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

PRINTED: 12/1/2003
FORM APPROVED
2567-L

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465142	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106

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F 252 SS=C	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations in the facility on 11/17/03 and 11/18/03 it was determined the facility failed to maintain a clean, comfortable and homelike environment as evidenced by multiple resident bathrooms had faucets on the sinks with heavy lime build-up and were corroding, had floors and shower floors in need of cleaning, had sinks coming loose from the wall, resident rooms had furniture in need of repair and the shower room on the West side had a heavy mold build-up around the perimeter of the shower tile coving and on two resident shower chairs. Findings include: 1. In resident bathrooms: a. In the bathroom in room 109 the ceiling vent was coming loose from the ceiling and was hanging down approximately 1 inch from the ceiling. It was also dusty. b. In the bathroom shared by residents in rooms 110 and 111 there was a dirt build-up in the tub. The top and seat area of the toilet seat was missing areas of varnish, which exposed the wood and would make the seat un-sanitizable. c. In the bathroom shared by residents in rooms 112 and 113 the chair in the shower room had a white substance on it. The floor was dirty around the perimeter of the coving. The faucet on the sink had a heavy lime build-up and was corroding around the hot and cold water handles and around the base by the sink.	F 252	POC acceptable completion date 1/10/04 [signature] Utah Department of Health DEC 10 2003 # 402016 H7 Bureau of Medicare/Medicaid Program Certification and Resident Assessment	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 12/10/03

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 after 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 252	Continued From page 1 d. In the bathroom shared by residents in rooms 210 and 211 one of the doorjambs closest to room 211 was rusty. The faucet on the sink had a heavy lime build-up and was corroding around the base by the sink. The faucet was dripping water and turning the hot and cold faucet knobs would not stop the drip and the hot and cold faucet knobs were two different styles from apparently 2 different sinks. e. In the bathroom shared by residents in rooms 212 and 213 the faucet on the sink had a heavy lime build-up. The faucet was dripping water and turning the hot and cold faucet knobs would not stop the drip. The sink was coming loose from the wall. f. In the bathroom shared by residents in rooms 214 and 215 the faucet had a heavy lime build-up and was corroding and the shower floor had a dirt build-up. g. In the bathroom shared by residents in rooms 216 and 217 one the doorjambs to room 217 has rusted away approximately 1 in up from the floor. h. In the bathroom in room 109 there was 1 light bulb missing and 1 was burned out. The light fixture held 3 light bulbs. i. In the bathroom in room 205 the faucet had a heavy lime build-up and the shower floor had a heavy dirt/mold build-up around the perimeter of the tiles. j. In the bathroom shared by residents in room 202 and 203 there was water dripping from the faucet in the bathtub and turning the hot and cold faucet knobs would not stop the drip. There was a dark build-up on the floor around the coving. There was a dirty build-up in the bathtub. k. In the bathroom shared by residents in rooms 106 and 201 there was a dirt/mold build-up around the perimeter of the tiles. l. In room 107 there were 2 boards in place under the sink in an apparent repair that were not treated and/or painted so they would not be sanitizable. 2. In resident rooms:	F 252	1. Resident bathrooms: a. The ceiling vent in bathroom 109 was attached properly and cleaned. b. In the bathroom of 110 and 111 the bathtub was cleaned and the toilet seat was replaced. c. In the bathroom of 112 and 113 the chair in the shower room was cleaned, the floor around the perimeter of the coving was cleaned and the sink faucet was replaced. d. In the bathroom of 210 and 211 the doorjamb was fixed and the sink faucet was replaced. e. In the bathroom of 212 and 213 the faucet was replaced and the sink was secured to the wall. f. In the bathroom of 214 and 215 the sink faucet was replaced and the shower floor was cleaned. g. In the bathroom of 216 and 217 the doorjamb was replaced. h. In the bathroom of 109 the lightbulbs were replaced. I. In the bathroom of 204 and 205 the sink faucet was replaced and the shower floor around the perimeter of the tiles was cleaned. j. In the bathroom of 202 and 203 the shower faucet was repaired and the floor and the bathtub were cleaned. k. In the bathroom of 106 and 210 the perimeter tiles were cleaned. I. In the bathroom of 107 the boards under the sink were treated and painted.	

