PRINTED: 03/15/2006 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	i	X3) DATE SURVEY COMPLETED	
		465075	B. WING		03/00/2000	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/09/2006	
ROCKY	MOUNTAIN CARE - W	VEST VALLEY		4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	TON
	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		F 161	F 161 A surety bond will be purchased to	0 5/4/0)6
			106	provide adequate insurance covera ensure the security of all personal of residents deposited with the fac	age to funds	
			Tool .	Office manager to conduct a mont audit of all personal funds of residence to ensure adequate coverage.		06
			Design of the second	Office manager to report findings audits monthly to Quality Assurar committee.	ice	′d€
	the surety bond ha	d been issued.	15/2	5/3/U - Complete	wus dals	
	The facility's surety	bond was reviewed on 3/6/06 been issued for \$25,000.	6	Changed to 5/1.	8/06 per	.
	Resident funds de reviewed on 3/6/06	posited with the facility were 6. As of 12/30/06, resident	De la company de	Submitted letter	rpr	
	exceeded the amo \$8,071.67.	acility totaled \$33,071.67. This unt of the surety bond by	7	& Basent	bakpe	
F 253 SS=E	483.15(h)(2) HOU	SEKEEPING/MAINTENANCE	F 253	Utah Department of		
	maintenance servi	rovide housekeeping and ces necessary to maintain a nd comfortable interior.		755314 MAR 2 4 2006		
	This REQUIREME by:	NT is not met as evidenced		Bureau of Health Facility Li Certification and Resident As		
ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) 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 day 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 1 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.



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.

rig.
experic.
s much bey

contact me directly

Charles

Health

Health 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 Administrator

Rocky Mountain Care – West Valley

Utah Department of Health 755853

Bureau of Health Facility Licensing, Certification and Resident Assessment

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

PRINTED: 03/15/2006 FORM APPROVED OMB NO. 0938-0396

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE	
	465075	B. WIN	6	03/0	0/2000
	EST VALLEY		4150 WEST 3375 SOUTH	ODE	9/2006
(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	DRRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
SECURITY The facility must puotherwise provide a Secretary, to assurfunds of residents of This REQUIREMED by: Based on review of the total of personal with the facility, it will did not assure the secretary.	archase a surety bond, or assurance satisfactory to the e the security of all personal deposited with the facility. NT is not met as evidenced the facility's surety bond and all funds of residents deposited as determined that the facility security of all personal funds	3	1 101	e coverage to ersonal funds the facility. a monthly of residents e.	5/4/06 5/4/06
Findings included: The facility's surety and found to have leaved on 3/6/06 funds kept by the facility by the facility is surety and found to have leaved on 3/6/06 funds kept by the facility is surety and found to have leaved on 3/6/06 funds kept by the facility is surety and founds kept by the facility except and facility is surety and facility except and facility excep	bond was reviewed on 3/6/06 been issued for \$25,000. bosited with the facility were As of 12/30/06, resident acility totaled \$33.071.67. This	O DAIL COMPONE	1000		
The facility must pr maintenance servic sanitary, orderly, ar This REQUIREMEN by:	ovide housekeeping and ces necessary to maintain a nd comfortable interior. NT is not met as evidenced		75581 MAR 2 4	기 2006 cillty Licensina.	
	PROVIDER OR SUPPLIER MOUNTAIN CARE - W SUMMARY STA (EACH DEFICIENCY REGULATORY OR L 483.10(c)(7) ASSU SECURITY The facility must pu otherwise provide a Secretary, to assur funds of residents of This REQUIREMENT by: Based on review of the total of personal with the facility, it we did not assure the s Specifically, the total with the facility except the surety bond had Findings included: The facility's surety and found to have the Resident funds dep reviewed on 3/6/06 funds kept by the face exceeded the amount \$8,071.67. 483.15(h)(2) HOUS The facility must pr maintenance service sanitary, orderly, and This REQUIREMENT by:	A65075 PROVIDER OR SUPPLIER MOUNTAIN CARE - WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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:	A BUIL 465075 PROVIDER OR SUPPLIER MOUNTAIN CARE - WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	A SULLING A SULLING B. WING STREET ADDRESS, CITY, STATE, ZIP CO 4150 WEST VALLEY CITY, UT 8412 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ASJ. 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. It was determined that the facility did not assure the security of all personal funds specifically, the total of residents 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. 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:	A65075 A65075 BUILDING BUILD

