STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	03/09/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VALLEY	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

(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 161 SS=B	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of the facility's surety bond and the total of personal funds of residents deposited with the facility, it was determined that the facility did not assure the security of all personal funds. Specifically, the total of resident funds deposited with the facility exceeded the amount for which the surety bond had been issued. Findings included: The facility's surety bond was reviewed on 3/6/06 and found to have been issued for $25,000. Resident funds deposited with the facility were reviewed on 3/6/06. As of 12/30/06, resident funds kept by the facility totaled $33,071.67. This exceeded the amount of the surety bond by $8,071.67.	F 161	F 161 A surety bond will be purchased to provide adequate insurance coverage to ensure the security of all personal funds of residents deposited with the facility. Office manager to conduct a monthly audit of all personal funds of residents to ensure adequate coverage. Office manager to report findings of audits monthly to Quality Assurance committee. 3/27/06 POC acceptable compliance date 5/4/06 LBarnbank RN 5/3/06 - Completion date for Tag F 253 was changed to 5/18/06 per approval by SA at submitted letter for change. L Barnbank RN	5/4/06 5/4/06 5/4/06
F 253 SS=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:	F 253	Utah Department of Health 755314 MAR 24 2006 Bureau of Health Facility Licensing, Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael J. Linder	administrator	3-23-06

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.

ROCKY MOUNTAIN CARE

Home Care • Skilled Nursing & Rehabilitation • Hospice

May 2, 2006

Ann E. Lee, Manager
Utah Department of Health
Bureau of Health Facility Licensing,
Certification and Resident Assessment
Long Term Care Survey Section
288 North 1460 West
Salt Lake City, Utah 84114-4103

Dear Ann:

I am writing on behalf of Rocky Mountain Care – West Valley concerning our most recent recertification survey conducted on March 9, 2006. Due to great difficulty in dealing with local and out of state vendors, we have yet to obtain a sufficient quantity of floor tiles needed to fully complete the stated plan of corrections by 5/4/06 for cited F Tag 253. And though several sections of the floor have been completed, other sections are awaiting repair.

Therefore I am asking for an additional two weeks time from or original competition date of 5/4/06 to 5/18/06. I assure you the difficulties we have been experiencing in obtaining adequate tiles are not of a financial nature but of circumstances much beyond our control.

If you have any concerns or questions I can answer, please contact me directly at (801) 397-4401 here at my office or my cell at 599-8524.

Thank you for your consideration,

Michael Fender

Michael Fender
Administrator
Rocky Mountain Care – West Valley

Utah Department of Health
755853
MAY 02 2006
Bureau of Health Facility Licensing,
Certification and Resident Assessment

5/3/06
accepted
completion date
5/18/06
Buenbank RN

Rocky Mountain Care-West Valley 4150 West 3375 South West Valley City, Utah 84120
Phone (801) 397-4400 • *Fax* (801) 397-4490

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKY MOUNTAIN CARE - WEST VALLEY	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 161 SS=B	483.10(c)(7) ASSURANCE OF FINANCIAL SECURITY The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on review of the facility's surety bond and the total of personal funds of residents deposited with the facility, it was determined that the facility did not assure the security of all personal funds. Specifically, the total of resident funds deposited with the facility exceeded the amount for which the surety bond had been issued. Findings included: The facility's surety bond was reviewed on 3/6/06 and found to have been issued for $25,000. Resident funds deposited with the facility were reviewed on 3/6/06. As of 12/30/06, resident funds kept by the facility totaled $33,071.67. This exceeded the amount of the surety bond by $8,071.67.	F 161	F 161 A surety bond will be purchased to provide adequate insurance coverage to ensure the security of all personal funds of residents deposited with the facility. Office manager to conduct a monthly audit of all personal funds of residents to ensure adequate coverage. Office manager to report findings of audits monthly to Quality Assurance committee.	5/4/06 5/4/06 5/4/06
F 253 SS=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:	F 253		

3/30/06 POC acceptable contingent upon 5/4/06 implementation per KW

Utah Department of Health
755814
MAR 2 4 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

