PRINTED: 04/10/2006 DEPARTMENT OF HEALTH AND HUMA. SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B, WING 465084 03/30/2006 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **187 WEST LAGOON STREET BASIN CARE AND REHABILITATION CENTER** ROOSEVELT, UT 84066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 253 483.15(h)(2) HOUSEKEEPING/MAINTENANCE SS=E The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Utah Department of Health 4/19/04 This REQUIREMENT is not met as evidenced Based on observations, from 3/27/06 through room of Hoolit Facility Licensing. 3/29/06, it was determined that the facility did not theat of bud hesiden. Assessm provide maintenance services to maintain a sanitary and comfortable interior. Findings included: 1. East Shower Room The fiberglass shower enclosure is being removed and Observations of the facility revealed the replaced with solid surface cultured marble material. following: This material will cover the entire shower floor and the three walls from the floor to the ceiling. Removal of 1. The East Shower room shower stall had a the existing fiber glass unit is scheduled for April 24th with installation of the cultured marble the first week in 8"X4" hole in the threshold that was May 2006. Installation time is scheduled to be two approximately 2" deep, that was located 6" from days. . the west wall, exposing a black substance. The edges of the hole were sharp and the hole itself was unsanitizable. 2. Bathroom #3 a.,b, 2. Bathroom #3 The flooring in front of the bathtub has been pulled up a. The caulking around the base of the and re-glued down to remove the ripple. The edge of bathtub and the wall perpendicular to it was pulled the flooring around the tub base and the wall away from the bathtub and the wall. perpendicular to it has been re-caulked. b. There was a 2 and 1/2 foot ripple in the linoleum in front of the bathtub. C. i..ii. c. The shower stall had the following The existing fiberglass wall material and the ceramic concerns: tile floor located in the wheelchair shower stall is being i. Between the hand rails on the side of removed and replaced with solid surface cultured the wall that the shower was located on were two marble material. This material will cover the entire quarter inch holes. The edges of the holes were

entrance there were 6 chipped one inch tiles and LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ii. On the floor of the shower, at the

TITLE

shower floor and the three walls from floor to ceiling.

(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 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.

sharp to the touch.

