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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465006	A. BUILDING _____ B. WING _____	09/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASATCH VALLEY REHABILITATION	2200 EAST 3300 SOUTH SALT LAKE CITY, UT 84109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309 SS=E	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Resident 14 (R#14) was admitted to the facility on 5/23/06 with diagnoses that included: diabetes mellitus, osteoporosis, cerebrovascular accident (stroke), emphysema, chronic obstructive pulmonary disease and cancer. The medical record for resident 14 was reviewed on 9/13/06. The medication administration record (MAR) revealed that nursing staff were giving R# 14 the medication Lorazepam 2 mg (mili-grams) po (by mouth) three times a day (tid) at 9:00 AM, 2:00 PM, and 9:00 PM and Ativan (Lorazepam) 0.5 mg po q 4 hrs (every 4 hours) and PRN (as needed) for agitation. Record review of physician telephone orders stated: On 8/17/06 "Ativan (Lorazepam) 2 mg tid. " On 8/20/06 " Increase Lorazepam to l mg tid." On 9/1/06 "DC (discontinue) Lorazepam' R# 14's Physician Orders for 8/1/06 to 8/31/06 were reviewed on 9/13/06. The order dated 7/10/06 stated "Ativan (Lorazepam) 0.5 mg po tid PRN unrelieved anxiety (in addition to scheduled dosing)" An order dated 6/29/06 stated "Ativan (Lorazepam) 0.5 mg po tid at noon, 4 PM, 8 PM."	F 309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by Wasatch Valley Rehabilitation of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. **F 309 SS=E** **CORRECTIVE ACTION PLAN FOR IDENTIFIED RESIDENTS** Resident #14's Ativan orders were reviewed and clarified by house physician on 09/14/06. Resident #4 admitted to Wasatch Valley Rehabilitation on 03/22/04. Resident #4 according to her medical record discharged to the hospital on 03/16/05 and returned to the facility on 03/17/05. Resident #4 did not admit with an order for C-PAP on either the 03/22/04 admit nor the 03/17/05 admit. The patient was never admitted with an order for C-PAP and the discontinuance order was written to correct the previous physician recertification orders that should never had that order in the first place. The Director of Nursing spoke with the Nurse Practitioner for the house physician, who is also Resident # 4's physician. It was clarified that the C-PAP order should never have been put on the physician recertification orders.	

10/6/06 POC acceptable Completion date 11/1/06 Vbuenbyn RN

Utah Department of Health

OCT 0 6 2006

Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ric Toomer	Ex. Director	10-6-06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 The telephone orders for 8/17/06 and 8/20/06 were not shown on the physician orders 8/1/06 to 8/31/06. From 8/17/06 to 9/19/06 the resident received Lorazepam 2 mg po tid and Ativan (Lorazepam) 0.5 mg po q 4 hrs PRN for agitation, as documented on the medication record (MAR). The telephone order to increase Lorazepam to l mg did not appear on the September MAR. The telephone order to discontinue the Lorazepam on 9/1/06 did not appear on the MAR. An interview was conducted with the Director of Nursing (DON) on 9/13/06 at 4:15 PM. She indicated that the order for Lorazepam written on 8/20/06 for l mg tid was probably wrong because the MAR did not indicate that order. She also stated that the order to discontinue Lorazepam written on 9/1/06 " apparently did not occur." Based on medical record review and interview it was determined that the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well being for 4 of 18 sampled residents. Resident identifiers, 3, 4, 8, and 14. Findings included: Resident 4 was admitted to the facility on 4/12/04 with diagnoses that included; chronic airway obstruction, chronic obstructive pulmonary disease, congestive heart failure, obstructive sleep apnea, diabetes mellitus, hypertension, obesity and hernia. The medical record for resident 4 was reviewed on 9/13/06. It revealed a physicians's telephone	F 309	The discontinue order was written to correct the future physician recertification orders. Resident #8 had a sleep study scheduled for 10/11/06. Resident #8 then cancelled own appointment for sleep study. House physician discontinued order for resident 8's sleep study secondary to patient's refusal to go. Resident #3's vital sign (VS) monitoring has been clarified with house physician and has returned to once a week VS monitoring (blood pressure, respirations, pulse, Temperature and oxygen saturations). **IDENTIFICATION FOR RESIDENTS POTENTIALLY AFFECTED** All resident have the potential to be affected. **MEASURES TO PREVENT RECURRENCE** The Director of Nursing (DNS) will inservice the licensed nurses, by 10/26/06. The inservicing will include: 1. How to accurately transcribe physician telephone orders and follow up on them 2. How to accurately transcribe readmission orders. 3. How to review monthly physician recertification orders for accuracy. 4. Importance of accurate documentation. 5. Importance of obtaining clarification orders from the physician when indicated.	