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

Michael N. Linder — Administrator — 3-23-06

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 253	Continued From page 1 Based on observation it was determined that the facility did not provide housekeeping and or maintenance services to maintain a sanitary, or comfortable home for its residents. Findings include: The following observations were made between 3/6/06 and 3/8/06. The floor in the facility has large areas of spider web-like cracks in the tile which encompasses nearly the entire building. The floor also has multiple areas where it is bumpy and uneven. This could be a potential hazard to ambulatory residents. The following resident doors were observed to be gouged and scratched significantly resulting in the entrance to there residents home appearing unkept and unattractive. Room numbers: 118,117, 116, 115, 114, 113, 110, 108, 109, 201, 202, 203, 204, 208, 205, 206, 207, 210, 211, 212, and 119. The doors to the east and west showers, the dining room, and the physical therapy room were also in poor repair. There were multiple areas where the walls in the facility were observed to have either wallpaper which was torn or bubble and lifting, or where the paint was gouged or scratched off. The handrails which the residents use to stabilize them, felt sticky in many areas. There were 2 wooden/upholstered chairs observed to be in use by residents for 3 days which were noted to be broken on both sides of the chair back.	F 253	F 253 Areas in the facility floors with spider web like cracks, as well as, areas in the floors that are bumpy and uneven, will be repaired by Maintenance Director. Facility doors of rooms 118, 117, 116, 115, 114, 113, 110, 108, 109, 201, 202, 203, 204, 208, 205, 206, 207, 210, 211, 212, 119, as well as, the East and West shower doors, dining room doors, and physical therapy room doors, will be repaired by Maintenance Director and staff. Facility walls with bubbled wall paper and scratched paint to be painted, replaced, or repaired by Maintenance Director and staff . Facility handrails will be cleaned by house-keeping staff. The two wooden dining room chairs to be repaired or replaced by Maintenance Director. The center patio area to have all trash and debris removed, hanging wire (or air conditioning tube) to be recon-figured, and chairs to be placed right side up by Maintenance Director. Missing baseboard will be repaired or replaced by Maintenance Director The exterior covering of the light fixture at the far East side of The building near room 107 to be replaced by Maintenance Director.	5/4/06 5/4/06 5/4/06 5/4/06 5/4/06 5/4/06

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F 253	Continued From page 2 The center patio where residents who wish to smoke or sit outside was observed to have multiple chairs upside down, trash on the ground, a stuffed bunny noted on the ground, and wires hanging from the roof left unattended. There were several areas observed to have the baseboard missing. The light fixture at the far east side of the building near room 107 was missing the exterior cover leaving the roof and pipes exposed from inside the facility. On 3/6/06, and 3/7/06 8 of 8 tablecloths in the dining room were noted to be very soiled. The top of the tablecloths are covered with glass; however, the skirt area which rests in the residents lap was soiled.	F 253	Dining room table clothes to be laundered by laundry department. Facility floors, doors, walls, handrails, dining room chairs, center patio, base boards, and light fixtures to be monitored monthly by Maintenance Director, housekeeping staff and Administrator for cleanliness, repair, and needed replacement. Housekeeping personnel to monitor dining room table clothes for cleanliness and repair weekly. Maintenance Director and Dietary Manager to report findings monthly to the Quality Assurance Committee.	5/4/06 5/4/06 5/4/06 5/4/06
F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279		

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F 279	Continued From page 3 psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, it was determined that the facility did not fully develop comprehensive care plans for 5 of 15 sample residents that addressed the residents' medical and nursing needs that were identified in the residents' comprehensive assessments. (Residents 1,2, 9, and .) Findings include: 1. Resident 1 was originally admitted to the facility on 11/29/05, with the diagnoses of dehydration, deconditioning, asthma, chronic leg pain, and gastroesophageal reflux disease. A review of resident 1's medical record was completed on 3/7/06. An MDS (minimum data set), a significant change assessment completed by the facility staff on 2/8/06, triggered the following RAP's (Resident Assessment Protocol) to be assessed: Delirium, Cognitive loss, communication, ADL functional/Rehabilitation potential, Urinary incontinence, Psychosocial well-being, Mood state, Behavioral symptoms, Falls, Nutrition, Dehydration, Pressure ulcers, and Psychotropic drug use. Of the 13 RAP's assessed, the facility documented that 12 areas would be care	F 279	F 279 Director of Nursing to construct a current care plan for resident #1 to include: Communications, Mood, and Behaviors. Director of Nursing to construct a current care plan for resident #2 to include: Communications, and Psychotropic drug use. Director of Nursing to construct a current care plan for resident #9 to include: Communication, Mood, and Behaviors. Director of Nursing to construct a current care plan of resident #3 to include Psychotropic drug use. Director of Nursing to construct a current care plan for resident #6 to include Communication. Director of Nursing to ensure the completeness of all resident care plans by using a checklist. Medical Records to perform a monthly audit of all current care plans to ensure they are compliant. Director of Nursing to report findings of audits to the Quality Assurance Committee monthly.	5/4/06 5/4/06 5/4/06 5/4/06 5/4/06 5/4/06 5/4/06 5/4/06

