DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465144	A. BUILDING ______ B. WING ______	05/10/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTER'S NURSING HOME	**126 WEST 200 NORTH ST GEORGE, UT 84771**

(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 252 SS=E	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility did not provide a safe, clean, comfortable or homelike environment. Specifically, several resident rooms and furniture were in various states of disrepair/unclean, a garbage can was damaged exposing its contents, several faciltiy doors were in various states of disrepair, and baseboards were missing from several facility walls. Findings included: 1. Observations of the resident rooms were conducted 05/08/06-05/10/06 and revealed the following: a. Room 21 was missing greater than 50% of the baseboard leaving streaks of black adhesive along the base of the wall extending about 4 inches up from the floor. b. Room 23 was missing approximately 50% of the baseboard leaving streaks of black adhesive along the base of the wall extending about 4 inches up from the floor. c. A blue recliner in room 6 was noted with numerous brown spots , not unlike feces, along the right side of the chair.	F 252 6/12/06 POC acceptable Completion date 6/30/06 [illegible] RN	**The Maintenance Director will install baseboards where missing in room 21.** **The Maintenance Director will install baseboards where missing in room 23.** **The Housekeeping Supervisor will either clean or replace the blue recliner in room 6.** **The Housekeeping Supervisor will either clean or replace the blue recliner in room 7.** **The Housekeeping Supervisor will either clean or replace the brown recliner as well as clean the floor in room 22.** **The Maintenance Director will install fixtures in the bathtub in room 1.** **The Maintenance Director will replace the overbed table top in room 11.** **The Maintenance Director will replace the linoleum floor tile with the missing corner in room 12.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrea K. Mitchell	Administrator	May 26, 2006

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.

Utah Department of Health
JUN 07 2006

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F 252	Continued From page 1 d. A blue recliner in room 7 was noted to be heavily soiled. The front of the chair appeared almost black with soil. e. Room 22 had a brown recliner with numerous spots of what appeared to be dried food on the seat cushion and on the headrest, as well as generally being soiled. The floor in the room was noted to be very sticky while walking. f. The bathtub in room 1 was noted to have water pipes extending approximately 6 inches from the wall where the water valves and discharge spout would normally be, but there were no fixtures present. g. The trim around the overbed table in room 11 was chipped, leaving numerous sharp edges. h. The corner of a linoleum tile, approximately 3 inches x 3 inches x 4.25 inches, was missing from the floor of room 12. 2. Observations of the general facility, and facility grounds were conducted 05/08/06-05/10/06, and revealed the following: a. The door to the community bathroom in the south hallway was substantially scuffed and had paint missing extending approximately 30 inches up from the floor. The exhaust fan in this restroom also failed to provide adequate movement of air to cause a piece of toilet tissue to adhere to the vent. b. The threshold underneath the whirlpool door was missing leaving a gap of about 2 inches between the linoleum in the hallway, and the tile	F 252	**(Continued From Page 1)** **The Maintenance Director will paint the door to as well as either repair or replace the exhaust fan in the community bathroom in the south hallway.** **The Maintenance Director will install the threshold underneath the whirlpool room door.** **The Maintenance Director will reinstall the baseboards along the back wall of the nurses station.** **The Maintenance Director will replace the green garbage can and lid along the north outside wall.** **The Maintenance Director will repair the gap between the main entry door to the facility and the threshold.** **The Administrator will monitor for completion once a week for one month, then once a month for three months, and then quarterly thereafter, where it will be reviewed in the facility quality assurance (QA) program.**	**06/30/06**

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F 252	Continued From page 2 in the whirlpool room. c. The baseboard along the back wall of the nurses station was missing and peeling away in some areas, leaving streaks of black adhesive extending approximately 4 inches up from the floor. d. Along the north outside wall, a green garbage can (approximately 33 gallon size) with liner and full to the top with garbage, was observed to have a break vertically along the side extending approximately 12 inches. The lid of the container was broken leaving an opening approximately 12 inches x 12 inches, and leaving the refuse contained exposed . e. The main entry door to the facility was observed to have a gap between the door and the threshold allowing light to be observed passing under the door.	F 252		
F 445 SS=B	483.65(c) INFECTION CONTROL - LINENS Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that facility personnel did not store linens so as to prevent the spread of infection. Specifically clean linens were stored outside, exposed to debris/soilage, then used in resident care.	F 445	**The staff will be trained in the next inservice to keep the clean linen cart inside the facility and not to place it outside the north entry door to the facility.** **The Administrator will check for compliance daily for two weeks, then weekly for one month, then monthly for three months, and then quarterly thereafter, where it will be reviewed in the QA program.**	**06/30/06**

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F 445	Continued From page 3 Findings included: An observation of facility grounds was conducted on 05/08 and 5/09/06. On 05/08, a clean linen cart was observed outside the north entry door to the facility. The cart had folded bed linens, incontinence pads, and what appeared to be gowns, on it. The cart was covered with a porous, ventilated cover and with leaves and debris on top. On 05/09, the cart was observed in the hallway, near the north entry door, in use by facility staff to provide linens. An interview with the Director of Nursing (DON) occurred on 08/10/06 at 3:45 PM. The DON stated that the cart had been left outside all night.	F 445		