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		Ħ	
			A. BUII		G	COMPLE	ETED	
NAME OF D	DOMEST OF CHEST	465075	B. WIN	IG _		03/0	9/2006	
	ROVIDER OR SUPPLIER	/EST VALLEY		4	EET ADDRESS, CITY, STATE, ZIP CODI 150 WEST 3375 SOUTH /EST VALLEY CITY, UT 84120		3.200	
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	IVE ACTION SHOULD BE ED TO THE APPROPRIATE		 P
F 253	Based on observat facility did not provimaintenance servic comfortable home. Findings include: The following obse 3/6/06 and 3/8/06. The floor in the fact web-like cracks in the nearly the entire but multiple areas whe This could be a pot residents. The following resid gouged and scratch entrance to there resunkept and unattra 118,117, 116, 115, 202, 203, 204, 208 and 119. The door showers, the dining therapy room were.	ion it was determined that the de housekeeping and or ces to maintain a sanitary, or for its residents. It was large areas of spider the tile which encompasses ilding. The floor also has re it is bumpy and uneven. The ential hazard to ambulatory ent doors were observed to be need significantly resulting in the esidents home appearing ctive. Room numbers: 114, 113, 110, 108, 109, 201, 205, 206, 207, 210, 211, 212, as to the east and west of room, and the physical also in poor repair. The areas where the walls in the red to have either wallpaper pubble and lifting, or where the coubbile and lifting, or where the	F 2	253	F 253 Areas in the facility floors with a like cracks, as well as, areas in that are bumpy and uneven, will by Maintenance Director. Facility doors of rooms 118, 117, 114, 113, 110, 108, 109, 201, 20, 208, 205, 206, 207, 210, 211, 21 well as, the East and West show dining room doors, will be repaired by Director and staff. Facility walls with bubbled wall scratched paint to be painted, reprepaired by Maintenance Director. The two wooden dining room of be repaired or replaced by Maint Director. The center patio area to have all and debris removed, hanging with (or air conditioning tube) to be refigured, and chairs to be placed aside up by Maintenance Director.	spider web he floors be repaired 7, 116, 115, 12, 203, 204, 2, 119, as er doors, therapy Maintenance paper and placed, or or and staff. d by house- nairs to tenance trash re econ- right r.	5/4/06 5/4/06 5/4/06 5/4/06	
The handrails which them, felt sticky in n There were 2 woods observed to be in us		h the residents use to stabilize			Missing baseboard will be repair replaced by Maintenance Director. The exterior covering of the light at the far East side of The building room 107 to be replaced by Main Director.	or at fixture ng near	5/4/06	:

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION 0	(X3) DATE SURVEY COMPLETED		ľ	
		465075	B. WIN	B. WING				
	ROVIDER OR SUPPLIER	VEST VALLEY	-	4	REET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH VEST VALLEY CITY, UT 84120	03/09	9/2006	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF T	DRE	(X5) COMPLETIO DATE	N
F 253	Continued From pa	ige 2	F 2	253				┝
	smoke or sit outsid multiple chairs upside down, trash	here residents who wish to be was observed to have on the ground, a stuffed be ground, and wires hanging mattended.			Dining room table clothes to be laundy laundry department. Facility floors, doors, walls, handrail dining room chairs, center patio, base	ls,	5/4/06 5/4/06	
T n le	There were several areas observed to have the baseboard missing. The light fixture at the far east side of the building				boards, and light fixtures to be monitored monthly by Maintenance Director, house- keeping staff and Administrator for cleanliness, repair, and needed replacement.			
	riear room 107 was	the far east side of the building s missing the exterior cover d pipes exposed from inside	is is is		Housekeeping personnel to monitor room table clothes for cleanliness an weekly.	dining id repair	5/4/06	
top of the tablecloth		/06 8 of 8 tablecloths in the loted to be very soiled. The has are covered with glass; area which rests in the soiled.			Maintenance Director and Dietary M to report findings monthly to the Qu Assurance Committee.		5/4/06	
F 279 SS=B	483.20(d), 483.20(l CARE PLANS	k)(1) COMPREHENSIVE	F 2	79				
	A facility must use to develop, review comprehensive pla	the results of the assessment and revise the resident's n of care.						
	objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's nd mental and psychosocial etified in the comprehensive						
	to be furnished to a	t describe the services that are attain or maintain the resident's physical, mental, and						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DAT			RVEY	╀	
•		DENTIFICATION NUMBER:	A. BUILDI		COMPLE	TED	
		465075	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		sı	REET ADDRESS, CITY, STATE, ZIP COL		/2006	╀
ROCKY	MOUNTAIN CARE - W	EST VALLEY		4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120	JE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	———— ID				Ļ
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	ы
F 279	Continued From pa	-	F 279	9 F 279			t
	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).			Director of Nursing to construct care plan for resident #1 to inclu Communications, Mood, and Be	de: chaviors. a current care	5/4/06 5/4/06	
	This REQUIREME	NT is not met as evidenced		plan for resident #2 to include: (and Psychotropic drug use.	ommunications	,	
	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 .)			Director of Nursing to construct plan for resident #9 to include: (Mood, and Behaviors.		5/4/06	
				Director of Nursing to construct plan of resident #3 to include Ps drug use.	a current care ychotropic	5/4/06	
	Findings include:			Director of Nursing to construct plan for resident #6 to include C	a current care ommunication.	5/4/06	
	racility on 11/29/05,	originally admitted to the with the diagnoses of ditioning, asthma, chronic leg		Director of Nursing to ensure the of all resident care plans by usin	e completeness g a checklist.	5/4/06	
	pain, and gastroeso	ophageal reflux disease.		Medical Records to perform a mall current care plans to ensure the	onthly audit of hey are complian	5/4/06 it.	
	completed on 3/7/0	t 1's medical record was 6.					
	An MDS (minimum assessment comple 2/8/06, triggered the Assessment Protoc Cognitive loss, comfunctional/Rehabilit incontinence, Psychological Sydenydration, Press drug use. Of the 13	data set), a significant change eted by the facility staff on e following RAP's (Resident col) to be assessed: Delirium		Director of Nursing to report fin- to the Quality Assurance Comm	dings of audits ittee monthly.	5/4/06	