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F 309	Continued From page 2 order dated 8/28/06 that stated "D/C (discontinue) C-PAP (continuous positive airway pressure) (secondary to) pt no longer has machine/non use" An interview was held with the DON (Director of nursing) on 9/13/06 at 2:00 PM. The surveyor asked the DON what had happened to resident 4's C-PAP machine. The DON stated that resident 4 did not own a C-PAP machine and that there wasn't a current order for use of a C-PAP machine. She went on to state that resident 4 had been discharged and re-admitted to the facility, and that the order for C-PAP was discontinued when she was readmitted. Resident 4's current recertification orders had an order for C-PAP at 14 cmH2o (centimeters of water pressure) QHS (every night). These recertification orders were review and signed by a facility nurse and the physician on 7/27/06. Resident 4's recertification orders for 7/1/06 - 7/31/06 had an order for C-PAP at 14 cmH2o (centimeters of water pressure) QHS (every night). These recertification orders were review and signed by a facility nurse and the physician on 7/14/06. Resident 4's recertification orders for 6/1/06 - 6/30/06 had an order for C-PAP at 14 cmH2o (centimeters of water pressure) QHS (every night). These recertification orders were review and signed by a facility nurse and the physician on 6/5/06 . Resident 4's overflow medical record was obtained from medical records. They revealed C-PAP orders on each recertification order that	F 309	**MONITORING/QUALITY ASSURANCE** The Director of Nursing (DNS) or designee will develop an audit tool by 10/26/06. The audit tool will monitor compliance with accurate transcription, follow up and documentation of physician telephone orders, readmission orders and monthly recertification orders. The obtaining of physician clarification orders as may be indicated will also be monitored. The DNS or designee will complete weekly audits for 6 weeks. The DNS or designee will then report to the Performance Improvement Committee (Quality Assurance). The committee will then determine the need for any further audits and reports. The Director of Nursing is responsible for continued compliance. Completion Date: 11/01/06	

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F 309	Continued From page 3 were reviewed and signed by a facility nurse and the physician each month from December 2005 (after the facilities last survey) to 5/1/06. An interview was conducted with the BOM (Business Office Manager) on 9/13/06 at 3:00 PM. The BOM stated that resident 4 has never been discharged from the facility, and that her records show resident 4 has been at the facility since 3/22/04. No documentation in resident 4's medical records could be found about resident's use, or non-use of a C-PAP machine. Resident 4 was interviewed on 9/13/06 at 3:45 PM. Resident 4 stated that she didn't remember using a C-PAP machine, at the facility, but she did use an oxygen concentrator. Resident 4 also stated that she doesn't sleep well because she stops breathing several times a night. Resident 8 was admitted to the facility on 4/21/06 with diagnoses that included; chronic obstructive pulmonary disease, chronic sleep disorder, osteomyelitis, low back pain, peripheral vascular disease, and constipation. The medical record for resident 8 was reviewed on 9/12/06. It revealed a physician's telephone order dated 6/2/06 for an overnight oximetry study for her sleep apnea syndrome. The results from this study could not be located in resident 8's medical record. An interview with the DON was held on 9/12/06 at 3:20 PM. The DON stated that resident 8's	F 309		