DEPARTMENT OF HEALTH AND HUMA. SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465084	B. WI	NG _	***	03/3	0/2006
	ROVIDER OR SUPPLIER ARE AND REHABILIT	TATION CENTER	-	18	REET ADDRESS, CITY, STATE, ZIP CODE 87 WEST LAGOON STREET COOSEVELT, UT 84066	, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 253	3"x4" area of missing that vicinity. 3. The West Showed away from 3 of the 4. The North Shown away from the entire bottom of the entral was a sharp 6 inch 5. The entrance foy 2 couches and 8 ch of scratched and de 6. In the East televicolored recliner that fabric to the back, a There was also 6 because of the cushion of the reclinity. In room 104, the wall next to the sink sink. The edges of 8. In room 106, the wall next to the sink sink. The edges of bathroom located of the total total a four exposing sharp edges of 9. In room 401, the wall next to the sink sink. The edges of the sink sink sink sink sink sink sink sink	e shower wall there was a ng tiles with 25 chipped tiles in er Room had the coving pulling 4 walls. Wer room had the coving pulling e wall behind the toilet. At the nce door facing the hallway section of rough metal. Wer and lobby had 2 love seats, nairs that had numerous areas ented wood. Wision room there was a peach at had dirty, worn and stained arms, seat and foot rest. Luttons missing from the back ner. Were two broken tile on the collected alcove below the level of the the tile were sharp. The off room 106 had a toilet tank inch area of broken porcelain ges. Were two broken tiles on the collected area of broken tiles on the collected area.	F	253	3. West Shower Room The floor coving has been re-glued. Manager will monitor the area monthly a deviations to the Quality Assurance Comm 4. North Shower Room The floor coving along the wall behind been repaired. The metal kick plate on door has been replaced. 5. Entrance foyer and main lobby. All couches, chairs, tables and other wo in the entrance foyer, main and East been repaired. The Housekeeping Diresponsible for checking this furniture one 6. East Television Room The Peach colored recliner in the East to has been removed from the facility. 7. Room 104 The broken corner wall tiles next to the below the level of the sink have been rewall corners of the sink alcove have been 11/2*x11/2*x36" plastic corner guards that the top of the baseboard to above the sink the top of the baseboard to above the sing The broken toilet tank lid between rooms has been replaced. 9. Room 401 The broken corner wall tiles next to the below the level of the sink alcove have been replaced. 9. Room 401 The broken corner wall tiles next to the below the level of the sink have been replaced. 9. Room 401 The broken corner wall tiles next to the below the level of the sink have been replaced. 9. Room 401 The broken corner wall tiles next to the below the level of the sink have been replaced.	the toilet has the entrance oden furniture Lobbies have been will be the a week. In the entrance oden furniture Lobbies have been will be the a week. In the entrance oden furniture Lobbies have been week. In the entrance oden for the a covered with at extend from the covered with the covered with at extend from the covered with the covered with at extend from the covered with the covered with the covered with at extend from the covered with the covered w	
	10. In room 402, th	nere were two broken tiles on					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU		COMPL	(X3) DATE SURVEY COMPLETED	
		465084	B. WII	NG _	03/3	30/2006
	ROVIDER OR SUPPLIER ARE AND REHABILI	TATION CENTER		11	REET ADDRESS, CITY, STATE, ZIP CODE 87 WEST LAGOON STREET ROOSEVELT, UT 84066	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	the sink. The edge 11. In room 405, the exposed metal with area of exposed moreoners of both side 11. In room 408, the wall next to the sink sink. The edges of On 3/30/06 at 7:20 (MM) was interview broken tiles in the it was on his list to to it yet. When ask bathrooms and the shower in the east that it was in the "c 2 shower areas but there 's only one mand we haven't be-	e sink alcove below the level of is of the tile were sharp. There was an 18 inch area of in plaster missing and a 24 inch letal and plaster missing on the les of the sink alcove. There was a broken tile on the is alcove below the level of the inthe tile were sharp. AM, the maintenance man level. When told about the residents' rooms he stated that fix and that he had not gotten led about the broken tiles in the elebroken threshold to the shower room, the MM stated capitol budget" to replace these it because "we live in the Basin, and who does this kind of work en able to get him into the look at it, let alone replace it."	F	253	10. Room 402 The broken corner wall tiles next to the sink alcove below the level of the sink have been removed. The wall corners of the sink alcove have been covered with 11/2"x11/2"x36" plastic corner guards that extend from the top of the baseboard to above the sink counter top. 11. Room 405 The exposed areas of the metal corner bead on both sides of the sink alcove have been re-plastered. The wall corners of the sink alcove have been covered with 11/2"x11/2"x36" plastic corner guards that extend from the top of the baseboard to above the sink counter top. 12. Room 408 The broken corner wall tiles next to the sink alcove below the level of the sink have been removed. The wall corners of the sink alcove have been covered with 11/2"x11/2"x36" plastic corner guards that extend from the top of the baseboard to above the sink counter top. The Facility Manager and Administrator will monitor the facility for deviations from the standard 483.15(h)(2) Housekeeping/Maintenance. The findings will be reported to the Quality Assurance Committee monthly.	
F 281 SS=D	The services provi	MPREHENSIVE CARE PLANS ded or arranged by the facility sional standards of quality.	F	281		5/29/06
	by: Based on observa review it was deter follow current profe	interview, and record mined the the facility did not essional standards of care g physicians' orders for 1 out of				