(X1) PROVIDER/SUPPLIER/CLIA //X2) MILITIPLE CONSTRUCTION	(3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
465075 B. WING	03/09/2006
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120	03/03/2006
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) BY PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROP	D.BE COMPLETION
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	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/15/2006 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 465075 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (X5) **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLÉTIC TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 279 Continued From page 5 F 279 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

3. Resident 9 was admitted to the facility on 7/2/05 with diagnoses including: Fall with fracture,

found in the residents medical record: Communication, and Psychotropic drug use.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/15/2006 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465075 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETIO PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 279 Continued From page 6 F 279 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

Safety Psychosocial

planned.

documented that 12 areas would be care

residents medical record.

9's medical record.
Mobility/ADL
Nutritional status
Dehydration
Skin Integrity
Comfort
Bowel/Bladder
Sleep/rest/naps

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

The following care plans were present in resident

Health deficit (including psychotropic drug

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465075 NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - WEST VALLEY (X2) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 4150 WEST 3375 SOUTH WEST VALLEY CITY, UT 84120		N
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4150 WEST 3375 SOUTH	(X5) COMPLETIC	N
ROCKY MOUNTAIN CARE - WEST VALLEY STREET ADDRESS, CITY, STATE, ZIP CODE 4150 WEST 3375 SOUTH	(X5) COMPLETIC	Z
THEOT VALLET CITY, UT 04120	COMPLETIC	N
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
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		

STATEMENT OF DEFICIENCIES (X1) PE AND PLAN OF CORRECTION IDI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		465075	B. WII	NG		0010		Ш
	PROVIDER OR SUPPLIER	WEST VALLEY	<u> </u>	41	EET ADDRESS, CITY, STATE, ZIP COI 150 WEST 3375 SOUTH /EST VALLEY CITY, UT 84120		9/2006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	*
F 279	Skin Integrity Comfort Bowel/Bladder Psychosocial Health deficit of Physical thera Occupational Commu Care Plans for the found in the reside Psychotropic drug 5. Resident 6 was facility on 12/27/03 hypertension, hypertension	(including psychotropic use) py therapy nication/Cognitive e following areas could not be ents medical record: use. s originally admitted to the 3, with the diagnoses of erthyroid, and quadriplegia. ent 6's medical record was o6. ent data set), a significant change bleted by the facility staff on the following RAP's (Resident ocol) to be assessed: Delirium, enabilitation potential, being, Mood state, Falls, schaviors, Cognitive loss, and use. Of the 11 RAP's illity documented that all 10 are planned. the DON (director of nursing), director of nursing), Recreation eschoic social services director) in 3/8/06. During this interview, tment heads stated that all the ch resident were present in each	F	279				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		465075	B. WIN	G		03/09/2006	
	ROVIDER OR SUPPLIER		,	4150	ET ADDRESS, CITY, STATE, ZIP CODE 0 WEST 3375 SOUTH ST VALLEY CITY, UT 84120	.1.	
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	3's medical record Mobility/ADL Nutritional state Dehydration Skin Integrity Comfort Bowel/Bladde Psychosocial Health deficit psychotropics) Sleep/r Cognitic Care Plans for the found in the resid Communication.	e plans were present in resident d. Intus er (including behaviors and est/ naps	F 2	79			
SS=E	PROCEDURES A facility must produced acquiring, receiving administering of the needs of each of the needs of each of the needs of each of the needs of interview medical records, did not provide put the accurate admitted the needs of its resampled resident diabetics. Five of dependent diabetics	ovide pharmaceutical services ures that assure the accurate ng, dispensing, and all drugs and biologicals) to meet		720			