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F 252	Continued From page 2 a. The door to room 109 had an approximate 2-inch by 1-inch piece of Formica missing from the front protector plate. b. In room 110 beside bed A the faceplate was missing from 4-pronged plug outlet. c. Above bed B there was an approximate 4-inch piece of ceiling hanging down. d. In room 113 behind bed B there were multiple dark scuff marks on the wall. e. In room 114 the bottom drawer to the chest underneath the television was broken. f. In room 115 the dresser belonging to the resident in bed B the top drawer was missing the handle and the bottom 2 drawers had broken handles. g. In room 212 bed B there was a rip in the wallboard and an approximate 4-inch section was coming loose from the wall. h. In room 209 bed D the closet door was broken and top hinge had pulled loose. Above bed B there was a dark brown stain on the ceiling above the bed. i. In room 204 the cover was missing from the mechanism used help the door close and the wires were exposed. j. In room 201 there was a hole into the drywall behind the room door. 3. In resident common areas: a. In the main dining room next to the pool table there was a plaid couch with stains on the seat and a broken right arm. On the South/West wall there were 6 gouges into the paint and the paint was peeling. This wall was blue, however, beige paint had been painted up the wall in several areas. b. In the West shower room the floor was dirty. There was a heavy dark mold build-up around the tile coving. There were 2 shower chairs made out of PVC pipe, they also had mold growing along the legs and	F 252	2. Resident rooms: a. The door formica to room 109 was repaired. b. In room 110 the faceplate was attached c. The ceiling in room 110 was repaired. d. In room 113 the dark scuffs on the walls were painted. e. In room 114 the chest underneath the television was replaced. f. In room 115 the dresser handles were repaired g. In room 212 the wallboard was repaired. h. In room 209 bed D the closet drawer was repaired and the ceiling was painted above bed b i. In room 204 the cover was replaced to the door mechanism. j. In room 210 the hole behind the door was repaired. 1. Resident common areas: a. The plaid couch was cleaned and repaired. The South/West wall was repaired and painted. b. The shower room floor and the tile coving were cleaned. The two PVC pipe chairs were cleaned thoroughly. All defeciencies cited were corrected. A resident room and bathroom check list was prepared to be used by the facility administrator and the facility maintenance supervisor to identify maintenance and housekeeping needs monthly. Housekeeping and maintenance concerns will be adressed monthly in a quality assurance meeting and the resident room and bathroom check list will be reviewed.	1/10/04

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F 252	Continued From page 3 underneath the seats.	F 252		
F 279 SS=B	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to maintain accurate care plans on three (7, 27, and 30) of 15 sampled residents,. Findings include: Resident 30 was admitted to the facility on 8/29/2003 with diagnoses of, HIV (human immunodeficiency virus), hepatitis, thrush, diarrhea, hypertension, and hypothyroidism. Resident 30's medical record was reviewed on 11/16/03. The following was documented on resident 30's admission MDS (minimum data set) dated 9/24/03, regarding resident 30's health conditions:	F 279	In service for all staff involved with MDS using RA manual. Resident 30, 7, 27 MDS was validated using MD orders, assessments and H & P by DON and MDS coordinator and any adjustments completed. During IDT meeting careplans will be addressed corrisponding with MD orders, MDS and RAPS and reported to QA Monthly.	12/12/03

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F 279	Continued From page 4 MDS Section J, Health Conditions, 4e. No falls/fractures MDS Section V, Resident Assessment Protocol Summary, #11, Falls: triggered, and marked with an "X" to be care planned. Resident 30 sustained a fall while an inpatient at the hospital, on 9/9/03, prior to being admitted at the facility. There was documentation in resident 30's medical record, staff notes from the hospital dated 9/10/03 which documents the following, "(resident's name) had a fall yesterday with trauma to left buttocks no hx (history) of LOC (loss of consciousness) as the cause of fall." Resident 30 sustained a fall at the facility on 11/15/03. A facility incident report dated 11/15/03 documents that resident 30 complained of pain in her left wrist, and knee. Resident 30 sustained a small superficial abrasion of the left knee. Resident 30's care plan was reviewed on 11/16/03. Resident 30's prior history of falling, and recent fall on 11/16/03 were not addressed in resident 30's plan of care. Resident 7 was admitted to the facility on 10/07/02 with diagnoses of, TBI (traumatic brain injury), hypertension, hypercholesterolemia, and seizure disorder. Resident 7's medical record was reviewed on 11/16/03. The following was documented on resident 7's annual MDS dated 9/19/03, regarding resident 7's special treatments and procedures. MDS Section P,4 devices and restraints, a. full bed rails on all open sides, 2 used daily.	F 279		