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F 279	Continued From page 4 planned. An interview with the DON (director of nursing), ADON (associate director of nursing), Recreation director, and the SSD(social services director) was conducted on 3/8/06. During this interview, each of the department heads stated that all the care plans for each resident were present in each residents medical record. The following care plans were present in resident 1's medical record. Mobility/ADL Nutritional status Dehydration Skin Integrity Comfort Bowel/Bladder Sleep/rest/naps Safety Psychosocial Health deficit (including psychotropic use) Physical therapy Occupational therapy Care Plans for the following areas could not be found in the residents medical record: Communication, Mood, and Behaviors. 2. Resident 2 was admitted to the facility on 9/6/05 with diagnoses including: Dementia, Colitis, mastectomy, eating disorder, and Major depressive disorder. A review of resident 2's medical record was completed on 3/7/06. An MDS (minimum data set), a significant change assessment completed by the facility staff on	F 279		

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F 279	Continued From page 5 11/25/05, triggered the following RAP's (Resident Assessment Protocol) to be assessed: Delirium, Cognitive loss, communication, ADL functional/Rehabilitation potential, Urinary incontinence, Psychosocial well-being, Mood state, Behavioral symptoms, Falls, Nutrition, Pressure ulcers, Activities and Psychotropic drug use. Of the 13 RAP's assessed, the facility documented that 12 areas would be care planned. An interview with the DON (director of nursing), ADON (associate director of nursing), Recreation director, and the SSD(social services director) was conducted on 3/8/06. During this interview, each of the department heads stated that all the care plans for each resident were present in each residents medical record. The following care plans were present in resident 2's medical record. Mobility/ADL Nutritional status Dehydration Skin Integrity Comfort Bowel/Bladder Sleep/rest/naps Safety Psychosocial Health deficit Cognitive Loss Care Plans for the following areas could not be found in the residents medical record: Communication, and Psychotropic drug use. 3. Resident 9 was admitted to the facility on 7/2/05 with diagnoses including: Fall with fracture,	F 279		

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F 279	Continued From page 6 hypertension, dementia with anxious features, glaucoma and osteoporosis. A review of resident 9's medical record was completed on 3/7/06. An MDS (minimum data set), a significant change assessment completed by the facility staff on 12/8/05, triggered the following RAP's (Resident Assessment Protocol) to be assessed: Cognitive loss, communication, ADL functional/Rehabilitation potential, Urinary incontinence, Psychosocial well-being, Mood state, Behavioral symptoms, Falls, Nutrition, Pressure ulcers, Activities and Psychotropic drug use. Of the 13 RAP's assessed, the facility documented that 12 areas would be care planned. An interview with the DON (director of nursing), ADON (associate director of nursing), Recreation director, and the SSD(social services director) was conducted on 3/8/06. During this interview, each of the department heads stated that all the care plans for each resident were present in each residents medical record. The following care plans were present in resident 9's medical record. Mobility/ADL Nutritional status Dehydration Skin Integrity Comfort Bowel/Bladder Sleep/rest/naps Safety Psychosocial Health deficit (including psychotropic drug	F 279		

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F 279	Continued From page 7 use) Cognitive Loss Care Plans for the following areas could not be found in the residents medical record: Communication, Mood, and Behaviors . 4. Resident 3 was originally admitted to the facility on 1/19/06 , with the diagnoses of rib fracture, diabetes, and end stage renal disease. A review of resident 3's medical record was completed on 3/7/06. An MDS (minimum data set), a significant change assessment completed by the facility staff on 1/24/06, triggered the following RAP's (Resident Assessment Protocol) to be assessed: Delirium, ADL functional/Rehabilitation potential, Psychosocial well-being, Mood state, Falls, Nutrition, Dehydration, Pressure ulcers, and Psychotropic drug use. Of the 8 RAP's assessed, the facility documented that all 7 areas would be care planned. An interview with the DON (director of nursing), ADON (associate director of nursing), Recreation director, and the SSD(social services director) was conducted on 3/8/06. During this interview, each of the department heads stated that all the care plans for each resident were present in each residents medical record. The following care plans were present in resident 3's medical record. Mobility/ADL Nutritional status Dehydration	F 279		

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F 279	Continued From page 8 Skin Integrity Comfort Bowel/Bladder Psychosocial Health deficit (including psychotropic use) Physical therapy Occupational therapy Communication/Cognitive Care Plans for the following areas could not be found in the residents medical record: Psychotropic drug use. 5. Resident 6 was originally admitted to the facility on 12/27/03 , with the diagnoses of hypertension, hyperthyroid, and quadriplegia. A review of resident 6's medical record was completed on 3/7/06. An MDS (minimum data set), a significant change assessment completed by the facility staff on 9/07/05, triggered the following RAP's (Resident Assessment Protocol) to be assessed: Delirium, ADL functional/Rehabilitation potential, Psychosocial well-being, Mood state, Falls, Pressure ulcers, Behaviors, Cognitive loss, and Psychotropic drug use. Of the 11 RAP's assessed, the facility documented that all 10 areas would be care planned. An interview with the DON (director of nursing), ADON (associate director of nursing), Recreation director, and the SSD(social services director) was conducted on 3/8/06. During this interview, each of the department heads stated that all the care plans for each resident were present in each residents medical record.	F 279		

