Utah Department of Health

adele

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING _____ B. WING _____	06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E #120 SALT LAKE CITY, UT 84102

(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
G1920	R432-600-25(4) Maintenance Services (4) All buildings, fixtures, equipment and spaces shall be maintained in operable conditions. This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY. Based on a facility walk through with the administrator, the facility did not meet the requirements of this statute. Findings include: The facility's communications room did not have two ceiling tiles firmly secured in place. This situation compromised the fire integrity of the room (2009 IFC 315.2.4).	G1920	R432-600-25(4) (4) 2009 IFC 315.24 Director of It will replace the 2 ceiling tiles in the communications room. This was completed by Fred Pennington, Director of It on 6/5/12 Utah Department of Health JUN 19 2012 Bureau of Health Facility Licensing, Certification and Resident Assessmen	

6-20-12 DC Acceptable Completion date 6-5-12

Your Agency Name Metro Health Center

Penn Davies TITLE VP 6/13/12 (X6) DATE

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

AW

PRINTED: 10/08/2013
FORM APPROVED

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT000535	A. BUILDING: _____ B. WING _____	10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HEALTH CENTER	160 S 1000 E SUITE #120 SALT LAKE CITY, UT 84102

(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
G2015	R432-600-26(3) Emergency Electric Service (3) There shall be provision for emergency exit lighting according to NFPA 101. This STANDARD is not met as evidenced by: THIS IS A CLASS II DEFICIENCY Based on observation and interview with the facility manager on 10/02/13, the facility did not provide emergency exit lighting at all required areas. Findings: 1. The east exit stairwell that serves as one of two required paths of egress from the clinic area was observed to not have a battery back-up emergency light to illuminate the stairwell in the event of a power failure. 2. In an interview with the facility manager, she indicated the normal hours of facility operation include evening hours on Monday when the natural light from the stairwell window would not illuminate the path of egress as required. This observation was made in the presence of the facility manager.	G2015	11-8-13 PoC Acceptable Completion date 11-20-13 • Will install battery back-up emergency light in east exit stairwell. by Nov 20, 2013 • light will be check monthly with clinic emergency facility check list. • Point person will be responsible to check all emergency lights including emergency light in east exit stair well. • East emergency light will be added to monthly emergency facility checklist	11-20-13

Your Agency Name
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: VGalindo — TITLE: Veronica Galindo-Clinic Manager, Utah Department of Health — (X6) DATE: 11/7/13

STATE FORM 6899 LU5911 If continuation sheet 1 of 1

OCT 28 2013

Bureau of Health Facility ...
Certification and Resident Assessme...