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

PRINTED: 04/11/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(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 223 SS=D	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility did not protect the resident's right to be free from involuntary seclusion for 1 of 16 sample residents. Resident identifier: 1 Findings included: Resident 1 had been admitted to the facility 3/2/06 with diagnoses that included Diabetes with neuropathy, dementia with psychotic features, and impaired vision. On 3/28/06 from 2:50 AM to 3:30 AM, observation was made, by two surveyors, of resident 1 while he was in his room. Observation was made from outside the facility through resident 1's window. Resident 1 was observed to be sitting in his wheelchair, alone in a quiet, darkened room with the door closed. Resident 1 was observed to be awake and fidgeting while in his wheelchair. A facility nurse and a nursing assistant were observed to be in a room next to resident 1's room. At 3:02 AM, resident 1 was observed to be leaning forward in his wheelchair. Resident 1's	F 223	F223 The facility will continue to provide residents free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Resident 1 no longer resides at the facility. Facility staff re-inserviced on abuse prohibiting and reporting by 04-18-06. Administrator/Designee will conduct weekly, unannounced, random focus rounds for abuse to protect and monitor resident safety. Any identified trends will be reported to the Quality Assurance Committee for review monthly and PRN until a lessor frequency is deemed appropriate. POC acceptable completion date 5/19/06 [handwritten, signature]	05/19/06

Utah Department of Health
4/21/06
APR 24 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christina [signature] TITLE: Administrator (X6) DATE: 4-19-06

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	**1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117**

(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 223	Continued From page 1 personal body alarm sounded as he reached for a blanket on the floor. At 3:03 AM, a nursing assistant entered resident 1's darkened room and assisted the resident to sit upright in his wheelchair. The nursing assistant reattached resident 1's personal body alarm, put a blanket over his lap, and left his room. The nursing assistant closed resident 1's bedroom door as she left the room. Resident 1 was observed to continue to fidget while in his wheelchair. The resident was able to remove the blanket and move it away from the front of his wheelchair. Resident 1 wheeled himself toward his bedroom door. Resident 1 attempted to open his bedroom door, but his wheelchair prevented him from opening the door. The surveyors entered the facility at 3:30 AM. The door to resident 1's room was observed, from the nurse's station, to remain closed until 3:50 AM, when the surveyor left to accompany a nursing assistant to another resident's room. At 4:15 AM, resident 1 was observed to be in his room with the door open. Resident 1 was sitting on the side of his low bed with his feet on a safety mat beside the bed. At 3:40 AM, an interview was conducted at the nurse's station with the nursing assistant who had provided cares for resident 1 that night. The nursing assistant stated that, earlier that night, resident 1 had been agitated and wandering in his wheelchair up and down the West Hall. The nursing assistant stated she had taken resident 1 to his room at 11:00 PM and	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(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 223	Continued From page 2	F 223		

closed the door to keep him from bothering other residents.

On 3/28/05 at 1:15 PM, nursing assistant 1, who provided cares for resident 1 during day shifts, was interviewed. Nursing assistant 1 stated that when resident 1 became agitated, she tried different interventions to help divert and calm him, including playing music in his room or letting him watch television in the day room. Nursing assistant 1, stated that she would never shut resident 1 in his room unless she was with him to provide cares that required privacy.

On 3/28/05 at 1:30 PM, nursing assistant 2, who had provided cares for resident 1, was interviewed. Nursing assistant 2 stated that resident 1 was usually calm, but demonstrated active / anxious behaviors approximately 3 out of every 24 hours. Nursing assistant 2 stated that when resident 1 had such behaviors, the nursing assistant would talk calmly to the resident to deescalate the resident. Nursing assistant 2 stated that other effective interventions included playing classical music in the resident's room or finding an available staff member to stay with the resident for 1 to 1 interaction. The nursing assistant stated that sometimes resident 2 just wanted to "walk" in his wheelchair. Nursing assistant 2 stated that he would not put resident 1 in his room alone.

On 3/28/06 at 1:45 PM, the Director of Nursing (DON) was interviewed. The DON stated that it is was not acceptable to put a resident in their room and close the door.

