that he did not have hysician orders for lab work to a san 89 year old female ity on 8/23/05 with the arthritis, senile with depressive y, congestive heart failure and esident 10's Pharmacy in her clinical record, it was a Pharmacist recommended Consider checking Hg A1C (a ily used to Identify the plasma entration over time)." Also, in Pharmacist recommended, (Hg)A1C." These two were not reported to the nor the DON. Resident 10's ains no documentation to ony test was completed or my by the resident's attending the held with the DON on and again on 3/23/06 at 8:30 and, at both meetings, that the charmacist had not submitted to the DON or to attending	F	129			

PRINTED: 04/03/2008 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 03/23/2006 465157 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 150 SOUTH WHITE SAGE AVENUE MILLARD COUNTY CARE CENTER **DELTA, UT 84624** PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 429 F 429 Continued From page 12 physicians since April 2005. During the 3/23/06 interview, the DON stated the facility did not have a system in place for nursing staff to go back into the individual clinical records and retrieve any recommendations written by the Pharmacist. The DON also stated she had not known the pharmacist's schedule for coming to the facility to do the drug regimen reviews. Pharmacist was educated on F 430 F 430 483.60(c)(2) DRUG REGIMEN REVIEW 04/05/06 as to facility expectation SS=F of a written monthly report to DON The pharmacist must report any irregularities and of all irregularities found, and any these reports must be acted upon. recommendations from monthly drug review. This REQUIREMENT is not met as evidenced

bv:

Based on interviews with the Director of Nursing (DON) and record review, it was determined that between April 2005 and March 2006, the facility did not receive reports of potential drug irregularities from their consultant pharmacist. Consequently, the facility was unable to ensure that potential drug irregularities were acted upon by the attending physician and the DON.

Findings include:

The facility's consultant pharmacist did not submit potential drug irregularities to the attending physician and the DON. Cross-Refer F-429.

An interview was held with the facility's DON on 3/23/06 at 8:30 AM. The DON stated that the facility contracted pharmacist had not submitted a pharmacy report to her or the attending physicians since April 2005. The DON stated that Pharmacist will deliver written report of April review to DON by May 5, 2006.

DON will review report and forward to individual physicians for review of comments and recommendations for their patients.

DON will follow-up on June 5, 2006 and document that recommendations were addressed by physician.

DON will continue to audit and follow above procedure monthly.

DON will give verbal and written report of compliance at quarterly QA meeting on 06/28/06. DON will give reports quarterly to OA committee thereafter.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED			
		465157	B. WING			03/23/2006			
NAME OF PROVIDER OR SUPPLIER  MILLARD COUNTY CARE CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 150 SOUTH WHITE SAGE AVENUE DELTA, UT 84624				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	(XS) COMPLETION DATE			
F 430	notes after each mere completed at that recommendate DON explained the pharmacist would her and that she wirectly to the attestated this has not	not review the pharmacist's nonthly medication reviews and therefore, could not ensure ions were acted upon. The at prior to April 2005, the submit the reports directly to could send the information ading physicians. The DON occurred since April 2005, and ertain why the pharmacist	F •	430					
	483.65(b)(3) PREVENTING SPREAD OF INFECTION  The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.  This REQUIREMENT is not met as evidenced by:  Based on observations of staff providing resident cares, it was determined that facility staff did not consistently wash their hands or use sanitizing gels after direct resident contact for which hand washing was indicated.  Findings include:  On 3/21/06 at 7:20 AM, a South Hall nurse was observed during medication pass. The registered nurse was observed to administer medications to three residents. As the nurse administered medications to these three residents, she was observed to touch the medication cups after the		F	444	F-444 Nursing staff will be ea appropriate hand wash indicated by acceptable practice, including han or use of sanitizing gel after gloving and after with resident or contain on May 2, 2006.  DON will observe one each neighborhood by  A verbal and written regiven by DON at quart on June 28, 2006.  DON will continue to comonthly and give quart reports to QA committee.	ing protocols as a professional d washing before and any contact minated items  med pass on May 30, 2006.  Aport will be early QA meeting observe early			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S	(X3) DATE SURVEY COMPLETED			
		465157	B. WING	·		2/2006			
NAME OF PROVIDER OR SUPPLIER  MILLARD COUNTY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 150 SOUTH WHITE SAGE AVENUE DELTA, UT 84624					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN O (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	N SHOULD BE COMPLETION DATE			
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150 South White Sage Ave. Delta, UE 84624 (+15) 864 2944 (415) So4 3481 PAX

April 13, 2006

To Whom It May Concern:

This is our written credible allegation of compliance for all federal regulations. The date for alleged completion of compliance is May 5, 2006.

Sincerely, Manay Damit

Nancy Schmid

Administrator