STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46G014	A. BUILDING _____ B. WING _____	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDALLION MANOR	1701 WEST 600 SOUTH PROVO, UT 84601

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A re-certification inspection was started on 9/5/2023 and completed on 9/6/2023. The facility was inspected according to the Intermediate Care Facilities for Individuals with Intellectual Disabilities regulations. Regulatory non-compliance was identified and deficiencies were cited.	W 000	**W240** Client 4's IHP and CFA have been reviewed and will be updated to meet her current capabilities by the QDDP. Interventions will be added to Client 4's IPP to support and help her towards independence. All clients IHP's will be reviewed and updated as necessary by the QDDP, and then annually at the IPP meeting by the IDT committee. If a client has any significant changes over the course of the year an addendum will be added to address that change. All client's CFA's will be reviewed and checked for accuracy and reviewed annually. The QDDP identifier is responsible for the monitoring of this POC. This plan of correction will be implemented into the quality assurance system on 10/31/23. 10/31/23 POC Date: 10/31/2023 This POC was approved by April Chlarson, LCSW, QIDP on 9/20/2023 April Chlarson	
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the individual program plan (IPP) did not describe relevant interventions to support the individual toward independence for 1 of 4 sampled clients. Client Identifier 4. Findings include: On 9/5/2023 at 9:35 AM, a record review of Client 4's IPP and comprehensive functional assessment (CFA) was conducted. Client 4 was a 35 year old female who was admitted to the facility on 4/29/2005 with diagnoses including severe intellectual disabilities, autism spectrum disorder and epilepsy. The IPP was dated 6/20/2023 and stated, "[Client 4] is toilet trained but still has frequent urinary accidents." The IPP did not include any interventions to support Client 4 with the urinary	W 240		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Moyes	Administrator	9/20/23

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
	46G014	A. BUILDING _____ B. WING _____	09/06/2023

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W 240	Continued From page 1 accidents. The CFA was dated 11/7/2022 and did not include an assessment of Client 4's abilities with regard to toileting. At 2:00 PM, an interview was conducted with Employee 1 who stated that Client 4 "sometimes has accidents but not most of the time." On 9/6/2023 at 8:00 AM, an interview was conducted with Employee 2 who stated that Client 4 "wears a brief all day." She doesn't change her own brief, the staff have to do that." Employee 4 also stated that, "we check her every hour or so to make sure she is not wet." At 7:55 AM, an observation was made of Client 4' bedroom where a package of briefs was observed on the dresser. At 1:30 PM, an interview was conducted with the facility's Qualified Intellectual Disabilities Professional who stated that Client 4 was "not toilet trained" and acknowledged that the IPP that was provided did not include interventions to support Client 4 toward independence in toileting.	W 240	**W259** Client 4's IHP and CFA have been reviewed and will be updated to meet her current capabilities by the QDDP. All clients IHP's will be reviewed and updated as necessary by the QDDP, and then annually at the IPP meeting by the IDT committee. If a client has any significant changes over the course of the year an addendum will be added to address that change. All client's CFA's will be reviewed and checked for accuracy and reviewed annually. The QDDP identifier is responsible for the monitoring of this POC. This plan of correction will be implemented into the quality assurance system on 10/31/23.	10/31/23
W 259	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the comprehensive functional assessment (CFA) of Client 4 was not	W 259		

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	46G014	A. BUILDING _____ B. WING _____	09/06/2023