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F 309	Continued From page 4 overnight sleep study had not been done due to some confusion about resident 8's pay source. No documentation could be located about this confusion in the nursing notes, social services notes or physician notes, nor was the order discontinued. On 9/13/06 the DON reported that the appointment for resident 8 to have the overnight oximetry study, had just been scheduled at a local sleep lab, for early October. Resident 3 was admitted to the facility on 2/9/06 with diagnosis that included; diabetes mellitus, hypertension, cerebra vascular accident, anemia, hypertension and congestive heart failure. The medical record for resident 3 was reviewed on 9/13/06. It revealed a physician ' s telephone order dated 8/9/06 that stated " VS q week " (vital signs each week). Resident 3 ' s vital sign flow sheet documents vital signs were taken for the following days: 8/9/06, 8/20/06, 9/1/06 and 9/6/06. Resident 3 ' s physician telephone orders dated 9/6/06 stated " VS (vital signs) O2 sats (oxygen saturation level) q (every) 8 h (hours) x (times) 72 h (hours) notify MD (medical doctor) sats (oxygen saturation level) < (less then) 88%, T (temperature) > (greater then) 100, rr (respiratory rate) > (greater then) 26 bp (blood pressure) < (less then) 90/60 " . Resident 3 ' s vital sign flow sheet documents vital signs were only taken on 9/6/06 at 13:30 (1:30 PM). An interview was conducted with RN 1 on 9/13/06	F 309		

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F 309	Continued From page 5 at 2:30 PM. RN 1 stated that that the orders had not been followed correctly. RN 1 sated that resident 3 ' s vital signs should have been taken 4 times in August or weekly and every 8 hours for 72 hours on 9/6/06.	F 309	Preparation and \or execution of this plan of correction does not constitute admission or agreement by Wasatch Valley Rehabilitation of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and \or executed solely because it is required by the provisions of federal and state law.	
F 371 SS=B	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation, and interview it was determined that the facility did not prepare, distribute and serve food under sanitary conditions. Finding included: On 9/11/06 at 2:30 PM, observations were made in the facility kitchen with the Nutrition Service Manager (NSM) present. Reach in refrigerator: 6 sandwiches in plastic bags not dated. Walk in refrigerator: 2 turkey breasts not dated 1 package raw chicken not labeled or dated Dry storage upstairs: 10 pie shells not dated Dry storage downstairs: 2 packages of pickles not labeled or dated	F 371	**F371 SS=B** **CORRECTIVE ACTION PLAN FOR IDENTIFIED OBSERVATIONS** All food items identified that had been properly prepared on day of observation were properly covered, dated and labeled. All other food items identified were discarded. The Nutritional Services Manager (N.S.M.) has reminded dietary staff to follow facility best practice when it comes to correction of these items. There will be an inservice education presented by the N.S.M. for all dietary staff to attend on October 10, 2006. Inservice will include: 1. Proper covering, labeling and dating of food. 2. Proper thawing of frozen food. 3. Proper refrigeration of food in need of refrigeration. 4. Keeping door outside closed and not propped open.	

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F 371	Continued From page 6 On 9/12/06 at 4:55 PM, observations were made in the facility kitchen with the NSM present. Walk in freezer: 4 large trays of pizza not covered or dated. On 9/13/06 starting at 6:30 AM, observations were made in the facility kitchen. The door to outside was propped open, and no screen was present from 6:30-7:35 AM. 3/4 case frozen spinach was sitting on prep table from 6:30-7:35 AM. A 2.5 gallon bucket of creamed margarine sat on the toaster table from 6:30-7:35 AM. Dry storage upstairs: 16 packages of hotdog buns not dated. On 9/13/06 at 10:35 AM an interview was held with the NSM. The NSM stated that the whipped margarine did not need to be refrigerated. The label on the bucket of whipped margarine was reviewed with the NSM which states " Keep Refrigerated " . The NSM also stated that the back door was not to be propped open at any time because it allows flies to enter the kitchen.	F 371	**MONITORING/QUALITY ASSURANCE** An audit tool will be developed to monitor the storing, preparing, distributing and serving of food. It will also include that the door to the outside is always closed, margarine does not sit out longer than recommended on the container and also proper thawing of food. The audit tool will be used twice daily by the N.S.M. or designee, until the monthly Performance Improvement Committee (Q.A.) meeting (Oct. 12). At which time the tool will be utilized as per the recommendations of the P.I. Committee. The N.S.M. is responsible for continued compliance. Completion Date: 11/01/2006	