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F 279	Continued From page 5 MDS section V. Resident Assessment Protocol Summary, # 18, Physical Restraints: triggered, and marked with an "X" to be care planned. Resident 7's care plan was reviewed on 11/16/03. Resident 7's care plan did not address the use of full bed side rails. On 11/17/03, a facility nurse was interviewed regarding the use of resident 7's side rails. The nurse stated that the resident used the side rails to prevent falling from bed, as well as positioning and turning in bed. The facility nurse was not able to locate in resident 7's care plan where the use of side rails was addressed. Resident 27 was admitted to the facility, on 10/24/03, with diagnoses that included fracture left femur, and Down's syndrome with depressive features. Resident 27's clinical record was reviewed on 11/18/03. The initial MDS, dated 11/07/03, documented the following: MDS Section H, Continence in last 14 days, 3, d, indwelling catheter. MDS Section I, 2., Infections, j., Urinary tract infection in last 30 days. MDS Section J. Health Conditions, 2, a/2, pain daily, and b/2, moderate pain. The Resident Assessment Protocol, dated 11/07/03, documented that urinary incontinence and indwelling catheter triggered. Resident 27's care plan was reviewed on 11/18/03. The care plan did not address the areas of the Foley catheter, the urinary tract infection that was diagnosed	F 279		

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F 279	Continued From page 6 on 11/06/03, for pain and comfort associated with the fractured femur. In an interview, on 11/17/03, at 2:45 PM, with the Director of Nursing, he confirmed that the care plans were not complete.	F 279		
F 323 SS=B	483.25(h)(1) QUALITY OF CARE The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observations in the facility on 11/17/03 and 11/18/03 with was determined the facility failed to ensure that the resident environment was free of accident hazards. Specifically, multiple razors were observed on bedside tables in resident rooms and were not securely locked, 3 bottles of unlabeled liquids were left unsecured in the resident's common shower room and 1 resident had a box of laundry detergent on his bedside table. Findings include: 1. Unlocked/Unsecured razors in resident rooms: a. On 11/17/03 observations were made in resident room 109. There were 2 disposable razors plus a new, unopened package of disposable razors on top of the bedside table next to bed A. There was one disposable razor on top of the bedside table next to bed B. b. On 11/17/03 observations were made in resident room 110. There was a disposable razor on top of the bedside table next to bed A. c. On 11/17/03 observations were made in resident room 105. There were 6 disposable razors on top of	F 323	All rooms searched for Razors , unlabeled Liquids and Laundry detergents. All laundry detergents locked in resident laundry closet. Combonation to lock placed at each nursing station. All Razors were desposed of. In-service all staff on razors, unlabeled liquids and laundry detergents. 12/10/03 Preform Random daily audits in resident rooms, Laundry Room, shower room for the mentioned above Items for 60 days Audits to be preformed by DON and reported to QA Monthly.	1/10/04

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F 323	Continued From page 7 the bedside table next to bed A. d. On 11/18/03 observations were made in resident room 211. There was a razor in a cup on top of a desk next to bed A. 2. Unlabeled/Unsecured liquids a. Observations in the West resident shower room on 11/17/03 at 3:12 PM revealed 2 unlabeled bottles of liquid and 1 spray bottle labeled window cleaner on the shelf next to tub. One bottle was a clear spray bottle that contained a pink liquid. Written on the bottle in faint red marker was "Film Free Window Cleaner". A second unlabeled bottle contained an unidentifiable green liquid. A third bottle, a two-liter soda bottle, contained a yellow liquid. This yellow liquid was not labeled. After exiting the shower room, a resident was observed to enter the room alone and shower. On 11/18/03 at 2:12 PM, the spray bottle containing the pink liquid labeled "Film Free Window Cleaner" and the unlabeled unidentifiable green liquid were still in the shower room. 3. Observations in room 110 on 11/17/03 revealed a box of "Classic X-tra with Color Safe Bleach Alternative" laundry detergent unsecured sitting on top of the bedside table next to bed A. The box read under first aide if ingested to rinse the mouth and give large amounts of milk or water, do not induce vomiting and to call a physician.	F 323		
F 371 SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