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SUF	RVEY
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(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL		ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
orders. (Residents Findings include: 1. Resident 1 was admitted to the facidiagnoses of Asthrodependent diabete gastroesophageal in the physician's orders units at bedtime. A based on the result (BS). The sliding is 150 - 200 = 2 U (ur 201 - 250 = 4 Ur 201 - 250 = 4 Ur 201 - 250 = 8 Ur 301 - 350 = 8 Ur 301 -	a 76 year old female who was ility on 11/29/05 with the ma, hypertension, insulin s mellitus (IDDM), and reflux disease. The facility, resident 10's were as follows: Lantus 50 Also, provide humalog insulin ts of resident 1's blood sugars scale ordered was as follows: hits) 12 U If facility were obtaining resident as follows: adaptated by the facility were as follows: hits) 12 U If facility were obtaining resident as follows: hits and Dinner, and Bedtime) from 1/27/06. On 1/27/06, the facility staff recorded a BS of the physician's orders, resident 1 and none. In facility staff recorded a BS of the physician's orders, resident 1 and none. Iter, facility staff recorded a BS the physician's orders, resident 1 and none.	F		Director of Nursing to ensure reside 11, 12, and 13 are currently receivin correct amount of insulin according physician's orders. Director of Nursing to audit the charresidents, who are insulin depender ensure they are receiving the correct of insulin according to physician's of Director of Nursing to in-service nu personnel on procedures for administrator amounts of insulin for all insulin dependent diabetics. Pharmacy Consultant to conduct me on all insulin dependent residents at written report to Director of Nursing Administrator monthly.	rts all nt, to t amount orders. rsing stering sulin onthly audits nd provide g and ndings of	5/4/06 5/4/06 5/4/06
1 should have rece	eived 6 units of insulin, but no					
	ROVIDER OR SUPPLIER MOUNTAIN CARE - W SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From particle of the continued of the fact diagnoses of Asthrologous diagnoses diagnoses of Asthrologous diagnoses diagno	A65075 ROVIDER OR SUPPLIER MOUNTAIN CARE - WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	ROVIDER OR SUPPLIER MOUNTAIN CARE - WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 275. 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	ROVIDER OR SUPPLIER **A65075** **A65075** **A65075** **ACHIDENTIFICATION NUMBER:** **ACHIDER OR SUPPLIER **ACHIDER OR SUPPLIER **SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **FORMATION OR LSC IDENTIFYING INFORMATION **FORMATION OR LSC IDENTIFY OR LSC	ROVIDER OR SUPPLIER 465075 465075 ROVIDER OR SUPPLIER MOUNTAIN CARE - WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 Ashtma, 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 Administrator monthly. Director of Nursing to in-service nu personnel on procedures for adminis correct amounts of insulin for all insulin dependent residents at written report to Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for administrator monthly. Director of Nursing to in-service nu personnel on procedures for adminis	A SULLINING A BUILDING

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
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	ROVIDER OR SUPPLIER	VEST VALLEY		41	EET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH FEST VALLEY CITY, UT 84120		72000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	7
F 426	On 12/4/05 at bedtime, facility staff recorded a BS		F	426				
	of 299. Based on the factor of 299. Based on the factor of	the physician's orders, resident eived 6 units of humalog insulin, se states "held". There is no the physician was notified, or received to hold the sliding						
	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.							
	given: discontinue NPH insulin 15 uni	lowing physicians order was Lantus and Humalog insulin. its in AM, and 25 units before lar insulin for sliding scale at						
	of 184. Based on 1 should have reconstruction that documentation that that an order was scale dose of insu	time, facility staff recorded a BS the physician's orders, resident eived 2 units of humalog insulin, se states " - ". There is no at the physician was notified, or received to hold the sliding lin. The scheduled dose of se also marked with " - ".						
	of 292. The staff of dose of Regular in however, the sche	time, facility staff recorded a BS documented the sliding scale isulin as given correctly; eduled NPH dose was not given. nentation that the physician to be held.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		Ħ
		465075	B. WI			-		
	ROVIDER OR SUPPLIER			STRI 41	EET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH /EST VALLEY CITY, UT 84120	03/09	9/2006	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	нх	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	<u>+</u>
F 426	On 12/8/05 the folgiven: NPH insulibefore dinner. On 12/11/05 the folgiven: NPH insulibefore dinner On 12/11/05 at be BS of 275. The st scale dose of Reg however, the sche There is no docum ordered the dose. On 12/13/05 at br BS of 118. The st given. There is no physician ordered. On 12/17/05 the folgiven: NPH insulibefore dinner. On 12/17/05 at br BS of 153. Based resident 1 should insulin, but no dos Under the schedurecorded; however lunch ordered. On 12/8/05 the folgiven: Discontinu NPH insulin 30 ur dinner. On 12/20/05 the folgiven: On 12/20/05 the folgiven: Discontinu NPH insulin 30 ur dinner.	owing physicians order was in 25 units in AM, and 35 units ollowing physicians order was in 35 units in AM, and 25 units of time, facility staff recorded a paff documented the sliding ular insulin as given correctly; oduled NPH dose was not given the entation that the physician		426				

