DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Acceptable POC 5/09/02 C. yne

PRINTED: 4/18/20
FORM APPROVE
2567

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465100	A. BUILDING _____ B. WING _____	4/11/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT ALTA	4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 241 SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not promote care for residents in a manner that maintained and enhanced each resident's dignity and respect in full recognition of his or her individuality, by answering call lights in a timely manner as evidenced by: a. Six of thirteen residents in a confidential group interview stated that call lights in their rooms would take from one half to one hour for staff to answer. b. Five of thirteen residents in a confidential group interview stated that call lights in their restrooms would take up to a half hour for staff to answer. c. Four supplemental residents stated that call lights would take up to an hour to answer or not answered at all on the afternoon shift. d. One family member stated that the call lights were not answered in a timely manner. e. Surveyor observation of a resident call light that was not answered for ten minutes. Findings include: 1. On 4/10/02, at 2:40 PM, the emergency call light for resident restroom 5 on the east hall was signaling at the west nurses station. At 2:45 PM, two certified nurse aides past resident room 5 but did not enter the room to assist the residents. At 2:46 PM, a staff nurse and another facility staff member were present at the west nurses station. Neither staff member was observed to answer the call light in resident restroom 5. At 2:50 PM, a certified nurse aide entered resident restroom 5 to assist the residents.	F 241 5/29/02	Review of proper time frames for answering call lights, will be held with C.N.A. staff by 5/10/02. Staff Developer will review and remind nurses and C.N.A.'s to be timely in answering call lights. Nurses will assign a C.N.A. to patrol hallways and answer call lights during busy times, and focusing on the afternoon shift. Quality Assurance "Spot Checks" will be completed quarterly by nursing administration, to observe and monitor length of time to respond to call lights. Completed by Staff Developer and monitored by Director of Nursing.	~~6/9/02~~ 6/01/02

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

TITLE Administrator

(X6) DATE 5/9/02

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 2. On 4/11/02, during a confidential interview conducted with three supplemental residents they were questioned concerning the length of time it took for facility staff to answer call lights to assist them. All three residents stated that it often takes one half hour to an hour for their call lights to be answered on the afternoon shift. 3. On 4/11/02, an interview was conducted with a family member of a resident in this facility. The family member stated that when they were present in the facility, they had been aware that the call lights were not answered in a timely manner. 4. On 4/09/02 from 1:30 PM until 2:30 PM a confidential group interview of 13 cognitive residents in the facility was conducted. The following was shared on call lights: a. During the interview, 6 of 13 residents stated that call lights were not answered in a timely manner; they stated that it could take between 30 to 60 minutes for a call light to be answered especially on evening and midnight shifts. b. During the interview, 5 of 13 residents stated that the call light in the bathrooms were not answered in a timely manner and it could take up to 30 minutes before a call light was answered. 5. On 4/11/02 between 1:15 PM and 2:230 PM, confidential interviews were conducted with 2 supplemental residents. One of the 2 supplemental residents stated that he used his call light and needed assistance to transfer from his wheelchair to his bed and from his bed to his wheelchair. He stated that his call light is not answered in a timely manner and it may take facility staff up to 30 minutes to respond to	F 241		

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F 241	Continued From page 2 his call light. The other resident stated she did not usually use her call light.	F 241		
F 287 SS=B	483.20(f)(1-4) Resident Assessment Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: Admission assessment; Annual assessment updates; Significant change in status assessments; Quarterly review assessments; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, if there is no admission assessment; Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the State information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by HCFA and the State. A facility must electronically transmit, at least monthly, encoded, accurate, complete MDS data to the State for all assessments conducted during the previous month, including the following: Admission assessment; Annual assessment;	F 287	The M.D.S. Coordinator at facility will work with the State Representative to properly submit all old or discharged MDS Assessments, which are currently being stored in the "Raven" file at the facility. The current system already in use at facility safeguards against any assessment's being transmitted more than 30 days late. Completed by M.R.S. Coordinator and monitored by Administrator.	6/1/02