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W 259	Continued From page 2 reviewed, at least annually, by the interdisciplinary team for relevancy for 1 of 4 sampled clients. Client Identifier 4. Findings include: On 9/5/2023 at 9:35 AM, a record review of Client 4's IPP and comprehensive functional assessment (CFA) was conducted. Client 4 was a 35 year old female who was admitted to the facility on 4/29/2005 with diagnoses including severe intellectual disabilities, autism spectrum disorder and epilepsy. The IPP was dated 6/20/2023 and stated, "[Client 4] is toilet trained but still has frequent urinary accidents." The CFA was dated 11/7/2022 and did not include an assessment of Client 4's abilities with regard to toileting. The section dedicated to toileting skills assessment was blank. At 2:00 PM, an interview was conducted with Employee 1 who stated that Client 4 "sometimes has accidents but not most of the time." On 9/6/2023 at 8:00 AM, an interview was conducted with Employee 2 who stated that Client 4 "wears a brief all day. She doesn't change her own brief, the staff have to do that." Employee 2 also stated that, "we check her every hour or so to make sure she is not wet." At 7:55 AM, an observation was made of Client 4's bedroom where a package of briefs was observed on the dresser.	W 259		

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W 259	Continued From page 3 At 1:30 PM, an interview was conducted with the facility Qualified Intellectual Disabilities Professional who stated that Client 4 was "not toilet trained" and acknowledged that the CFA that was provided included an section intended for toileting skills assessment but was left blank; further acknowledging the CFA of Client 4 was not reviewed by the interdisciplinary team for relevancy at least annually. THIS IS A REPEAT DEFICIENCY FROM THE RECERTIFICATION SURVEY DATED 8/3/2022	W 259		

This plan of correction is accepted on 09/20/2023
with a compliance date of 10/31/2023

PRINTED: 09/18/2023
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46G014	A. BUILDING 01 B. WING	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDALLION MANOR	1701 WEST 600 SOUTH PROVO, UT 84601

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E 000	Initial Comments Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 09/07/2023 in the presence of the plant manager are found in 42 Code of Federal Regulations, Section 483.475 The facility was found to be in compliance with the requirements for participation in Medicaid. No deficiencies cited.	E 000	**K355** The fire company will be called and all portable fire extinguishers will be reinspected and documented correctly to meet current regulations. Maintenance will follow up by reviewing records after inspections are completed in the future to ensure all portable fire extinguishers have been inspected and documented correctly. Documentation will include: 1) Date, agency name, name of person conducting maintenance. 2) Date of last recharge and name of person and agency performing recharge. 3) Hydrostatic retest date and the name of the person and the agency performing test. 4) Description of dents remaining after passing of the hydrostatic test. 5) Date of the 6-year maintenance for stored pressure dry chemical and halogenated agent types. Any extinguishers found to have been missed by the fire company or incomplete documentation found will be reported to the said company and the inspections and documentation will be completed correctly. The maintenance supervisor will monitor the completion of this plan of correction. Implemented into the quality assurance plan on 10/31/23 10/31/23	
K 000	INITIAL COMMENTS Statutory and regulatory authority for this Life Safety Code survey that was conducted on 09/07/2023 in the presence of the plant manager are found in 42 Code of Federal Regulations, Section 483.470(j), and the 2012 Edition, NFPA 101 Life Safety Code including NFPA publications referenced therein. The facility was found (not) to be in compliance with the requirements for participation in Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (j) Life Safety from fire.	K 000		
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based upon observations made in the presence of the plant manager on 09/07/2023, it was determined that the facility did not maintain portable fire extinguishers in accordance with	K 355		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Moyes	Administrator	9/20/23

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K 355	Continued From page 1 NFPA 10. Findings include: During the record review the facility failed to provide a list indicating which extinguishers were serviced. In addition to the required tag or label, a permanent file record should be kept for each fire extinguisher. This file record should include the following information, as applicable: (1) Maintenance date and the name of the person and the agency performing the maintenance (2) Date of the last recharge and the name of the person and the agency performing the recharge (3) Hydrostatic retest date and the name of the person and the agency performing the hydrostatic test (4) Description of dents remaining after passing of the hydrostatic test (5) Date of the 6-year maintenance for stored-pressure dry chemical and halogenated agent types. In accordance with NFPA 101 19.3.5.12 and NFPA 10 A.7.3.3.	K 355		