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F 371	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations in kitchen on 11/17/03 and 11/18/03, observations in the medication refrigerator on 11/17/03 and staff interview it was determined that that facility failed to store food under sanitary conditions. Specifically, the wall behind the shelves used to store food in the dry storeroom was wet, the paint was bubbling from the wall and it was covered in black mold. Additionally, there were food items in the freezer that were not labeled and/or dated and there was expired milk in the walk-in refrigerator. Findings include: 1. Observations on 11/17/03 during an initial tour of the kitchen from 7:42 AM to 8:04 AM revealed the following: a. The wall behind the shelves used to store food in the dry storeroom was wet, the paint was bubbling from the wall and it was covered in black mold. Standing water was observed on the floor underneath a plastic container of pinto beans. b. In the freezer labeled "Freezer #1" there was a block of frozen meat wrapped in tin foil with a heavy frosty build-up that was not labeled or dated. There was an open bag containing 5 hotdogs and an open bag containing 4 hotdogs, which were not dated and there was a bag of breaded meat that was not labeled or dated. c. In the walk-in refrigerator there were expired 3 gallons of 2% (percent) milk with the sell by date of 11/15/03 (2 days old). There was a tray with approximately 20 peanut butter and jelly ½ sandwiches that were not dated. 2. Observations in the kitchen on 11/17/03 at 4:19 PM	F 371	a. The wall behind the shelves to store room was cleaned and sanitized. A tarp was placed on th outside of the building to assure that the room did not leak. The wall and ceiling was painted to assure sanitation. A complete inspection was completed and all non-labled and/or outdated items were disposed of. The facility will store, prepare, distribute, and receive food following HACCP guidelines. All food items will be received and handled in accordance with HACCP guidelines. The dietary manager will properly receive all items and check for the following: Quantity, Quality, Labels, and Manufacturere Date. All dietary department employees were in serviced and acquainted with standards and guidelines for all types of food for the following: labeling, covering, dating, shelf life, detailing, defrosting. Focus rounds will be completed during the AM shift by the dietary manager and PM by the evening cook. Focus rounds will be checked weekly by the dietary manager and monthly by the registered deitician consultant. Focus rounds will be reviewed monthly by the Quality Assurance Committee.	1/10/04

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F 371	Continued From page 9 revealed the following: a. The wall behind the shelves used to store food in the dry storeroom was wet, the paint was bubbling from the wall and it was covered in black mold. Standing water was observed on the floor underneath a plastic container of pinto beans. b. In the walk-in refrigerator there were expired 2 gallons of 2% (percent) milk with the sell by date of 11/15/03 (2 days old). There was a tray with approximately 20 peanut butter and jelly ½ sandwiches that were not dated. 3. Observations of the refrigerator in the medication room behind the North nurses station on 11/17/03 at 9:15 AM revealed the following: a. There was a large container of what appeared to be chocolate pudding that was not labeled or dated. There were 2 syrofoam containers of applesauce that were not dated an there was one 32-ounce container of Resource 2.0 nutritional supplement that was opened but not dated. b. There was a blue container used to store plastic bags containing medications including vaccines, insulin and suppositories. There was a sticky cream-colored substance that had spilled into the container and coated the plastic bags containing resident medications and the bottom of the container. 4. Observations in the kitchen on 11/18/03 at 1:45 PM with the food service supervisor present revealed the following: a. In the freezer labeled "Freezer #1" there was a block of frozen meat wrapped in tin foil with a heavy frosty build-up that was not labeled or dated. There	F 371		

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F 371	Continued From page 10 was an open bag containing 5 hotdogs and an open bag containing 4 hotdogs, which were not dated and there was a bag of breaded meat that was not labeled or dated. b. In the walk-in refrigerator there were expired 2 gallons of 2% (percent) milk with the sell by date of 11/15/03 (3 days old). c. The wall behind the shelves used to store food in the dry storeroom was wet, the paint was bubbling from the wall and it was covered in black mold. Standing water was observed on the floor. The ceiling above the shelves was wet with condensation. On 11/18/03 at 1:45 PM the facility food service supervisor was interviewed. She acknowledged that the leaking ceiling had caused the wall to become wet had been a problem in the past. She stated that the roof needed to be treated to prevent the water from leaking into the building and that they had painted the ceiling to try and help with the problem but acknowledged that this was not working. On 11/18/03 at approximately 2:00 PM, the facility maintenance man was interviewed. He stated that he felt the roof above the dry storeroom needed to be tarred but the project would have to wait until the weather was warmer. He stated that he had thought about placing a tarp on the roof to try and prevent the water from leaking through the ceiling but had not yet done so.	F 371		
F 406 SS=G	483.45(a)(1)&(2) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health	F 406		

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	465142	A. BUILDING ____ B. WING ____	11/25/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106

