

PRINTED: 12/18/2008
FORM APPROVED

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: UT207338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2008
NAME OF PROVIDER OR SUPPLIER HERITAGE PLACE - LEVEL II		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 SOUTH MAIN STREET BOUNTIFUL, UT 84010		
(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
A 000	Initial Comments An annual survey was conducted on 5/8/08. 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.	A 000		

Your Agency Name

TITLE

(X6) DATE

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