STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING ______ B. WING ______	C 6/28/2002

COMPLAINT NUMBER. 10478

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT OGDEN	**524 EAST 800 NORTH OGDEN, UT 84404**

(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
F 151 SS=G	483.10(a)(1)&(2) EXERCISE OF RIGHTS	F 151 8-1-02 accepted	See Attached.	

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

This REQUIREMENT is not met as evidenced by:
Based on interviews with facility staff and record review, it was determined that the facility did not give a resident the right to be free from coercion as evidenced by the facility had compelled a resident to take a shower. This limited the resident's autonomy and freedom of choice. (Resident 1)

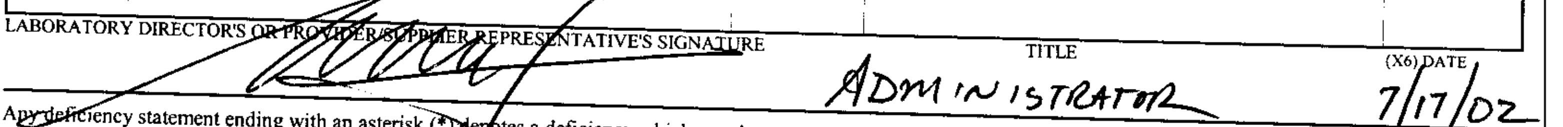
Findings include:

Resident 1 was an 81 year old female admitted to the facility on 1/13/00 with diagnoses of Type II diabetes mellitus, mild vascular dementia, major depression, panic disorder with agoraphobia, obsessive-compulsive disorder and chronic renal failure.

Resident 1's medical record was reviewed on 6/24/01.

A quarterly Minimum Data Set (MDS) assessment, completed by facility staff on 3/4/02, documented that resident 1 had a short-term memory problem and her cognitive skills for daily decision-making were moderately impaired. The facility documented that resident 1 had persistent anger with self and others, and made repetitive anxious complaints/concerns. The facility also documented that resident 1 resisted care and was totally dependent on staff for personal hygiene and bathing.

Utah Dept. of Health
JUL 18 2002
Bur. of Medicare/Medicaid Prog.
Certification and Res. Assessment



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

TITLE: ADMINISTRATOR

(X6) DATE: 7/17/02

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING ___ B. WING ___	C 6/28/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT OGDEN	**524 EAST 800 NORTH OGDEN, UT 84404**

(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 151	Continued From page 1	F 151		

A care plan dated 12/10/01, and updated 3/10/02 for resident 1, documented that resident 1 required extensive assistance with ADLs (activities of daily living), and had refused care at times. The goal was that resident 1 would allow ADL care daily. The approach was that resident 1 would allow and accept assistance in showering, dressing and toileting. The care plan also documented that resident 1 had covert, open conflict with and/or repeated criticism of staff. The approach was to assign the caregiver that related best to resident 1 daily and to approach her in a quiet and accepting manner.

A Psychosocial Assessment dated 12/12/01, completed by facility staff, documented that resident 1 was usually alert and oriented to person, place, time and situation.

A nurses note for resident 1,dated 5/30/02, documented as a late entry for 5/26/02 at 4:00 PM, documented, "[NA] came to me et [and] said that they gave [resident 1] a shr.[shower] et that she was combative. [NA] said it had been five days since last shr."

An NA note for resident 1, dated 5/26/02 at 3:00 PM, documented, "Pt [patient] Refused Shower. Checked charted She had ref [refused] five Days. So client was put in Shower [with] 3 aides asst. [assist] became combative [with] staff. Shower given @ [at] her dislike....]

A facility-nursing assistant (NA1) was interviewed by telephone on 6/26/02 at 10:30 AM. NA1 stated that resident 1 was given a shower on 5/26/02 in the afternoon. NA1 stated resident 1 wanted the shower until she was put into the shower, "then she just went ballistic." NA1 stated that she had reported the incident to the facility nurse before and after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING ____ B. WING ____	C 6/28/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT OGDEN	524 EAST 800 NORTH OGDEN, UT 84404