Resident 1's medical record was reviewed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ____ B. WING ____	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(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 223	Continued From page 3 1/28/05. The care plan for resident 1 included a concern regarding the resident's behaviors. Approaches the staff planned to implement to help resident 1 adjust to placement at the facility included: Encourage him to express his feelings to the staff, Redirect him when he demonstrated inappropriate behaviors, Encourage participation in activities, Incorporate his customary routines into the facility routine.	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ____ B. WING ____	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(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 225 SS=D	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 225	**F225** The facility will report and investigate alleged violations of abuse within the required time frame to the appropriate state agencies. There is no substantiated abuse in the cited allegations. Facility staff re-inserviced on abuse prohibiting and reporting by 04-18-06. Administrator/Designee will submit completed written abuse investigations to state survey and certification agency within five business days and abuse reporting log will be reviewed weekly. Any identified trends will be reported to the Quality Assurance Committee for review monthly and PRN until a lessor frequency is deemed appropriate.	05/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(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 225	Continued From page 5	F 225		

Based on record review and interview with facility staff it was determined that the facility did not ensure that all alleged violations of abuse were reported in the required time frame. Specifically, one allegation of abuse between a facility resident and a CNA was not reported to the the State survey and certification agency or Adult Protective Services as required immediately. Further, the facility's completed investigation of abuse between a facility resident and nurse was not faxed to the State survey and certification agency within the 5 days as required.

Findings include:

A review of the facility's " Alleged Resident Abuse/Neglect Investigation Checklist " on 3/29/06 revealed the following documentation.

On 2/8/06 at 1:30 PM an allegation was made from a resident reporting mistreatment by a facility CNA (Certified Nursing Assistant). The Administrator was notified at 3:00 PM the same day. The State survey and certification agency was notified of the allegation on 2/10/06 at 12:10 PM.

On 2/10/06 at 10:30 AM an allegation was made from a resident reporting mistreatment by a facility nurse. The Administrator was notified at 11:00 AM the same day. The State survey and certification agency was notified of the allegation on at 12:10 PM the same day. The facility then submitted the completed written investigation to the State agency on 2/24/06 at 5:00 PM.

In accordance with State law, the facility ' s completed written investigation should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	**1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117**

(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 225	Continued From page 6 submitted to the State agency by 2/17/06. On 2/14/06 at 12:30 PM an allegation was made from a resident reporting mistreatment by a facility nurse. The Administrator was notified at that time. The State survey and certification agency was notified of the allegation on at 1:50 PM the same day. The facility then submitted the completed written investigation to the State agency on 2/24/06 at 4:30 PM. In accordance with State law, the facility ' s completed written investigation should have been submitted to the State agency by 2/21/06. On 3/29/06 at approximately 3:00 PM, the facility Administrator was interviewed about the delay in notification of State officials for the above incidents. She stated that a misunderstanding had occurred, and that she believed that investigations which appeared to not be abuse did not need to be reported within 5 days.	F 225		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility did not promote care in a manner that maintained each resident's dignity and respect for 9 of 9 residents observed to sit at	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(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 241	Continued From page 7 the assistive dining tables during first dining service, for 3 of 4 residents in a confidential group interview, and for 1 of 15 sample residents. Resident identifier: 9 Findings included: 1. A group interview was conducted with four alert and oriented residents chosen by the facility. One of the four residents stated that there were times when she did not feel she was treated with dignity or respect. The resident stated that there were times when she had been watching television that she would suddenly find her wheelchair moving in a direction out of the television room. The resident stated that staff would come up behind her, and without saying a word to her, they would turn her chair around and move her out toward the dining room. The resident stated that, when her wheelchair began to move, she couldn't tell who was pushing her. Two residents stated that staff would come into their rooms without knocking, or enter as they knocked without waiting for a response. A resident stated that she was uncomfortable at times when she awakened in her bed at night to find a man in her room who did not speak to her as he entered or before he left. Three of the four residents in the group interview stated that they were disturbed by children being allowed to run through the hallways at night. The residents stated that they understood some families wanted to bring their children when they came to visit. They stated that that it disturbed their sleep when some of the children were	F 241	F241 The facility will promote care for residents in a manner and environment that maintains each resident's dignity and respect in full recognition of his/her individuality. Resident Council addressing Dignity/Respect/Grievance procedures conducted by 04-28-06. Facility nursing staff re-inserviced on providing resident dignity and respect by 04-18-06. Administrator to conduct Family Council to review patient rights, educate on dignity, respect, visiting hours and grievance procedures by 05-19-06. Administrator/Designee will conduct weekly Dignity/Respect focus rounds including resident door knocking, resident attire, enhanced dining, and staff members actively engaging residents during meal process. Any identified trends will be reported to the Quality Assurance Committee for review monthly and PRN until a lessor frequency is deemed appropriate.	05/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(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 241	Continued From page 8	F 241		

allowed to run and shout in the hallways.