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F 406	Continued From page 11 rehabilitative services for mental illness and mental retardation are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with s483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on family, staff and Specialized Rehabilitaion Services (SRS) provider interviews, and review of facility, SRS provider and State Survey Agency records, the facility failed to ensure that Specialized Rehabilitation Services were provided for a resident with an assessed need for SRS, related to mental retardation caused by a closed head injury prior to his eighteenth birthday. The facility, receiving an add-on rate for the provision of SRS for resident 55, failed to maintain payment to the SRS provider, resulting in the services being denied to the resident. Findings include: On 11/17/03 a medical record review was conducted which evidenced the following: Resident 55 was admitted to the facility on 4/28/97 with the diagnoses of closed head injury, gastrotomy, seizure, dysphasia. A review of resident 55's medical record review was completed on 11/24/03. On 4/28/97, a representative of the State PASSAR (Pre-Admission Screening and Annual-Resident Review) Authority, completed a PASSAR level 2 evaluation of resident 55. The PASSAR Authority made a recommendation that a diagnosis of mental retardation, as a result of a closed head injury prior to his eighteenth birthday, be added to resident 55's diagnoses.	F 406	The facility denies acceptance of this defeciency as an actual harm. Since 10/7/03 all services have been provided to resident 55 by the SRS provider. A phone call was made on Friday December 5th to the SRS Provider clarifying terms of payment and reassurance of future on time payment. A letter was emailed to the Infinia Corporate office Accounts Payables Department on Monday Decemeber 8th stating the importance of on time payment to the SRS Provider to assure continued service to resident 55. The facility administrator along with the business office will be responsible to track the account payables with all SRS providers and to assure timely payments to continue necessary services to all residents on SRS programs. The quality assurance committee will address monthly those residents on SRS programs and the services being provided by SRS providers	12/10/03

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F 406	Continued From page 12 On 8/15/01, a physician telephone order included documentation that resident 55, "needs a specialized rehabilitation service program , for soc.[social] skills, sens [sensory] stimuli, rom [range of motion], basic living skills." A psychosocial assessment, dated 10/29/02, included a recommendations that resident 55 be referred for SRS, day treatment, ten times a month. A social service note, dated 7/18/03, included the following, "[Resident 55] continues with SRS , enjoys work at community intervention". A note, dated 9/08/03, included, "resident continues to attend SRS." A note, dated 9/20/03, included, "refuses assist to meals. Continues with SRS program. Needs assist into community." A note, dated 10/15/03, included, "resident continues with SRS. Needs lots of assist and supervision with ADL'S [activity daily living]. Also that Tuesdays , and Thursdays were the chosen days to attend the [SRS Provider]." On 1/14/03, the SRS Provider documented a yearly goal for resident 55 to be, "[Resident 55] will maintain his physical strength and increase his speech clarity." On 8/21/03, facility staff completed a quarterly Minimum Data Set (MDS) for resident 55. Facility staff assessed resident 55 as follows: SECTION B. 4. COGNITIVE PATTERNS - Moderately impaired; SECTION C. 4. COMMUNICATION/HEARING PATTERNS, MAKING SELF UNDERSTOOD - Sometimes understood; SECTION C. 6. ABILITY TO UNDERSTAND OTHERS - Usually understands;	F 406		

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F 406	Continued From page 13 SECTION G. 4. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS , FUNCTIONAL LIMITATION IN RANGE OF MOTION - Limitation of range of motion, with loss of voluntary movement to an arm, hand, wrist, elbow, shoulder, foot, ankle, and leg; SECTION P. 1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS RECEIVED IN THE LAST 14 DAYS - Training to return to community; and, SECTION P. 3. NURSING REHABILITATION / RESTORATIVE CARE TRAINING AND SKILL PRACTICE - Transfer and walking. Resident 55's comprehensive plan of care did not include the resident's need and participation in a SRS program. An interview was held with resident 55's mother on 11/20/03 at 8:30 AM. Resident 55's mother stated her son had been denied services by the SRS Provider due to the facility's failure to pay for the services. She stated that representatives of the SRS Provider had given her notice prior to the services being denied. She stated she had informed the facility Administrator that the facility needed to pay for the SRS so that the services could resume. She stated that the facility's failure to pay for her son's SRS services had been an on-going problem for a long time. When asked about her son's response to the SRS program, resident 55's mother stated, "he loved to go to the [SRS] program." In fact, she stated, if resident 55 was given the choice to go to McDonald's for a hamburger, or to the SRS Provider, the resident would choose the SRS Provider. On 11/24/03 at 9:30 AM, a telephone interview was held with the program coordinator at the SRS	F 406		