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				UNID NO.	0900-03	╃┷
	IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	URVEY ETED	
		465075	B. Wil	1G _		03/0	9/2006	
	ROVIDER OR SUPPLIER	VEST VALLEY		4	REET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH VEST VALLEY CITY, UT 84120		3/2006	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE	dN ON
F 426	before dinner. On 12/25/05 at bre BS of 92. Based or resident 1 should hinsulin. There was On 12/28/05 the form given: NPH insuling before dinner. On 12/29/05, 12/30 time the facility stan NPH insulin were gorder, resident 1 sl NPH insulin. On 1/1/06 at dinner order, resident 1 sl NPH insulin. There on 1/2/06 at break order, resident 1 sl NPH insulin. There on 1/2/06 at dinner order, resident 1 sl NPH insulin. There on 1/2/06 at dinner order, resident 1 sl NPH insulin. There on 1/2/06 at dinner order, resident 1 sl NPH insulin. There on 1/3/06 at dinner order, resident 1 sl NPH insulin. There on 1/3/06 at dinner order, resident 1 sl NPH insulin. There on 1/3/06 at dinner order, resident 1 sl NPH insulin. There on 1/3/06 at dinner order, resident 1 sl NPH insulin. There	eakfast, facility staff recorded a on the physician's order, have received 35 units of NPH	F	426	<u> </u>			
	order, resident 1 s	hould have received 20 units of						

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SU COMPLE	JRVEY	Ì
		465075	B. WING			03/04	9/2006	
	ROVIDER OR SUPPLIER	VEST VALLEY	<u> </u>	4	EEET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH VEST VALLEY CITY, UT 84120	<u> </u>	572.000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	,
F 426	NPH insulin. There order, resident 1 sl NPH insulin. There order, resident 1 sl NPH insulin. There order, resident 1 sl NPH insulin. There on 2/12/06 at dinne order, resident 1 sl NPH insulin. There on 2/16/06 at brea order, resident 1 sl NPH insulin. There on 2/20/06 at brea order, resident 1 sl NPH insulin. There order, resident 10 is admitted to the fact of the sl NPH insulin. There order ord	e was 15 units of insulin given. r, based on the physician's hould have received 20 units of e was 15 units of insulin given. r, based on the physician's hould have received 20 units of e was no insulin given. er, based on the physician's hould have received 20 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given. ekfast, based on the physician's hould have received 40 units of e was no insulin given.	F	426				

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<u> </u>		465075	B. WING			9/2006	
	NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - WEST VALLEY			EET ADDRESS, CITY, STATE, ZIP 50 WEST 3375 SOUTH EST VALLEY CITY, UT 84	CODE	1912006	
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F 426	301 - 350 = 8 U 351 - 400 = 10 U 401 - 450 = 12 U greater than 451 = On 2/11/06 at brea BS of 153. Based resident 10 should insulin, but no insu On 2/19/06 at dinr of 200. Based on 10 should have re insulin dosage wa On 2/26/06 at brea BS of 151. Based resident 10 should insulin, but no insu On 1/9/06 at dinne order, resident 10 of NPH insulin. T On 1/17/06 at dinne order, resident 10 of NPH insulin. T On 1/19/06 at bre order, resident 10 of NPH insulin. T On 1/26/06 at bre order, resident 10 of NPH insulin. T On 1/26/06 at bre order, resident 10 of NPH insulin. T	call MD akfast, facility staff recorded a on the physician's orders, I have received 2 units of ulin dosage was recorded her, facility staff recorded a BS the physician's orders, resident ceived 2 units of insulin, but no	F 426				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	URVEY	
	465075 B. WING		03/0	03/09/2006		
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Continued From	page 16	F 426				П
order, resident 10 of NPH insulin. On 2/16/06 at broorder, resident 10 of NPH insulin. On 2/19/06 at broorder, resident 10 of NPH insulin. On 2/19/06 at dirorder, resident 10 of NPH insulin. 3. Resident 13 vadmitted to the fincluding IDDM. Resident 13's properties at bedtime based on the resident 10 units at bedtime b	O should have received 15 units There was no insulin given. Beakfast, based on the physician's O should have received 15 units There was no insulin given. Beakfast, based on the physician's O should have received 15 units There was no insulin given. Inner, based on the physician's O should have received 12 units There was no insulin given. Inner, based on the physician's O should have received 12 units There was no insulin given. Insuling the was a 78 year old male who was acility on 2/6/03 with diagnoses anysician's orders were as follows: Inits in AM. and Lantus insulin 24. Also, provide Regular insulin sults of resident 13's blood sugars g scale ordered was as follows: In a Call physician The facility were obtaining resident the facility were obtaining resident					
Breakfast, Lunc	h, Dinner,and Bedtime).					-
	ROVIDER OR SUPPLIEF MOUNTAIN CARE - SUMMARY S (EACH DEFICIENT REGULATORY OF Continued From On 2/7/06 at breat order, resident 10 of NPH insulin. On 2/16/06 at breat order, resident 10 of NPH insulin. On 2/19/06 at directory of NPH insulin. On 2/19/06 at breat order, resident 10 of NPH insulin. On 2/19/06 at directory of NPH insulin. 3. Resident 13 valuation and the resident 14 valuatio	A65075 ROVIDER OR SUPPLIER MOUNTAIN CARE - WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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	A BUILDING A 65075 ROVIDER OR SUPPLIER MOUNTAIN CARE - WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 Con 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 direct to should have received 15 units of NPH insulin. There was no insulin given. On 2/19/06 at direct to should have received 12 units of NPH insulin. There was no insulin given. 3. 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	ROVIDER OR SUPPLIER MOUNTAIN CARE - WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 2/19/06 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 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 331 - 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	A BUILDING 465075 A BUILDING 8. WING 3. TREET ADDRESS. CITY. STATE, ZIP CODE 4150 WEST 3375 SOUTH WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECCEEDE DE YEULL (REGULATORY OR LSC IDENTIFYING INFORMATION) 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 2/18/06 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 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. 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. 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. 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. 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. 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. On 2/19/06 at dinner, based on the physician's order, 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 based on the results of resident 13's blood sugars (BS) four times a day (at	ROVIDER OR SUPPLIER ### A65075 ### A65075 ### A65075 ### STREET ADDRESS, CITY, STATE, ZIP CODE ### WEST VALLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 16 On 217/06 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 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 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 breakfast, based on the physician's order, resident 10 should have received 12 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 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 - 160 = 0 U 301 - 350 = 5 U 351 - 400 = 6 U greater than 400 = call physician Nursing staff at the facility were obtaining resident to blood sugars (BS) four times a day (at