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F 279	Continued From page 9 The following care plans were present in resident 3's medical record. Mobility/ADL Nutritional status Dehydration Skin Integrity Comfort Bowel/Bladder Psychosocial Health deficit (including behaviors and psychotropics) Sleep/rest/ naps Cognitive loss Care Plans for the following areas could not be found in the residents medical record: Communication.	F 279		
F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident medical records, it was determined that the facility did not provide pharmaceutical services (including the accurate administration of all drugs) to meet the needs of its residents. Specifically, of the 15 sampled residents, 5 were insulin dependent diabetics. Five of these 5 residents with insulin dependent diabetes did not receive the correct amount of insulin based upon the physician's	F 426		

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ROCKY MOUNTAIN CARE - WEST VALLEY	4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120

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F 426	Continued From page 10 orders. (Residents 1, 10, 11, 12 , and 13) Findings include: 1. Resident 1 was a 76 year old female who was admitted to the facility on 11/29/05 with the diagnoses of Asthma, hypertension, insulin dependent diabetes mellitus (IDDM), and gastroesophageal reflux disease. Upon admission to the facility, resident 10's physician's orders were as follows: Lantus 50 units at bedtime. Also, provide humalog insulin based on the results of resident 1's blood sugars (BS). The sliding scale ordered was as follows: 150 - 200 = 2 U (units) 201 - 250 = 4 U 251 - 300 = 6 U 301 - 350 = 8 U 351 - 400 = 10 U greater than 400 = 12 U Nursing staff at the facility were obtaining resident 1's blood sugars (BS) four times a day (at Breakfast, Lunch, Dinner,and Bedtime) from 11/29/05 through 1/27/06. On 1/27/06, the physician ordered that the BS be checked only twice a day at Breakfast and Dinner. On 12/5/05 at lunch, facility staff recorded a BS of 205. Based on the physician's orders, resident 1 should have received 4 units of humalog insulin, but instead received none. On 12/5/05 at dinner, facility staff recorded a BS of 277. Based on the physician's orders, resident 1 should have received 6 units of insulin, but no insulin dosage was recorded..	F 426	F 426 Director of Nursing to ensure residents 1, 10, 11, 12, and 13 are currently receiving the correct amount of insulin according to physician's orders. Director of Nursing to audit the charts all residents, who are insulin dependent, to ensure they are receiving the correct amount of insulin according to physician's orders. Director of Nursing to in-service nursing personnel on procedures for administering correct amounts of insulin for all insulin dependent diabetics. Pharmacy Consultant to conduct monthly audits on all insulin dependent residents and provide written report to Director of Nursing and Administrator monthly. Director of Nursing to review the findings of the Pharmacy Consultants audit to the Quality Assurance Committee monthly.	5/4/06 5/4/06 3/16/06 5/4/06 5/4/06

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	465075	A. BUILDING _____ B. WING _____	03/09/2006

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F 426	Continued From page 11 On 12/4/05 at bedtime, facility staff recorded a BS of 299. Based on the physician's orders, resident 1 should have received 6 units of humalog insulin, but instead the dose states "held". There is no documentation that the physician was notified, or that an order was received to hold the sliding scale dose of insulin. On 12/5/05 at bedtime, facility staff recorded a BS of 410. Based on the physician's orders, resident 1 should have received 12 units of humalog insulin, but instead the dose states "held". There is no documentation that the physician was notified, or that an order was received to hold the sliding scale dose of insulin. On 12/6/05 the following physicians order was given: discontinue Lantus and Humalog insulin. NPH insulin 15 units in AM, and 25 units before dinner. Use Regular insulin for sliding scale at current doses. On 12/6/05 at bedtime, facility staff recorded a BS of 184. Based on the physician's orders, resident 1 should have received 2 units of humalog insulin, but instead the dose states " - ". There is no documentation that the physician was notified, or that an order was received to hold the sliding scale dose of insulin. The scheduled dose of Lantus Insulin was also marked with " - ". On 12/7/05 at bedtime, facility staff recorded a BS of 292. The staff documented the sliding scale dose of Regular insulin as given correctly; however, the scheduled NPH dose was not given. There is no documentation that the physician ordered the dose to be held.	F 426		