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F 406	Continued From page 14 Provider. The program coordinator stated that she had telephoned the facility Administrator on 10/06/03 to inform him not to send resident 55 to the SRS Provider because services would be denied, due to non-payment. The program coordinator stated that resident 55 was transported to the SRS Provider on 10/07/03, and was denied service. Resident 55 was sent back to the facility without having received service. On 11/24/03 at 10:00 AM, a telephone interview was conducted with the IPM (individual program manager) who had been working at the SRS Provider since August. She stated she worked with resident 55 for two to three hours each time the resident attended the SRS program, which she indicated was two days a week. The IPM stated she was present on the morning of 10/07/03, when resident 55 arrived at the SRS Provider. She stated she had to inform resident 55 that he could not attend the SRS program and that he would need to go back to the facility. The IPM stated that resident 55 was "upset" and waved his arm in an angry gesture and that he tried to say "I'm mad". She stated that resident 55 withdrew from everyone and would not talk to anyone until the tram driver arrived to transport him back to the facility. The IPM stated it was not typical for resident 55 to withdraw and that he loved to attend the SRS program. An interview was held with the facility Administrator on 11/18/03, at 1:30 PM. The Administrator was interviewed again, by telephone, on 11/26/03 at 8:30 AM. The Administrator stated that he was aware of the bills from the SRS Provider, and he knew that the services for resident 55 had been denied a couple of times. The Administrator stated that he was aware of check number 29734, dated 7/07/03, and in the amount of	F 406		

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F 406	Continued From page 15 $3,312.66, being returned for insufficient funds. He stated that check was to bring the facility's account with the SRS Provider up to date. The Administrator stated he hand delivered a check, in the amount of $1,467.61, to the SRS Provider on 10/10/03 in order for the SRS Provider to reinstate services to resident 55. The Administrator confirmed that on 10/06/03, he received notice from the program coordinator of the SRS Provider, that resident 55's services were being denied. The Administrator stated on 10/07/03, resident 55 was still transported to the SRS Provider and that the resident was denied service and returned to the facility. He stated resident 55 was upset about not being able to participate in the SRS program. A review of records, provided by the SRS Provider, was completed on 11/24/03. Per documentation, resident 55 was denied service, due to lack of payment, on 7/03/03, 7/08/03, 7/10/03, 10/07/03, and 10/09/03. On 6/16/03, the SRS Provider provided the facility with written notice that the bill was ". . .seriously in arrears. . ." and they would suspend services to resident 55 unless they received payment before 6/25/03. On 7/07/03, the SRS received check numbered 29734, in the amount of $3,312.22. On 7/10/03, check numbered 29734 did not clear the bank due to insufficiant funds. On 7/21/03, the SRS Provider provided the facility with written notice that "All services to your company are suspended as of today due to non-payment."	F 406		

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F 406	Continued From page 16 On 9/08/03, the SRS Provider provided the facility with written notice that their "account is seriously in arrears . . ." and that they would suspend services to resident 55 unless they received would be suspended, due to non-payment, as of 9/30/03 . The past due amount must be received payment before 9/25/03. On 11/24/03, a review of the State Survey Agency's Specialized Rehabilitation Services records was completed. The facility is receiving an additional $19.23, per day, to provide a SRS program for resident 55. The facility had been receiving the additional $19.23, per day, since 8/15/01.	F 406		
F 460 SS=C	483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to have resident rooms equipped to assure full visual privacy for each resident with curtains suspended from the ceiling which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains as evidenced by 20 of 26 resident rooms shared by 2 or more residents did not have curtains that provided residents with full visual privacy. Room identifiers: 105, 107, 109, 110, 111, 112, 113, 115, 201, 202, 204, 205, 209, 210, 211, 212, 213, 214, 216, 217.	F 460	All rooms identified as being defecient in terms of providing full visual privacy to the residents have been corrected. All rooms are now equipped to provide full visual privacy for the residents. A facility maintenance check list was created to audit resident rooms for full visual privacy. This audit will be performed monthly by the maintenance supervisor and reviewed monthly in a qualiity assurance meeting.	1/10/04