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F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Resident # 12 was admitted on 12/21/4 to the facility with diagnoses of diabetes, macular degeneration, hypothyroid, dementia, peripheral neuropathy, atrial fibrillation, hypertension and dementia. Record review on 9/12/6 revealed a physician's order written on 7/18/05 for "Sats (Oxygen Saturations) BID (twice a day) times 72 hours. Notify MD if below 88% on oxygen". The recertification order sheet found on the chart and signed by the physician on 7/31/06 listed an order that read "monitor sats BID to maintain sats above 88%" with an order date of 7/18/05. Based on record review and interview it was determined the facility did not accurately document administered of medications, transcribation of medication orders accurately or document information for one resident and did not follow order for SATS (oxygen saturation level) for another resident as precribed by physician's for 2	F 514	Preparation and/or execution of this plan of correction does not constitute admission or agreement by Wasatch Valley Rehabilitation of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of the federal and state law require it. **F 514 SS=D** **CORRECTIVE ACTION PLAN FOR IDENTIFIED RESIDENTS** Resident #12's physician order for oxygen saturation monitoring was clarified on 09/13/06 to monitor oxygen saturation's as needed and report to house physician if saturation <88%. Routine monitoring of resident #12's oxygen saturation was discontinued by her physician. Resident #12's oxygen saturation is now being documented. Resident #15 had an order clarification on 09/14/06 for KCL 20 meq twice daily and the medical record corrected accordingly. Resident #15 was receiving the correct dose at the time. **IDENTIFICATION FOR RESIDENTS POTENTIALLY AFFECTED** All residents have the potential to be affected.	

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F 514	Continued From page 8 of 18 sample residents. Resident identifiers: 12 and 15. Findings included: 1. Resident 15 was admitted to the facility on 04/17/06 with diagnoses that included: congestive heart failure, Alzheimer's disease, hypokalemia and hypothyroidism. Record review for Resident 15 revealed a physicians telephone order dated 8/7/06 to increase KCL (potassium chloride) to 20 meq (milliequivalent) bid (twice daily). Resident 15's current Medication Administration Record (MAR) documented an order for potassium chloride 20 meq tablet bid however the 20 was marked out and 30 meq is written in, with a date of 8/7/06. Resident 15 ' s MAR for August 2006 revealed an order for K-DUR (potassium chloride) 20 meq po (by mouth) qd (every day) that was discontinued on 8/7/06 and an order for KCL 30 meq po bid starting on 8/8/06. An interview was held with the Director of Nursing (DON) on 9/13/06 at 2:30 PM. The DON stated that the Potassium Chloride order had changed on 8/7/06 from 20 meq qd to 20 meq bid and that someone had made an error on the MAR when they wrote in 30 meq po bid.	F 514	**MEASURES TO PREVENT REACCURANCE** Medical records and the licensed nursing staff will be inserviced by 10/26/06, by the Director of Nursing (DNS) on the importance of accurate transcription of and following of physician orders and documentation of resident monitoring. **MONITORING/QUALITY ASSURANCE** An audit tool will be developed by the DNS or designee by 10/30/06 to monitor compliance on accurate transcription following, and documentation of physician orders. The DNS or designee will complete weekly audits for 6 weeks. The DNS or designee will then report compliance to the Performance Improvement Committee (Quality Assurance). The committee will then determine the need for any further audits or reports. The DNS is responsible for continued compliance. Completion Date: 11/01/06	