

PRINTED: 11/03/2007
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(01) PROVIDER/CLINIC IDENTIFICATION NUMBER UT207228	(02) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(03) DATE SURVEY COMPLETED 11/02/2007
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CARE - NORTH		STREET ADDRESS, CITY, STATE, ZIP CODE 890 SOUTH GENEVA ROAD ORION, UT 84658		
(04) ID PREFIX TAG A6400 SS=D	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 R432-8. 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 coat 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	(05) PREFIX TAG A6400	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) see Attached paper. 1) 11-2-07 2) 11-2-07 3) 11-4-07 4) 11-4-07 5) 11-4-07 6) 11-6-07 Administrator to insure it is completed and doesn't repeat itself -	(06) COMPLETE DATE

*Not accepted
see attached
12-11-07
CHLW:PH*

Your Agency Name: *Renee Ridgway* TITLE: *Administrator* DATE: *11-14-07*
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE SIGNATURE
STATE FORM 5000 MFR111 1 of 1

