PRINTED: 11/08/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT207238	A. BUILDING ______ B. WING ______	11/02/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING OREM - NORTH	880 SOUTH GENEVA ROAD OREM, UT 84058

(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
A5400 SS=D	R432-270-25(1) Maintenance Services The facility shall conduct maintenance, including preventive maintenance, according to a written schedule to ensure that the facility equipment, buildings, fixtures, spaces, and grounds are safe, clean, operable, in good repair and in compliance with R432-6. This Statute is not met as evidenced by: THIS IS A CLASS II DEFICIENCY. The following items were found to be in need of repair or correction: 1) There was an excessive amount of lint behind the dryer. 2) Room #329 had a broken electrical plate. 3) The first floor East emergency light was on all the time. 4) The first floor SW exit sign did not have any lights illuminated. 5) The first floor West and East exit doors had dead bolts on them. 6) The second floor East emergency light did not illuminate when tested. 7) The fire extinguishers were not being checked monthly. Utah Department of Health DEC 05 2007 Bureau of Health Facility Licensing, Certification and Resident Assessment	A5400 PoC accepted as attached CHunt, RN 12-11-07	see Attached paper. 1) 2) 3) 4) 5) 6) Administrator to insure it is completed and doesn't repeat itself -	 11-2-07 11-2-07 11-4-07 11-4-07 11-4-07 11-6-07

Your Agency Name: Renee Ridigy

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator (X6) DATE 11-14-07

STATE FORM M1R111 If continuation sheet 1 of 1