

PRINTED: 12/09/2008  
FORM APPROVED

Utah Department of Health

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  UT207207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/04/2008
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2011 WEST 4700 SOUTH TAYLORSVILLE, UT 84118
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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) COMPLETE DATE
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A 000

Initial Comments

An annual survey was conducted on 12/4/08. The facility was surveyed against the R432-270 rules for assisted living facilities. The facility met the minimum standards set forth in those rules. No deficiencies were cited.

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Thank you for your help and advise. you are always very helpful to us.

12-13-08

Utah Department of Health

DEC 22 2008

Bureau of Health Facility Licensing,  
Certification and Resident Assessment

Your Agency Name

Golden Living Center / Carolyn Tenkham  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
Administrator

(X6) DATE  
12-18-08