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F 287	Continued From page 3 Significant change in status assessment; Significant correction of prior full assessment; Significant correction of prior quarterly assessment; Quarterly review; A subset of items upon a resident's transfer, reentry, discharge, and death; Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. The facility must transmit data in the format specified by HCFA or, for a State which has an alternate RAI approved by HCFA, in the format specified by the State and approved by HCFA. This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's current resident roster, and the "Center of Medicare and Medicaid Services (CMS) State-End of Month Roster Report" for February 2002 it was determined that the facility did not encode or transmit Minimum Data Sets (MDS) discharge tracking forms to the State database for 25 of 74 residents. Resident identifiers: C1, C4, C7, C10, C13, C14, C17, C26, C31, C34, C35, C36, C37, C43, C47, C48, C49, C51, C53, C56, C58, C59, C66, C67 and C74. Findings include: The facility's current resident roster and the CMS State Report (a report that documents the MDS assessments that were encoded and transmitted by the corporate office), dated February 2002, were reviewed. This review revealed that 25 of the 74	F 287		

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F 287	Continued From page 4 residents listed on the CMS State Report were not listed as current residents on the facility's resident roster. In an interview with a corporate IS (information services) employee on 4/10/02 it was revealed that this deficiency was corrected during the recertification survey. A new computer program had been installed that day in the facility and they would be able to encode and transmit the discharge tracking forms from the facility.	F 287	F-314 1) The pressure relieving air mattress that was inadvertently turned off, was turned on during survey, and kept on continuously, until it was replaced by a "First Step TriCell" pressure relief overlay, on April 25, 2002. Completed by C.N.A.'s, monitored by Director of Nursing. 2) The resident is being properly turned per turning schedule. Documentation is placed on an improved "Turn Sheet", that also includes checking to ensure air bed is turned on. Completed by C.N.A.'s, monitored by Charge Nurse. 3) Resident is no longer placed in a geri chair. Completed by C.N.A.'s, monitored by Skin Treatment Nurse. 4) For Quality Assurance purposes, the Skin Treatment Nurse will be included in Quality Assurance meetings, and the Skin/Nutrition meetings. Completed by Skin Treatment Nurse, monitored by Director of Nursing.	6/01/02
F 314 SS=G	483.25(c) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, interview, and the comprehensive assessment, the facility did not ensure that a resident having a pressure sore received necessary treatment and services to promote healing for one of fifteen sampled residents as evidenced by: One resident entered the facility with a stage II pressure sore that developed into a stage IV pressure sore. The resident had a comprehensive assessment identifying pressure sores and a careplan with interventions of a pressure relieving device to her bed and to turn and reposition every two hours, to be put in place. The pressure relieving devices consisted of a pressure relieving mattress covered with a pressure relieving mattress overlay that was made of	F 314		

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F 314	Continued From page 5 plastic and filled with air, and a gel pad in her geri chair. The facility did not implement the interventions on a consistent basis which had potential results of worsening the pressure sore. Resident identifier 31 Findings include: Resident 31 was a ninety four year old female admitted to this facility on 7/10/01, with diagnoses of paralysis agitans, dementia, depression, parkinsonism, malnutrition, chronic pain, and small stage II decubitus ulcers on the coccyx area and bilateral ears. According to the nursing admission assessment resident 31 was admitted on bedrest and was totally dependent on the facility staff for her cares and mobility. The resident's weight on admission was 69 pounds and her height was five feet five inches tall. On 4/8/02, resident 31 weighed 70 pounds. Observation of resident 31, during a skin evaluation, done by the facility wound treatment nurse, on 4/10/02, revealed that resident 31's coccyx area had an open wound that had a full thickness skin loss with extensive destruction of tissue involving the muscle. During the skin evaluation the nurse identified the wound as a stage IV pressure ulcer with tunneling. Observations: 1. On 4/8/02, at 12:30 PM, resident 31 was positioned on her right side with a pillow between her knees. There was a pillow under her back and lumbar area to maintain her position on her right side. The pressure relieving mattress overlay was not on, placing a solid plastic barrier between the resident and the pressure relieving mattress. At 1:15 PM, resident 31 remained in the same position. The pressure relieving mattress overlay was not on.	F 314		

