State of Utah

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Utah Department of Health
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Division of Family Health and Preparedness
Marc E. Babitz, M.D.
Division Director

Paul R. Patrick
Deputy Director

Bureau of Health Facility Licensing, Certification and Resident Assessment
Joel Hoffman
Bureau Director

LC-502

April 15, 2010

Mr. Nate Boswell, Administrator
Our House Of West Sandy
115 West 9400 South
Sandy, UT 84070

Dear Mr. Boswell:

On April 8, 2010, the Utah Department of Health, Division of Family Health and Preparedness, Bureau of Health Facility Licensing, Certification and Resident Assessment completed an annual survey of your Assisted Living Type I. No deficiencies were cited. A focus survey was also completed, which found Our House of West Sandy to be in compliance with the requirements for participation in the Medicaid Waiver program.

We would like to commend your agency for the quality of care provided to Medicaid clients. Enclosed is a Statement of Deficiencies, please sign and date this document, make a copy for your file and return the original to our office within 10 days of receipt of this notice.

If you have any questions, please contact me at (801) 538-6158 or toll free at 1-800-662-4157.

Sincerely,

Carmen Richins, Health Program Manager
Licensing Survey Section

cc: Bureau of Long Term Care

Utah Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	UT207225	A. BUILDING ______ B. WING ______	04/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR HOUSE OF WEST SANDY	115 WEST 9400 SOUTH SANDY, UT 84070

(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 completed on 04/08/10. The facility was found to be in substantial compliance with R432-270 Rules governing assisted living facilities No deficiencies were cited. This inspection included a sample of clients on the home and community based waiver service program, to ensure health and safety.	A 000		

Your Agency Name

TITLE

(X6) DATE

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