DEPARTMENT OF HEALTH AND HUMA. LERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
465084 B. WING			03/30/2006			
	PROVIDER OR SUPPLIER		18	EET ADDRESS, CITY, STATE, ZIP CODE 17 WEST LAGOON STREET OOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION	
F 281	12 residents. Resident 2 was a with diagnoses th CHF, pulmonary hypothyroidism, efractured ankle. Resident 2's med 3/27/06. Resident 2's had 3/17/06 to wear T stockings) during edema. (Anti-eml help prevent bloofrom forming in the swelling in the leg On 3/27/06 from observation of resident 2 was observed rin bed watching to observed a pair of nightstand next to observed to be in nightstand next to observed to be in nightstand next to On 3/28/06 at 8:0 not wearing TED observed to be in nightstand next to on 3/28/06 at 8:0 not wearing TED	dmitted to the facility 03/17/06 at included downs syndrome, embolism and infarction, esophageal reflux, gout, and a dical record was reviewed on a physician's orders dated ED hose (anti-embolism waking hours AM to PM for bolism stockings are used to diclots and decubitus ulcers he legs or to help decrease gs.) 3:45 PM to 5:35 PM continuous eldent 2 was obtained. Resident not wearing his TED hose while elevision. The surveyor of TED hose located on the pother resident. During the pother resident. During the pother resident 2 was observed.	F 281	F 281 The facility ensures that and potential residents will imedical services and meet standards of quality that are appropriate qualified persons. Resident #2 TED hose was or currently wearing them daily completed after the exit However, at times he continue. The skilled staff are document. Upon admission, the skilled meet directly with the Certiff Assistants to instruct them redirect care needed. Direct creviewed with the nursing stathe first 10 days from admissic continuity of direct care. The Nursing Services will contact nurse regarding direct sup Certified Nursing Assistants care responsibilities. An in-service will be held of 2006 to inform the Certifical Assistants that the resident concare plans will be placed with charting for review and compin-service for the skilled nursing be held April 26, 2006 to procedure and the follow throughters.	dered and is This was interview. es to refuse. ing refusal. murse will ied Nursing garding the are will be ff daily for on to ensure Director of each skilled ervision of and direct n April 18, ed Nursing aprehensive the ADL pliance. An ag staff will address the	

DEPARTMENT OF HEALTH AND HUMA. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		465084	B. WI			03/3	0/2006
	ROVIDER OR SUPPLIER ARE AND REHABILIT	TATION CENTER		18	EET ADDRESS, CITY, STATE, ZIP CODE B7 WEST LAGOON STREET OOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	nightstand next to to On 3/28/06 at 8:30 not wearing TED he observed to be in the nightstand next to to On 3/28/06 at 9:00 not wearing TED he observed to be in the nightstand next to to On 3/28/06 at 9:30 not wearing TED he observed to be in the nightstand next to to On 3/28/06 at 10:40 not wearing TED he observed to be in the nightstand next to to On 3/29/06 at 9:40 not wearing TED he observed to be in the nightstand next to to On 3/29/06 at 9:40 not wearing TED he observed to be in the previous day on the resident. On 3/29/06 at 9:45 assistant) was inter his TED hose should check the resident. On 3/29/06 at 10:00 observed to be asson the TED hose, were able to put on	he resident. AM resident 2 was observed ose. A pair of TED hose were he same position on the he resident. AM resident 2 was observed ose. A pair of TED hose were he same position on the he resident. AM resident 2 was observed ose. A pair of TED hose were he same position on the he resident. O AM resident 2 was observed ose. A pair of TED hose were he same position on the he resident.	F	281	The facility will develop a visu identify residents who wear TEI staff members will be interviewed for understanding of the require compliance until 90% has been Target date for completion is 2006. Monitoring will continue every until the staff is able to verb demonstrated 100% compliance, monitoring will continue until the committee determines compliance. A quality monitor is in place as reviewed by the quality committee compliance and variances month.	D hose. 5 ed weekly ements of a reached. May 31, 2 weeks alize and Monthly he quality ee. and will be mittee for	5/29/06