STATEMENT AND PLAN O	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY	
		465075	B. Wit	1G _		03/00	9/2006	
	ROVIDER OR SUPPLIER	WEST VALLEY	<u></u>	4	EET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH /EST VALLEY CITY, UT 84120	1 03/03	5/2006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	7
F 426	of 321. Based on 13 should have reunits of insulin were on 12/11/05 at lur of 201. Based on 13 should have reunits of insulin were on 12/11/05 at be BS of 316. Based resident 13 should insulin, but 6 units on 12/25/05 a phy Lantus insulin (PM by the facility. On 12/27/05 at dir of 224. Based on 13 should have reunits of insulin were units of insulin should insulin, but 4 units on 12/19/05 at brophysician's order, received units of insulin given. On 12/25/05, base resident 13 should insulin given.	time, facility staff recorded a BS the physician's orders, resident ceived 5 units of insulin, but 6 re given. Inch, facility staff recorded a BS the physician's orders, resident ceived 3 units of insulin, but 4 re given. Inch, facility staff recorded a BS the physician's orders, and the physician's orders, and have received 5 units of of insulin were given. Inch, facility staff recorded a on the physician's orders, and have received 5 units of of insulin were given. Inch, facility staff recorded a BS the physician's orders, resident ceived 3 units of insulin, but 4	F	426				
	On 12/26/05, base	ed on the physician's order,						