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F 460	Continued From page 17 that provided residents with full visual privacy. Room identifiers: 105, 107, 109, 110, 111, 112, 113, 115, 201, 202, 204, 205, 209, 210, 211, 212, 213, 214, 216, 217. Findings include: Observation of resident rooms on 11/17/03 revealed the following in relationship to the privacy curtains: Room 109: The privacy curtain for bed A allowed 2 1/2 feet of visualization of this resident because it was not long enough to extend around the bed. The privacy curtain for bed B allowed 1 foot of visualization of this resident because it was not long enough to extend around the bed. Room 110: The privacy curtain at the foot of bed A was missing allowing full visualization of this resident. The privacy curtain in the center of the room, dividing the area between the two beds, allowed one foot of visualization between bed A and bed B. The privacy curtain at the foot of bed B was missing allowing full visualization of this resident. Room 111: The privacy curtain in the center of the room, dividing the area between the two beds, allowed one foot of visualization between bed A and bed B. Room 112: The privacy curtain at the foot of bed A allowed 1 foot of visualization of this resident because it was too short to reach the center of the room. : The privacy curtain at the foot of bed A allowed 1 ½ feet of visualization of this resident because it was too short to reach the center of the room. The privacy curtain in the center of the room, dividing the area between the two beds, allowed one foot of visualization between bed A and bed B.	F 460		

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F 460	Continued From page 18 Room 113: The privacy curtain in the center of the room, dividing the area between the two beds, allowed one foot of visualization between bed A and bed B. Room 115: The privacy curtain for bed A allowed 1 foot of visualization of this resident because it was not long enough to extend around the bed. Room 210: The privacy curtain beside bed A allowed for 2 feet of visualization of this resident because it was not long enough to extend around the bed. The center privacy curtain, dividing the area between the two beds, could not be pulled closed because a screw was sticking down from the guide rail, this allowed 5 ½ feet of visualization between bed A and B. The privacy curtain beside bed b allowed for 1 foot of visualization of this resident because it was not long enough to extend around the bed Room 211: The privacy curtain in the center of the room, dividing the area between the two beds, allowed one foot of visualization between bed A and bed B. Room 212: The privacy curtain at the foot of bed A was missing allowing full visualization of this resident. The privacy curtain in the center of the room, dividing the area between the two beds, allowed one foot of visualization between bed A and bed B. Room 213: This room was occupied by only 1 resident during the observation on 11/17/03, however, was equipped for 2 residents. The privacy curtain beside bed A allowed 1 foot of visualization of this resident when pulled, however, the curtain track was on such a slant that the curtain would not stay pulled closed and slid on it's own down the track towards the door when released. This would allow for full visualization of the resident in bed A. The privacy curtain in the center of the room, dividing the area	F 460		

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F 460	Continued From page 19 between the two beds, allowed one foot of visualization between bed A and bed B. Room 214: The privacy curtain at the foot of bed B allowed for 5 ½ feet of visualization of this resident because it was not long enough to extend around the bed. The center privacy curtain, dividing the area between the two beds, allowed for 4 feet of visualization between bed A and B. Room 216: This room was occupied by only 1 resident during the observation on 11/17/03, however, was equipped for 2 residents and the resident occupying the room stated he had lived with a roommate in that room. The privacy curtain at the foot of bed A allowed for 1 foot of visualization of this resident because it was not long enough to extend around the bed. The center privacy curtain, dividing the area between the two beds, allowed for 2 feet of visualization between bed A and B. Room 217: The privacy curtain at the foot of bed B allowed for 10 inches of visualization of this resident because it was not long enough to extend around the bed. The center privacy curtain, dividing the area between the two beds, allowed for 10 inches of visualization between bed A and B. Room 209: The center privacy curtain, dividing the area between beds A and B, allowed for 5 feet of visualization between the beds. The long privacy curtain at the foot of beds A and B would not pull closed, it was stuck on the track and allowed approximately 6-7 feet of visualization of the 2 residents in beds A and B. Room 205: The privacy curtain in the center of the room, dividing the area between the two beds, allowed 4 ½ feet of visualization between bed A and bed B.	F 460		

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F 460	Continued From page 20 Room 204: The privacy curtain at the foot of bed B allowed for 1 foot of visualization of this resident because it was not long enough to extend around the bed. The center privacy curtain, dividing the area between the two beds, allowed for 4 ½ feet of visualization between bed A and B. Room 202: The privacy curtain in the center of the room, dividing the area between the two beds, allowed 2 feet of visualization between bed A and bed B. Room 201: The privacy curtain in the center of the room, dividing the area between the two beds, allowed 1 ½ feet of visualization between bed A and bed B. Room 105: The privacy curtain in the center of the room, dividing the area between the two beds, was missing allowing full visualization of the residents. Room 107: The privacy curtain around bed A would not pull further than approximately 5 feet because it stuck on the track. This allowed approximately 15 feet of visualization of this resident because it would not extend around the bed. A C.N.A. (certified nurse's aide) was in the room and was asked if she could pull the curtain around bed A. She was unable to do so. The privacy curtain around bed B also became stuck on the track and would not fully extend around the bed allowing approximately 10 feet of visualization of the resident. The privacy curtain around bed C was very difficult to pull closed and was not long enough to fully extend around the bed leaving approximately 10 feet of visualization of the resident.	F 460		
F 494 SS=D	483.75(e)(2)-(3) ADMINISTRATION A facility must not use any individual working in the	F 494		