2. Resident 9 was admitted to the facility February 2002 with diagnoses including Parkinson's disease. As documented in resident 9's Minimum Data Set (MDS) assessment, dated 1/2/06, the resident required extensive assistance of staff for dressing, eating, hygiene and bathing.

On 4/3/06, resident 9's family member was interviewed by telephone. The family member stated the times when she visited resident 9, without notifying the facility that she was coming, she was disturbed to find the resident needing to be bathed and wearing clothes with holes in them.

Resident 9's family member stated that during a visit in December 2005, she entered the facility to find the resident asleep at the dinner table with his head on his hand and his hand on his plate. The family member stated that a male nursing assistant was seated next to resident 9 at the table. The family member stated that the nursing assistant was reading a magazine while the resident slept. The family member stated that when she awakened resident 9, he ate his meal.

3. Observations were made of staff to resident interactions during three different meal times.

On 3/27/06, observation was made in the dining room during lunch meal service. Nine residents, who required physical assistance with their meals, were seated at two horseshoe tables. One nursing assistant sat at each table in order to assist the residents to eat. The nursing assistants were observed to put a spoonful of

PRINTED: 04/11/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117

(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 241	Continued From page 9 food or a cup of liquid to the residents' mouths without telling the residents what they were getting or asking the residents what they wanted. The nursing assistants were observed throughout the meal to feed the residents without speaking to them. On 3/28/06, observation was made in the dining room during breakfast meal service. Two nursing assistants helped residents who were seated at the horseshoe tables. One nursing assistant sat with her elbow on the table and her head in her hand as she assisted two residents with beverages. As they fed the meals to the residents who required assistance, one nursing assistant spoke to the other nursing assistant about a previous discussion they had. Throughout the meal, the nursing assistants did not speak to the residents they were assisting. On 3/28/06, observation was made in the dining room during lunch meal service. Two nursing assistants helped residents who were seated at the horseshoe tables. As they fed the meals to the residents who required assistance, one nursing assistant spoke to two other nursing assistants who were standing near the tables. Neither of the nursing assistants who were seated at the horseshoe tables spoke to the residents they were assisting.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ______ B. WING ______	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	**1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117**

(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 432 SS=D	483.60(e) STORAGE OF DRUGS AND BIOLOGICALS In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not ensure that the resident environment remained as free of accident hazards as was possible. Specifically, the nurse's medication carts were left unlocked and unsupervised three times by two different nurses. Findings include: On 3/28/06 during the west hall morning medication pass, it was observed that the nurse failed to lock the medication cart prior to entering the resident's room where the cart could not be visualized. The morning med pass occurs during the time when residents are traveling to and from the dining room for breakfast. On 3/29/06 during the east hall morning	F 432	**F432** The facility will store all drugs and biologicals in locked compartment to keep resident's environment free of accidents and hazards. During survey on 03-29-06 licensed nursing staff re-inserviced on locking medication carts. No negative outcome from unlocked medication carts. Nurses re-inserviced on locking medicine carts by 04-18-06. DON/Designee will conduct focus rounds two to three times a week to ensure medications are supervised or locked when unattended. Any identified trends will be reported to the Quality Assurance Committee for review monthly and PRN until a lessor frequency is deemed appropriate.	05/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. BUILDING ____ B. WING ____	03/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW WOOD CARE CENTER	**1204 EAST 4725 SOUTH SALT LAKE CITY, UT 84117**

(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 432	Continued From page 11 medication pass, it was observed that the nurse failed to lock the medication cart on two occasions prior to entering the resident's room where the cart could not be visualized.	F 432		