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F 426	Continued From page 12 On 12/8/05 the following physicians order was given: NPH insulin 25 units in AM, and 35 units before dinner. On 12/11/05 the following physicians order was given: NPH insulin 35 units in AM, and 25 units before dinner On 12/11/05 at bedtime, facility staff recorded a BS of 275. The staff documented the sliding scale dose of Regular insulin as given correctly; however, the scheduled NPH dose was not given. There is no documentation that the physician ordered the dose to be held. On 12/13/05 at breakfast, facility staff recorded a BS of 118. The scheduled NPH dose was not given. There is no documentation that the physician ordered the dose to be held. On 12/17/05 the following physicians order was given: NPH insulin 30 units in AM, and 20 units before dinner. On 12/17/05 at breakfast, facility staff recorded a BS of 153. Based on the physician's orders, resident 1 should have received 2 units of regular insulin, but no dose was recorded as being given. Under the scheduled dose column, 20 units is recorded; however, there is no scheduled dose at lunch ordered. On 12/8/05 the following physicians order was given: Discontinue regular sliding scale insulin. NPH insulin 30 units in AM, and 15 units before dinner. On 12/20/05 the following physicians order was given: NPH insulin 35 units in AM, and 15 units	F 426		

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F 426	Continued From page 13 before dinner. On 12/25/05 at breakfast, facility staff recorded a BS of 92. Based on the physician's order, resident 1 should have received 35 units of NPH insulin. There was no insulin given. On 12/28/05 the following physicians order was given: NPH insulin 40 units in AM, and 20 units before dinner. On 12/29/05, 12/30/05, and 12/31/05 at dinner time the facility staff documented that 15 units of NPH insulin were given. Based on the physicians order, resident 1 should have received 20 units of NPH insulin. On 1/1/06 at dinner, based on the physician's order, resident 1 should have received 20 units of NPH insulin. There was no insulin given. On 1/2/06 at breakfast, based on the physician's order, resident 1 should have received 40 units of NPH insulin. There was 35 units of insulin given. On 1/2/06 at dinner, based on the physician's order, resident 1 should have received 20 units of NPH insulin. There was 15 units of insulin given. On 1/2/06 at dinner, based on the physician's order, resident 1 should have received 20 units of NPH insulin. There was 15 units of insulin given. On 1/3/06 at dinner, based on the physician's order, resident 1 should have received 20 units of NPH insulin. There was 15 units of insulin given. On 1/4/06 at dinner, based on the physician's order, resident 1 should have received 20 units of	F 426		

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F 426	Continued From page 14 NPH insulin. There was 15 units of insulin given. On 1/5/06 at dinner, based on the physician's order, resident 1 should have received 20 units of NPH insulin. There was 15 units of insulin given. On 2/7/06 at dinner, based on the physician's order, resident 1 should have received 20 units of NPH insulin. There was no insulin given. On 2/12/06 at dinner, based on the physician's order, resident 1 should have received 20 units of NPH insulin. There was no insulin given. On 2/16/06 at breakfast, based on the physician's order, resident 1 should have received 40 units of NPH insulin. There was no insulin given. On 2/20/06 at breakfast, based on the physician's order, resident 1 should have received 40 units of NPH insulin. There was no insulin given. On 2/23/06 at breakfast, based on the physician's order, resident 1 should have received 40 units of NPH insulin. There was no insulin given. 2. Resident 10 is a 68 year old female who was admitted to the facility on 10/21/04 with IDDM. Upon admission to the facility, resident 10's physician's orders were as follows: Lantus 50 units at bedtime. Also, provide humalog insulin based on the results of resident 1's blood sugars (BS). The sliding scale ordered was as follows: 150 - 200 = 2 U (units) 201 - 250 = 4 U 251 - 300 = 6 U	F 426		

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F 426	Continued From page 15 301 - 350 = 8 U 351 - 400 = 10 U 401 - 450 = 12 U greater than 451 = call MD On 2/11/06 at breakfast, facility staff recorded a BS of 153. Based on the physician's orders, resident 10 should have received 2 units of insulin, but no insulin dosage was recorded.. On 2/19/06 at dinner, facility staff recorded a BS of 200. Based on the physician's orders, resident 10 should have received 2 units of insulin, but no insulin dosage was recorded.. On 2/26/06 at breakfast, facility staff recorded a BS of 151. Based on the physician's orders, resident 10 should have received 2 units of insulin, but no insulin dosage was recorded.. On 1/9/06 at dinner, based on the physician's order, resident 10 should have received 12 units of NPH insulin. There was no insulin given. On 1/17/06 at dinner, based on the physician's order, resident 10 should have received 12 units of NPH insulin. There was no insulin given. On 1/19/06 at breakfast, based on the physician's order, resident 10 should have received 15 units of NPH insulin. There was no insulin given. On 1/26/06 at breakfast, based on the physician's order, resident 10 should have received 15 units of NPH insulin. There was no insulin given. On 2/1/06 at dinner, based on the physician's order, resident 10 should have received 12 units of NPH insulin. There was no insulin given.	F 426		