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F 494	Continued From page 21 facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of ss483.151-483.154 of this part; that individual has been deemed or determined competent as provided in s483.150(a) and (b). A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and review of personnel files, it was determined that 2 of the 5 nurse aides who were reviewed had been employed by the facility for longer than four months and were not yet certified. Employee identifiers: E2 and E3. Findings include: Personnel files were reviewed on 11/18/03 and revealed the following: Employee E2 was hired on 7/7/03. There was no documentation to evidence that employee E2 had become certified. The state nurse aide registry was called on 11/18/03 at 10:02 AM and it was reported that employee E2 was not certified. During interview with the DON (director of nurses) on 11/18/03 at 10:20 AM, he stated that employee E2 was not yet certified. Employee E2 was 11 days over the four month time limit to become certified. Employee E3 was hired on 5/28/03. There was no documentation to evidence that employee E3 had	F 494	Any Nursing Assistant (NA) hired will complete certification within 120 days of hire. Audits of new hire will be completed per DON and reported to QA Monthly. Employee's E2, E3 were suspended on 11/25/03 until verification of certification. Audit of all Certified Nursing Assistant and Nursing Assistant performed for verification of certification.	12/12/03

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INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106

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F 494	Continued From page 22 become certified. During interview with the DON on 11/18/03 at 10:20 AM, he stated that employee E3 was waiting to take the test to become certified. He stated that she had taken her classes but was not yet certified. Employee E3 was 8 weeks over the four month time limit to become certified. Both of these employees were on the current November 2003 nurse aide schedule to provide direct care to residents.	F 494		
F 496 SS=D	483.75(e)(5)-(7) ADMINISTRATION Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility personnel files, it was determined that for 2 of 5 nurse aides hired in the past 4 months, there was no documented	F 496	Call on all employee's to verify abuse. Complete log of all current employee's of abuse verification. Completion date 12/18/03 Add all new hires to Abuse log. Audit of Abuse log to be completed by DON monthly and reported to QA monthly.	12/18/03

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
	465142	A. BUILDING ______ B. WING ______	11/25/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106

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F 496	Continued From page 23 evidence that the facility had contacted the State nurse aide registry and the nurse aides had been providing resident care since their hire dates. Employee identifiers: E2 and E5. Findings include: 1. E2 was hired as a nurse aide on 7/7/03. The personnel file of E2 was reviewed on 11/18/03. The personnel file did not contain any documentation to evidence that the facility had sought information from the State nurse aide registry regarding E2 prior to allowing her to serve as a nurse aide and provide care to residents. 2. E5 was hired as a nurse aide on 10/9/03. The personnel file of E5 was reviewed on 11/18/03. The personnel file did not contain any documentation to evidence that the facility had sought information from the State nurse aide registry regarding E5 prior to allowing her to serve as a nurse aide and provide care to residents. On 11/18/03 at 10:20 AM an interview was conducted with the facility's DON (director of nursing). He stated that the ADON (assistant director of nursing) would have been the one to call the nurse aide registry and that he had not documented that he called regarding employees E2 and E5 prior to their employment.	F 496		

PLAN OF CORRECTION

F371—The facility will store, prepare, distribute, and receive food following HACCP guidelines.

PROCEDURE:

1.All food items will be received and handled in accordance with HACCP guidelines.

2.The dietary manager will properly receive all items and check for the following:

A. Quanity
B. Quality
C. Labels
D. Manufacturer date

3. All dietary department employees will be inserviced and aquainted with standards and guidelines for the following:

A. labeling
B. covering
C. Dating
D. Shelf life
E. Detailing
F. Defrosting
{For all different types of food items}

4. Focus rounds will be completed durring the A.M. by the dietary manager and P.M. by the evening cook. Focus rounds will also be checked weely by the dietary technician followed by monthly from the Registered dietitian consultant. Quarterly checks to be reviewed by the Quality Assurance Team.