DEPARTMENT OF HEALTH AND HUMA. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	JLTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING				
		465084	B. WING		03/3	0/2006	
NAME OF PROVIDER OR SUPPLIER BASIN CARE AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 187 WEST LAGOON STREET ROOSEVELT, UT 84066	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 281	Continued From pa	age 5	F 2	81			
F 514 SS=E	notes was complet documented that rethe TED hose. No TED hose were do 483.75(I)(1) CLINIC The facility must mare resident in accordant standards and practically organizately document systematically organizately organizately organizately document systematically organizately o	cal records on each ance with accepted professional ctices that are complete; and anized. must contain sufficient tify the resident; a record of the nents; the plan of care and the results of any ening conducted by the State; s. NT is not met as evidenced eviews and interview it was a facility did not maintain accordance with accepted ards and practices to meet the 2 sampled residents and 1 lent.	F 5	accepted professional st practices that are comple documented, readily acc systematically organized. All orders for MOM that without frequency were re-w exit interview. (MOM 30cc constipation), resident #4 N	were written ritten after the po daily, prn fom was re- comotil was fom the were written after the po daily, prn fom was re- comotil was fom the was re- written. Sident #6, the nationed. The was clarified eam. In physician's each Skilled a scheduled on review and rician orders. Hers will be sing staff for the reviewed ring Services		
	1. Resident 6 was	admitted to the facility on		signature. Target date for com 31, 2006.	May Is May		

DEPARTMENT OF HEALTH AND HUMAI. JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE		
		465084	B. WII	√G	AT a while was the street of the street	03/30	0/2006
NAME OF PROVIDER OR SUPPLIER BASIN CARE AND REHABILITATION CENTER			1	REET ADDRESS, CITY, STATE, ZIP CODE 87 WEST LAGOON STREET ROOSEVELT, UT 84066	,	130/2006	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	heart failure, deep dementia, and ed Resident 6's med 3/28/06. It was documented Physician's Recelled "Lasix 20 milligrameded" had been specify the frequentime intervals between intervals between administration Reflection of the frequency of administration of the frequency of the frequen	noses that included congestive ovein thrombosis, Alzheimer's, ema. ical record was reviewed on ed on resident 6's March 2006 rtification Orders that on 6/29/05 ms (mg) 1 tablet oral PRN (as en prescribed. The order did not ency of administration nor any ween administrations. ed on resident 6's Medication ecord (MAR) that on 6/29/05 blet oral PRN" had been order did not specify the inistration nor any time intervals	F	514	2 resident charts per week will be for compliance with physician frequency until 90% compliance compliance is obtained 10% resident charts will be review 1 month for 90 days. Monthly monicontinue until the quality determines compliance. A quality monitor is in place ar reviewed by the quality common compliance and variances monthly	orders for ce. When audit of time per toring will committee	-5/29/0L

DEPARTMENT OF HEALTH AND HUMAI. JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:]` ′	IULTIPL LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		465084	B. WII	NG	31 Add 10 Add	03/	30/2006
NAME OF PROVIDER OR SUPPLIER BASIN CARE AND REHABILITATION CENTER		.	187	ET ADDRESS, CITY, STATE, ZIP CODE WEST LAGOON STREET OSEVELT, UT 84066			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	had been prescrithe frequency of intervals between It was document 2/24/06 "Dulcolated PRN" had been proceed to be specify the frequency time intervals be 2. Resident 11 vroughle 12/1/05 with diagramentia, depredisease, constipated as a constitution of the constituti	bed. The order did not specify administration nor any time in administration. ed on resident 6's MAR that on a Suppository 1/1 per rectum (pr) prescribed. The order did not ency of administration nor any tween administrations. I was admitted to the facility on proses that included Parkinson's, asion, gastric esophogeal reflux ation, spasm of muscles and edical record was reviewed on ed on resident 11's March 2006 ertification Orders that on 1/15/06	F	514			
	"Milk of Magnesi been prescribed frequency of adribetween administ was document 1/15/06 "Milk of PRN" had been specify the frequence intervals be	a (MOM) 30 ml oral PRN" had The order did not specify the ninistration nor any time intervals					
		04 with diagnoses that included		i i			