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F 426	Continued From page 16 On 2/7/06 at breakfast, based on the physician's order, resident 10 should have received 15 units of NPH insulin. There was no insulin given. On 2/16/06 at breakfast, based on the physician's order, resident 10 should have received 15 units of NPH insulin. There was no insulin given. On 2/19/06 at breakfast, based on the physician's order, resident 10 should have received 15 units of NPH insulin. There was no insulin given. On 2/19/06 at dinner, based on the physician's order, resident 10 should have received 12 units of NPH insulin. There was no insulin given. 3. Resident 13 was a 78 year old male who was admitted to the facility on 2/6/03 with diagnoses including IDDM. Resident 13's physician's orders were as follows: NPH insulin 40 units in AM. and Lantus insulin 24 units at bedtime. Also, provide Regular insulin based on the results of resident 13's blood sugars (BS). The sliding scale ordered was as follows: 0 - 150 = 0 U 151 - 250 = 3 U 251 - 300 = 4 U 301 - 350 = 5 U 351 - 400 = 6 U greater than 400 = call physician Nursing staff at the facility were obtaining resident 's blood sugars (BS) four times a day (at Breakfast, Lunch, Dinner,and Bedtime).	F 426		

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F 426	Continued From page 17 On 12/8/05 at bedtime, facility staff recorded a BS of 321. Based on the physician's orders, resident 13 should have received 5 units of insulin, but 6 units of insulin were given. On 12/11/05 at lunch, facility staff recorded a BS of 201. Based on the physician's orders, resident 13 should have received 3 units of insulin, but 4 units of insulin were given. On 12/11/05 at bedtime, facility staff recorded a BS of 316. Based on the physician's orders, resident 13 should have received 5 units of insulin, but 6 units of insulin were given. On 12/25/05 a physicians order to change the Lantus insulin (PM) dose to 22 units was received by the facility. On 12/27/05 at dinner, facility staff recorded a BS of 224. Based on the physician's orders, resident 13 should have received 3 units of insulin, but 4 units of insulin were given. On 12/28/05 at bedtime, facility staff recorded a BS of 250. Based on the physician's orders, resident 13 should have received 3 units of insulin, but 4 units of insulin were given. On 12/19/05 at breakfast, based on the physician's order, resident 13 should have received units of NPH insulin. There was no insulin given. On 12/25/05, based on the physician's order, resident 13 should have received 22 units of Lantus insulin. There was no insulin given. On 12/26/05, based on the physician's order,	F 426		

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F 426	Continued From page 18 resident 13 should have received 22 units of Lantus insulin. There was no insulin given. On 12/27/05, based on the physician's order, resident 13 should have received 22 units of Lantus insulin. There was no insulin given. On 1/2/06 at breakfast, facility staff recorded a BS of 230. Based on the physician's orders, resident 13 should have received 3 units of insulin, but no units of insulin were given. On 1/9/06 at lunch, facility staff recorded a BS of 178. Based on the physician's orders, resident 13 should have received 3 units of insulin, but 4 units of insulin were given. On 1/15/06 at breakfast, facility staff recorded a BS of 175. Based on the physician's orders, resident 13 should have received 3 units of insulin, but 4 units of insulin were given. On 1/28/06 at breakfast, facility staff recorded a BS of 268. Based on the physician's orders, resident 13 should have received 4 units of insulin, but 5 units of insulin were given. On 1/30/06, based on the physician's order, resident 13 should have received 22 units of Lantus insulin. There was no insulin given. On 1/31/06, based on the physician's order, resident 13 should have received 22 units of Lantus insulin. There was no insulin given. On 2/1/06 at bedtime, facility staff recorded a BS of 165. Based on the physician's orders, resident 13 should have received 3 units of insulin, but 4 units of insulin were given.	F 426		

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F 426	Continued From page 19 On 2/7/06 at dinner, facility staff recorded a BS of 254. Based on the physician's orders, resident 13 should have received 4 units of insulin, but 3 units of insulin were given. On 2/22/06 at bedtime, facility staff recorded a BS of 260. Based on the physician's orders, resident 13 should have received 4 units of insulin, but 6 units of insulin were given. On 2/25/06 at bedtime, facility staff recorded a BS of 157. Based on the physician's orders, resident 13 should have received units of insulin, but 2 units of insulin were given. On 2/26/06 at lunch, facility staff recorded a BS of 155 . Based on the physician's orders, resident 13 should have received 3 units of insulin, but 4 units of insulin were given. 4. Resident 12 was admitted to the facility on 2/10/06. Resident 12's "Diabetic Record" for the month of February was reviewed. Documentation was found that for February 1st through the 9th of 2006, resident 12 was to receive the following insulin order: Humalog insulin sliding scale <60 - give 50 milliters of D5W 151 - 200 = 3 U 201 - 250 = 5 U 251 - 300 = 7 U 301 - 350 = 10 U 351 - 400 = 12 U	F 426		