STATEMENT AND PLAN C	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE		
		465075	B. Wit	1G —		03/09	9/2006	
	ROVIDER OR SUPPLIER	VEST VALLEY		41	REET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH VEST VALLEY CITY, UT 84120	1 0010	5/2000	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	N
F 426	resident 13 should Lantus insulin. The On 12/27/05, base resident 13 should Lantus insulin. The On 1/2/06 at break of 230. Based on 13 should have requnits of insulin were given on 1/9/06 at lunch 178. Based on the should have received insulin were given of insulin were given of 1/15/06 at break of 175. Based resident 13 should insulin, but 4 units On 1/28/06 at break of 268. Based resident 13 should insulin, but 5 units On 1/30/06, based resident 13 should Lantus insulin. The On 1/31/06 at bedt of 165. Based on 1/2/1/06 at bedt of 165.	have received 22 units of ere was no insulin given. It don't he physician's order, have received 22 units of ere was no insulin given. It have received 22 units of ere was no insulin given. It have received 32 units of ere was no insulin given. It have received 3 units of insulin, but no re given. It facility staff recorded a BS of e physician's orders, resident 13 yed 3 units of insulin, but 4 units en. It have received 3 units of ereceived 3 units of ereceived 3 units of ereceived 3 units of ereceived 4 units of ereceived 22 units of ereceived 22 units of ereceived 22 units of ereceived 22 units of ereceived 3 units of ereceived 22 units of ereceived 3 units of ereceived 4 units of ereceived 4 units ereceived 5	F	426				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		E CONSTRUCTION	(X3) DATE S COMPL		\prod
		465075	B. WIN	IG		03/0	9/2006	
	ROVIDER OR SUPPLIER		<u> </u>	415	ET ADDRESS, CITY, STATE, ZIP CO WEST 3375 SOUTH EST VALLEY CITY, UT 8412	ODE	312006	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	7
F 426	Continued From p	page 19	F	426				H
	254. Based on the should have received insulin were given of 2/22/06 at bed of 260. Based on 13 should have resured in the should	Attime, facility staff recorded a BS the physician's orders, resident eceived 4 units of insulin, but 6 are given. Attime, facility staff recorded a BS the physician's orders, resident eceived units of insulin, but 2 are given. Ch, facility staff recorded a BS of the physician's orders, resident eceived 3 units of insulin, but 4						
	4. Resident 12 v 2/10/06. Resident 12's "D February was rev found that for February 1st	was admitted to the facility on iabetic Record" for the month of viewed. Documentation was through the 9th of 2006, resident to the following insulin order: sliding scale liters of D5W						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY	
		465075	B. WIN	IG		03/0	9/2006
	ROVIDER OR SUPPLIER			41	EET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH (EST VALLEY CITY, UT 84120	1 00/0	5.2000
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	х	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 426	meals. Documentation withat resident 12's documented. The the resident received that time. Documentation withat resident 12's as 253. There was resident received time. (resident 12 sliding scale). Documentation withrough the 28th or receive the follow sliding scale regulation with the scale of 1 - 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 meals. Documentation with the following days the following days the side of the following days the f	as found for 2/04/06 at bedtime, blood sugar was not ere was no documentation that wed any sliding scale insulin at as found for 2/05/06 at 4:30 PM, blood sugar was documented as no documentation that the any sliding scale insulin at that should have received 7 units of was found that for February 10th of 2006, resident 12 was to ing insulin order: lar insulin and CALL MD	F	126			
	was documented	as 243, no documentation was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	URVEY ETED	
		465075	B. WING		_	20000	
	ROVIDER OR SUPPLIER	•	415	ET ADDRESS, CITY, STATE, ZIF 0 WEST 3375 SOUTH EST VALLEY CITY, UT 84	PCODE	09/2006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	,
F 426	found that sliding at that time. (the 4 units of sliding s On 2/11/06 at 6:0 was documented documentation where eived any insus should have received any insus should have received any insus should have received any should that the time. On 2/11/06 at 4:3 was documented found that reside insulin at that time received 2 units of the compact of the c	scale was given to the resident resident should have received scale) O AM, the residents blood sugar as being 157. No as found that the resident din at that time. (the resident ived 2 units of sliding scale) 30 PM, the residents blood cumented. No documentation e resident received any insulin at as 180. No documentation was nt 12 received any sliding scale e. (the resident should of					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE S COMPL	
		465075	B. WING _		03/0	9/2006
	ROVIDER OR SUPPLIEF	•	4	REET ADDRESS, CITY, STATE, ZIP 150 WEST 3375 SOUTH VEST VALLEY CITY, UT 841	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	On 2/27/06 at 4:3 was documented documentation w	ave received 2 units of sliding 30 PM, the residents blood sugar I as being 153. No vas found that the resident ing scale at that time. (the	F 426			
	resident should he scale) 5. Resident 11 2/24/06, with the disease, chronic	was admitted to the facility on following diagnoses: peptic ulcer renal failure, chronic obstructive se, and diabetes.				
	reviewed. Docu resident 11 was orders for Febru February 26th:	eudatory "Diabetic Record" was mentation was found that receiving the following insulin ary 24th through the afternoon				
	Regular insulin s <60 give 1/2 am 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	p of Ď5W or juice. J J				
	not receive the the following da On 2/24/06 at the was documented.	was found that the resident 11 did correct dose of sliding scale on ys: 3:00 PM, resident 11's blood sugared as 128. No documentation was lent 11 did not receive any sliding	r			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLE		
		465075	B. Wil	1G _		03/0	9/2006	
	ROVIDER OR SUPPLIEF		•	4	REET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH VEST VALLEY CITY, UT 84120		9,2000	
(X4) ID PREFIX TAG	(EACH DEFICIENT	STATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 426	scale. (the residence of sliding scale) On 2/26/06 at 8:	ent should have received 4 units 00 AM, resident 11's blood sugar	F	426 ⁻				
ĺ	found that reside	d as 170. No documentation was ent 11 received 4 units of sliding ent should have received 6 units						
	reviewed. Docur resident 11 was orders for Februa	ebruary "Diabetic Record" was mentation was found that receiving the following insulin ary 26th through February 28th:						
	Discontinue the Give lantus 5 un	sliding scale. its every morning						
		was found that the resident 11 did scheduled lantus on the following						
	was documented	:00 AM, resident 11's blood sugar d as 88. No documentation was ent received any insulin.						
	was documente	:00 AM, resident 11's blood sugar d as 91. No documentation was ent_received any insulin.						
F 431 SS=E	, ,	LING OF DRUGS AND	F	431				
	labeled in accor professional prii appropriate acc	gicals used in the facility must be dance with currently accepted nciples, and include the essory and cautionary d the expiration date when						j

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		465075	B. WING	78-10	03/09	9/2006	
	ROVIDER OR SUPPLIER	WEST VALLEY	4	EET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH VEST VALLEY CITY, UT 84120			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	Continued From p applicable.	age 24	F 431				
	by: Based on observa facility was using labeled in accorda professional princ was using medica	ention, it was determined that the medications that were not ance with currently accepted iples. Specifically, the facility ations that were not dated when		F 431 Director of Nursing to ensure that medications stored both in the We refrigerators are all dated.		5/4/06	
	they were opened Findings include:			Director of Nursing to in-service r on dating all medications as they a and stored.	_	3/16/06	
	medication refrige The following me	ıs Insulin		Pharmacy Consultant to provof all medication refrigerators in tensure medications are dated in accurrently accepted professional standards to be provided to Director Administrator.	cordance with andards.	h 	
	medication refrig	us Insulin olin R Insulin		Director of Nursing to report find audits to the Quality Assurance C monthly.		5/4.06	
	following for Lan	6 Drug Handbook states the tus Insulin. "Discard opened as whether refrigerated or not".					
F 492 SS=6		NISTRATION	F 492	2			

AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465075	B. WING			03/09/2006		
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - WEST VALLEY				4	EET ADDRESS, CITY, STATE, ZIP CODE 150 WEST 3375 SOUTH VEST VALLEY CITY, UT 84120	03/03	9/2006	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	N SHOULD BE COMPLÉT E APPROPRIATE DATE		
F 492	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:		F4	492	F 492 Employee's A, B, C, D, and E to he BCI checks performed by HR personnel in-serviced on Utah Section 26-21-9.5.	onnel.	5/4/06 5/4/06	
					HR Director to use a new hire chec on all new hired personnel to ensur BCI check has been performed.		5/4/06	
	personnel files, it was not in compli laws. Specifically reviewed, the fac-	w and review of facility was determined that the facility ance with all applicable State r, for 5 of 5 personnel files ility had not completed the background check performed			HR Director to audit personnel file to ensure all personnel files are con and compliant. HR Director to report audit finding	nplete	5/4/06 5/4/06	
	through the Burea	au of Health Facility Licensing, Resident Assessment.			to QA Committee			
	a Bureau of Crim referred to as BC elderly adult licer screening be con	Section 26-21-9.5, requires that inal Identification screening, I, and a child or disabled or asing information system aducted on each person who are to a patient for the following are facilities:						
		ncies; facilities;						
	"Within ten days	ule is the requirement that of initially hiring an individual, a are facility shall submit the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CON	(X3) DATE SURVEY COMPLETED		
						·		
	465075		B. WIN	√G		03/09/2006		
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - WEST VALLEY				41	EET ADDRESS, CITY, STATE, ZIP CODE 50 WEST 3375 SOUTH EST VALLEY CITY, UT 84120			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE	04	
F 492	individual's inform accordance with S Five random pers 3/8/06. Employee A was I Employee B was I Employee C was Employee E was Employee E was I The personnel file not contain any do the required BCI of The staff member checks at the Bur Certification and I	ation to the department in Subsection (1)." onnel files were reviewed on hired on 12/15/05. hired on 12/22/05. hired on 2/3/06. hired on 1/6/06.	F	492				
F 496 SS=D	that the facility had of the above lister 483.75(e)(5)-(7) INURSING AIDES Before allowing a aide, a facility muthat the individual requirements unleemployee in a traevaluation prograindividual can prosuccessfully composuccessfully composuccessful	d not sent in information for any dipersonnel. REQUIRED TRAINING OF	F	496	F 496 Identified personnel has had a state registre check completed clearing them of any form of abuse. HR Director to use a new hire checklist to ensure state registry has been checked print to a new hire can provide patient care. HR Director to audit personnel files mont to ensure all personnel files are complete compliant. HR Director to report audit findings mont to the Quality Assurance Committee.	5/4/0 or hly 5/4/0	6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLI	
		465075	B. WING		03/0	09/2006
	ROVIDER OR SUPPLIER		4150	T ADDRESS, CITY, STATE, ZIP WEST 3375 SOUTH ST VALLEY CITY, UT 84	CODE	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 496	Before allowing a aide, a facility mu State registry est (2)(A) or 1919(e) believes will include a training and conthere has been a consecutive more individual provide services for mone individual must be competency evancompetency	n individual to serve as a nurse st seek information from every ablished under sections 1819(e) (2)(A) of the Act the facility de information on the individual. dual's most recent completion of impetency evaluation program, a continuous period of 24 of the during none of which the ed nursing or nursing-related etary compensation, the complete a new training and fluation program or a new duation program. MENT is not met as evidenced interviews and review of personnel remined that the facility did not in from the state registry for 1 of 3 of allowing those newly hired rive as nurse's aides, to ensure ons with histories of verbal, and abuse were not employed.	F 496	DEFICIENCE		
	Two nurse surv files on 3/08/06 found that the n prior to the emp	een providing direct care. eyors reviewed the employee's No documentation could be surse aide registry was checked ployee providing resident care.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		֓֟֝֟֓֓֓֟֟֝ ֡	
465075			B. WII	1G		03/00/2006		$ \ $	
NAME OF PROVIDER OR SUPPLIER ROCKY MOUNTAIN CARE - WEST VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROFICIENCY)	OULD BE	(X5) COMPLETIC DATE	3N	
F 496	Assistant Director They stated that w immediately check they stated that the into the employee's surveyors why the report was not in h had seen it earlier When the facility p employee's nurse documentation wa	of Nursing were interviewed. hoever does the hiring, s the nurse aide registry. Then ey then place the registry report is file. When asked by the employee's nurse aide registry er file, staff replied that they that day. Tovided a faxed copy of the aide registry report, s found that the report was ecked on 3/08/06. (35 days	F	496					
				:				1	