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F 314	Continued From page 6 At 2:45 PM, resident 31 was repositioned on her left side with a pillow between her knees. There was a pillow under her back and lumbar area to maintain her position on her left side. The pressure relieving mattress overlay was not on. At 3:10 PM, resident 31 remained in the same position. The pressure relieving mattress overlay was not on. At 4:00 PM, resident 31 was repositioned on her right side with a pillow between her knees. There was a pillow under her back and lumbar area to maintain her position on her right side. The pressure relieving mattress overlay was not on. At 4:30 PM, resident 31 remained in the same position. The pressure relieving mattress overlay was not on. At 4:45 PM, a certified nurse aide entered the room to provide cares for resident 31. When the CNA left the room, the nurse surveyor observed that the pressure relieving mattress overlay had been turned on. These observations revealed that resident 31 was positioned in her bed for four hours and fifteen minutes without the pressure relieving mattress overlay on. 2. On 4/9/02, at 9:55 AM until 3:00 PM, observation of resident 31 revealed that she was positioned on her right side with a pillow between her knees. There was a pillow under her back and lumbar area to maintain her position on her right side. Resident 31 remained in the same position for five hours and five minutes. 3. Review of the weekly nurses notes, dated 4/1/02, documented that resident 31 had spent two hours in	F 314		

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F 314	Continued From page 7 her geri chair after her shower. The nurses note did not document if the resident had been repositioned during the time she was up in the geri chair. On 4/10/02, an interview was conducted with the wound treatment nurse concerning resident 31's pressure sore. She was questioned concerning the worsening of the wound. When asked if resident 31's worsening of the pressure sore could be related to the time spent in the geri chair she stated that the resident was in a slow decline as of recent and that it was possible. When asked if resident 31's wound could have received trauma during that time in the geri chair and have the damage recognized at a later time, she stated that it was certainly possible. Review of resident 31's minimum data set (MDS), dated 3/26/02, documented in G-1a that she was totally dependent on the facility staff for all of her cares, including bed mobility. The MDS also documented that resident 31 had a pressure relieving device in her bed and chair and was on a turning and repositioning program. Resident 31 had a care plan with a problem identified by facility staff in incontinence, as at risk for skin breakdown with a goal to have no further breakdown and an intervention to turn and reposition every two hours and as needed, initiated 4/2/02 . A second problem identified by facility staff in alterations in activities of daily living functioning, with an intervention to turn and reposition every two hours, initiated 1/2/02. A third problem identified by facility staff was skin integrity diagnosis of a decubitus ulcer to the coccyx (stage III), initiated 3/26/02 and updated 4/2/02. Review of resident 31's nurse's treatment notes, documented by the wound treatment nurse, on 3/25/02, revealed that resident 31 had a stage III right coccyx wound that measured: North to south 2.7cm (centimeters), east to west 1.8cm, depth 1.4cm.	F 314		