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F 426	Continued From page 20 > 400 = 14 U Blood sugars were to be taken before and after meals. Documentation was found for 2/04/06 at bedtime, that resident 12's blood sugar was not documented . There was no documentation that the resident received any sliding scale insulin at that time. Documentation was found for 2/05/06 at 4:30 PM, that resident 12's blood sugar was documented as 253. There was no documentation that the resident received any sliding scale insulin at that time.(resident 12 should have received 7 units of sliding scale). Documentation was found that for February 10th through the 28th of 2006, resident 12 was to receive the following insulin order: sliding scale regular insulin <60 Give juice and CALL MD 61 - 150 = 0 U 151 - 200 = 2 U 201 - 250 = 4 U 251 - 300 = 6 U 301 - 350 = 8 U 351 - 400 = 10 U > 400 CALL MD Blood sugars were to be taken before and after meals. Documentation was found that the resident 12 did not receive the correct dose of sliding scale on the following days: On 2/10/06 at bedtime, resident 12's blood sugar was documented as 243, no documentation was	F 426		

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F 426	Continued From page 21 found that sliding scale was given to the resident at that time. (the resident should have received 4 units of sliding scale) On 2/11/06 at 6:00 AM, the residents blood sugar was documented as being 157. No documentation was found that the resident received any insulin at that time. (the resident should have received 2 units of sliding scale) On 2/11/06 at 4:30 PM, the residents blood sugar was not documented. No documentation was found that the resident received any insulin at that time. On 2/19/06 at 4:30 AM, the residents blood sugar was documented as 180. No documentation was found that resident 12 received any sliding scale insulin at that time. (the resident should of received 2 units of sliding scale) On 2/20/06 at 12:00 PM, the residents blood sugar was documented as being 156. No documentation was found that the resident received any sliding scale at that time. (the resident should have received 2 units of sliding scale) On 2/22/06 at 6:00 AM, the residents blood sugar was documented as being 251. No documentation was found that the resident received any sliding scale at that time. (the resident should have received 6 units of sliding scale) On 2/27/06 at 6:00 AM, the residents blood sugar was documented as being 151. No documentation was found that the resident received any sliding scale at that time. (the	F 426		

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F 426	Continued From page 22 resident should have received 2 units of sliding scale) On 2/27/06 at 4:30 PM, the residents blood sugar was documented as being 153. No documentation was found that the resident received any sliding scale at that time. (the resident should have received 2 units of sliding scale) 5. Resident 11 was admitted to the facility on 2/24/06, with the following diagnoses: peptic ulcer disease, chronic renal failure, chronic obstructive pulmonary disease, and diabetes. Resident 11's Feudatory "Diabetic Record" was reviewed. Documentation was found that resident 11 was receiving the following insulin orders for February 24th through the afternoon February 26th: Regular insulin sliding scale <60 give 1/2 amp of D5W or juice. 60 - 120 = 0 U 121 - 150 = 4 U 151 - 180 = 6 U 181 - 210 = 8 U 211 - 250 = 10 U 251 - 300 = 12 U 301 - 400 = 14 U > 400 CALL MD Documentation was found that the resident 11 did not receive the correct dose of sliding scale on the following days: On 2/24/06 at 8:00 PM, resident 11's blood sugar was documented as 128. No documentation was found that resident 11 did not receive any sliding	F 426		

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F 426	Continued From page 23 scale. (the resident should have received 4 units of sliding scale) On 2/26/06 at 8:00 AM, resident 11's blood sugar was documented as 170. No documentation was found that resident 11 received 4 units of sliding scale. (the resident should have received 6 units of sliding scale) Resident 11's February "Diabetic Record" was reviewed. Documentation was found that resident 11 was receiving the following insulin orders for February 26th through February 28th: Discontinue the sliding scale. Give lantus 5 units every morning Documentation was found that the resident 11 did not receive the scheduled lantus on the following days: On 2/27/06 at 8:00 AM, resident 11's blood sugar was documented as 88. No documentation was found that resident received any insulin. On 2/28/06 at 8:00 AM, resident 11's blood sugar was documented as 91. No documentation was found that resident received any insulin.	F 426		
F 431 SS=E	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	F 431		