DEPARTMENT OF HEALTH AND HUMAIN JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE S COMPLE	
		465084	B. WII	1G _		03/3	0/2006
	ROVIDER OR SUPPLIER ARE AND REHABIL		•	18	EET ADDRESS, CITY, STATE, ZIP CODE 37 WEST LAGOON STREET OOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514		j	F	514			
	Resident 4's med 3/29/06.	ical record was reviewed on					
	Physician's Receins 11/13/05 "MOM Comprescribed."	ed on resident 4's March 2006 rtification Orders that on 30 ml (milliliters) oral PRN." had The order did not specify the inistration nor any time intervals trations.					:
	MAR that on 11/1 had been prescril	ed on resident 4's March 2006 3/05 "MOM 30 ml oral PRN." bed. The order did not specify administration nor any time administrations.					
		s admitted to the facility in May noses that included dementia, akness.					
	Resident 8's med 3/28/06.	lical records were reviewed on					
	Physician's Rece "Lomotil 1 tablet of been prescribed.	ed on resident 8's March 2006 intification Orders that on 9/1/05 oral PRN LOOSE STOOL." had The order did not specify the ninistration nor any time intervals tration.					
	MAR that on 9/1/ LOOSE STOOL. did not specify th	ed on resident 8's March 2006 05 "Lomotil 1 tablet oral PRN " had been prescribed. The order e frequency of administration nor s between administration.	i				

DEPARTMENT OF HEALTH AND HUMA: JERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`	IULTIP	LE CONSTRUCTION	(X3) DATE SI COMPLE	
		465084	B. WI	NG	<u> </u>	03/3	0/2006
	ROVIDER OR SUPPLIER ARE AND REHABIL	TATION CENTER	•	18	EET ADDRESS, CITY, STATE, ZIP CODE 7 WEST LAGOON STREET DOSEVELT, UT 84066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	Continued From p	age 9	F	514			
	September of 200	s admitted to the facility in 3 with diagnoses that included se and hypertension.					
	Resident 13's med 3/28/06.	dical record was reviewed on					
	Physician's Recer "MOM 30 ml oral The order did not	d on resident 13's March 2006 tification Orders that on 1/04/06 PRN." had been prescribed. specify the frequency of any time intervals between					
	1/04/06 "MOM 30 prescribed. The o	d on resident 13's MAR that on 0 ml oral PRN." had been rder did not specify the inistration nor any time intervals ration.					
	Physician's Recer that "Bumetanide tablet oral QD (ev needed for edema no documentation	d on resident 13's March 2006 tification Orders that on 9/15/03 (BUMEX) 1 mg (milligram) 1 teryday) 1 PO (by mouth) as a" was prescribed. There was a in the March 2006 MAR that to be administered Bumex as					
	interviewed. Nurs resident 13's Mar Recertification Or the order, nurse 1 be administered E edema. Nurse 1	f 3/28/06 nurse 1 was see 1 was asked to review ch 2006 Physician's ders for Bumex. After reviewing was asked if resident 13 was to Bumex QD and as needed for stated that she wasn't sure and all the physician and get a					

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		465084	B. WING		03/30/2006		
NAME OF PROVIDER OR SUPPLIER BASIN CARE AND REHABILITATION CENTER				REET ADDRESS, CITY, STATE, ZIP COD 187 WEST LAGOON STREET ROOSEVELT, UT 84066			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 514	gave the surveyor It was documente Bumex that reside mg each day and	proximately 4:30 PM, nurse 1 r a clarification order for Bumex. ed on the clarification order for ent 13 was to receive Bumex 1 that the resident "May have n (as needed) q (every)	F 514	4			