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F 314	Continued From page 8 increased tunneling at 12:00-to 3.8cm, 3:00-1 cm, 6:00-2.8cm 9:00-3.4cm. On 4/1/02, a second entry on the nurse's treatment notes, documented by the wound treatment nurse, revealed that the right coccyx stage III pressure ulcer had additional tunneling area at 11:00-6.8cm. On 4/8/02, a third entry on the nurse's treatment notes, documented by the wound treatment nurse, revealed that there was "significant rapid decline." The stage III pressure ulcer was now a stage IV pressure ulcer with increase in size with measurements of north to south 4.8cm, east to west 2.6cm, depth at the center was 1.4cm, tunneling at 12:00-3.7cm, 3:00-1.4cm, 6:00-3.1cm, 7:00-4.1cm, 9:00-3.2cm, 11:00-6.9cm. "The tunnel at 7:00 was not there on 4/5/02." The nurse providing care for resident 31 was questioned on 4/10/02, concerning how records were kept for turning and repositioning of the resident. She obtained a copy of the turn sheet, documented by the certified nurse aides, and stated that as the resident was turned, the nurse aide documented the time and signed with a signature. The nurse stated that as the papers were filled they were placed in an area for medical records to add to the resident charts. Review of resident 31's turn sheet, documented by the certified nurse aides (CNA), according to when resident 31 was turned and repositioned, revealed that there was no documentation available for the dates 4/1/02 until 4/8/02. A request was made to the medical records director for the turn sheets for the dates of 4/1/02 until 4/8/02. The medical records director was unable to obtain the documentation.	F 314		
F 318 SS=D	483.25(e)(2) QUALITY OF CARE Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited	F 318		

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F 318	Continued From page 9 range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and medical record review, it was determined that for 1 of 15 sampled residents, the facility did not ensure that a resident who was assessed as needing a hand splint to prevent further decrease in range of motion, received services. (Resident 16) Findings include: Resident 16 was a 74 year old male with diagnoses of Parkinson's Disease, left hip fracture, paralysis agitans, failure to thrive, hypertension and organic brain syndrome. A review of the Minimum Data Set (MDS) dated 2/11/02 revealed that resident 16 was assessed as having limited range of motion and full loss of voluntary movement in one hand. A review of resident 16's medical record revealed that a physician's order dated 9/18/01 for a splint for his left hand. Observations were made of resident 16 during the recertification survey from 4/9/02 through 4/11/02; specifically during breakfast and lunch on 4/9/02 and 4/10/02 and during an individual interview on 4/9/02 at 8:20 AM. During all observations, resident 16 was not wearing a splint on his left hand. A review of the medical record restorative documentation for the months of December 2001 through April 10, 2002 revealed notations made by the restorative aide that resident 16's splint was missing	F 318	A new splint has been ordered to replace the lost one. A cloth, drawstring bag will be attached to the identified resident's wheelchair. When the splint is not in use, it will be stored in the bag, to prevent it's being lost again. For Quality Assurance purposes, a special "Incident Report" sheet is to be completed by Restorative Aides, and turned into Restorative Nurse, regarding any lost restorative equipment. Completed by Restorative Aides, and monitored by Director of Nursing.	6/11/02 6/11/02

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F 318	Continued From page 10 and he was not wearing his splint. The notes include the following: a. 12/30/01 "Res(ident) doesn't wear splint last couple days. I can not find it." b. 01/7/02 "Resid(ent) doesn't have splint anymore" c. 01/29/02 "Still doesn't have splint" d. 02/04/02 "Res(ident) doesn't have splint It's been lost" e. 03/04/02 "Res(ident) doesn't have a splint" f. 03/08/02 "Res(ident) missing splint hand checked &washed, missing splint reported to PT (physical therapy) waiting for new one." g. 03/21/02 "Splint still missing will cont(inue) to work with PT and res(ident) til we get the splint back" h. 03/28/02 "Splint missing-see ROM sheet cont(inue) to check &wash L (left) hand. placed disposable wash cloth in hand-but it is reported that they do not stay in place" i. 04/01/02 "Res(ident) still doesn't have splint" On 4/11/02 at 9:30 AM during an interview, the restorative aide stated that she and the other restorative aide worked with resident 16's left hand approximately 6 days a week. She stated that the documentation checks on the restorative therapy progress notes documented the days that resident 16's hand was checked, cleaned and worked with for movement. She stated that resident 16 was to have a soft splint placed in his left hand. She stated that resident 16 has had approximately 3 splints and the last one has been missing since 3/4/02.	F 318		