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(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 24 applicable. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility was using medications that were not labeled in accordance with currently accepted professional principles. Specifically, the facility was using medications that were not dated when they were opened. Findings include: Observation was made of the West hall medication refrigerator on 3/6/06 at 1:20 PM. The following medications were found to be opened, but no date could be found as to when the medication was opened. 1. 2 vials of Lantus Insulin 2. 4 vials of Novolin Insulin Observation was made of the East hall medication refrigerator on 3/7/06 at 2:35 PM. The following medications were found to be opened, but no date could be found as to when the medication was opened. 1. 2 vials of Lantus Insulin 2. 5 vials of Novolin R Insulin 3. 4 vials of Novolin N Insulin The Nursing 2006 Drug Handbook states the following for Lantus Insulin. "...Discard opened vials after 28 days whether refrigerated or not....". (page 797).	F 431	F 431 Director of Nursing to ensure that all current medications stored both in the West and East refrigerators are all dated. Director of Nursing to in-service nursing staff on dating all medications as they are opened and stored. Pharmacy Consultant to provide monthly audits of all medication refrigerators in the facility to ensure medications are dated in accordance with currently accepted professional standards. Audits to be provided to Director of Nursing and Administrator. Director of Nursing to report findings of audits to the Quality Assurance Committee monthly.	5/4/06 3/16/06 5/4/06 5/4/06
F 492 SS=E	483.75(b) ADMINISTRATION	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. BUILDING _____ B. WING _____	03/09/2006

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F 492	Continued From page 25 The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility personnel files, it was determined that the facility was not in compliance with all applicable State laws. Specifically, for 5 of 5 personnel files reviewed, the facility had not completed the required criminal background check performed through the Bureau of Health Facility Licensing, Certification and Resident Assessment. Findings include: The Utah Code, Section 26-21-9.5, requires that a Bureau of Criminal Identification screening, referred to as BCI, and a child or disabled or elderly adult licensing information system screening be conducted on each person who provides direct care to a patient for the following covered health care facilities: (1) Home Health care agencies; (2) Hospice agencies; (3) Nursing Care facilities; (4) Assisted Living facilities; (5) Small Health Care facilities; and (6) End Stage Renal Disease facilities. Included in this rule is the requirement that "Within ten days of initially hiring an individual, a covered health care facility shall submit the	F 492	F 492 Employee's A, B, C, D, and E to have BCI checks performed by HR personnel. HR personnel in-serviced on Utah Code, Section 26-21-9.5. HR Director to use a new hire checklist on all new hired personnel to ensure BCI check has been performed. HR Director to audit personnel files monthly to ensure all personnel files are complete and compliant. HR Director to report audit findings monthly to QA Committee	5/4/06 5/4/06 5/4/06 5/4/06 5/4/06

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F 492	Continued From page 26 individual's information to the department in accordance with Subsection (1)." Five random personnel files were reviewed on 3/8/06. Employee A was hired on 12/15/05. Employee B was hired on 12/22/05. Employee C was hired on 2/3/06. Employee D was hired on 1/6/06. Employee E was hired on 12/5/05. The personnel files for these five employees did not contain any documentation to evidence that the required BCI check had been completed. The staff member in charge of processing BCI checks at the Bureau of Health Facility Licensing, Certification and Resident Assessment was interviewed by telephone on 3/8/06. She stated that the facility had not sent in information for any of the above listed personnel.	F 492		
F 496 SS=D	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.	F 496	F 496 Identified personnel has had a state registry check completed clearing them of any form of abuse. HR Director to use a new hire checklist to ensure state registry has been checked prior to a new hire can provide patient care. HR Director to audit personnel files monthly to ensure all personnel files are complete and compliant. HR Director to report audit findings monthly to the Quality Assurance Committee.	3/9/06 5/4/06 5/4/06 5/4/06

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F 496	Continued From page 27 Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on staff interviews and review of personnel files, it was determined that the facility did not seek information from the state registry for 1 of 3 persons, prior to allowing those newly hired individuals to serve as nurse's aides, to ensure that those persons with histories of verbal, physical or sexual abuse were not employed. Findings include: The employee was hired on 2/01/2006, and since then she has been providing direct care. Two nurse surveyors reviewed the employee's files on 3/08/06. No documentation could be found that the nurse aide registry was checked prior to the employee providing resident care. On 3/08/06 at 2:25 PM, the Staff Developer and	F 496		

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F 496	Continued From page 28 Assistant Director of Nursing were interviewed. They stated that whoever does the hiring, immediately checks the nurse aide registry. Then they stated that they then place the registry report into the employee's file. When asked by the surveyors why the employee's nurse aide registry report was not in her file, staff replied that they had seen it earlier that day. When the facility provided a faxed copy of the employee's nurse aide registry report, documentation was found that the report was dated as being checked on 3/08/06. (35 days after the employee was hired).	F 496		