(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 151	Continued From page 2 shower. NA1 stated that the facility nurse, "told me to try and talk her into it, try to negotiate with [resident 1]." An interview was held with facility NA2, on 6/26/02 at 2:30 PM. NA2 stated that she was at the nurse's station when she over-heard the facility nurse say that resident 1 had refused her shower for so long that she needed to have one. NA2 stated that NA1 and NA3 took resident 1 into the 300 Hall shower room, "...kicking, screaming and biting." NA2 stated that resident 1 continued to exhibit the behaviors during the shower. NA2 stated that, "You could hear [resident 1] down the hall." NA2 stated that when the shower was completed for resident 1, NA1 went to the nurses' station. The facility nurse asked NA1 if that had been resident 1 yelling. NA1 stated that it was resident 1 and the facility nurse told NA1 to document that resident 1 had been yelling during her shower. An interview was conducted on 6/27/02 at 11:00 AM, with the facility nurse who had provided care for resident 1 on 5/26/02. The nurse stated that no other options, besides the shower, had been given to resident 1. The nurse stated that she had been informed of resident 1's behavior, by the facility's NA's, after the shower. The nurse also stated that she could hear something in the shower room, "I didn't think anything of it." Review of an investigation, dated 6/5/02, completed by the facility social worker, revealed a statement written by NA 2. The statement documented, "I was in the shower room when (2) aides brought [resident 1] into the shower room. She was yelling and swinging her arms. I asked one of the aides why she was yelling. Aide stated she had asked resident if she wanted her shower and resident said no. The aide stated she checked her chart and she had refused her	F 151		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465065	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 6/28/2002
NAME OF PROVIDER OR SUPPLIER: INFINIA AT OGDEN	STREET ADDRESS, CITY, STATE, ZIP CODE: 524 EAST 800 NORTH OGDEN, UT 84404		

(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 151	Continued From page 3 shower for five days. So she was told by the nurse that she needed to give her the shower. The resident continued to hit & kick...." Two surveyors interviewed nurse 1 on 6/27/02 at 11:00 AM. NA1 was interviewed on 6/26/02 at 10:30 AM. NA2 was interviewed on 6/26/02 at 2:30 PM. NA3 was interviewed on 6/26/02 at 10:50 AM. None of the facitly staff members reported giving resident 1 any alternative options for bathing, after resident 1 had stated she did not want a shower. Resident 1 was still given a shower.	F 151		
F 223 SS=G	483.13(b) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview,it was determined that the facility did not ensure that a resident was free from abuse, as evidenced by, facility staff giving a resident a shower when the resident had stated that she did not want a shower. A written report by a CNA that witnessed the incident, documented that following the shower, the resident presented as being withdrawn making no eye contact and or speaking to facility staff. (Resident 1) Findings include: Resident 1 was an 81 year old female admitted to the facility on 1/13/00 with diagnoses of Type II diabetes mellitus, mild vascular dementia, major depression, panic disorder with agoraphobia, obsessive-compulsive disorder and chronic renal	F 223 8-1-02 accepted [illegible]		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING ______ B. WING ______	C 6/28/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT OGDEN	524 EAST 800 NORTH OGDEN, UT 84404

(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 223	Continued From page 4	F 223		

failure.

Resident 1's medical record was reviewed on 6/24/01.

A quarterly Minimum Data Set (MDS) assessment, completed by facility staff on 3/4/02, documented that resident 1 had a short-term memory problem and her cognitive skills for daily decision-making were moderately impaired. The facility documented that resident 1 had persistent anger with self and others, and made repetitive anxious complaints/concerns. The facility also documented that resident 1 resisted care and was totally dependent on staff for personal hygiene and bathing.

A care plan dated 12/10/01, and updated 3/10/02 for resident 1, documented that resident 1 required extensive assistance with ADLs (activities of daily living), and had refused care at times. The goal was that resident 1 would allow ADL care daily. The approach was that resident 1 would allow and accept assistance in showering, dressing and toileting. The care plan also documented that resident 1 had covert, open conflict with and/or repeated criticism of staff. The approach was to assign the caregiver that related best to resident 1 daily and to approach her in a quiet and accepting manner.

A Psychosocial Assessment dated 12/12/01, completed by facility staff, documented that resident 1 was usually alert and oriented to person, place, time and situation.

A nurses' note for resident 1, dated 5/30/02, documented as a late entry for 5/26/02 at 4:00 PM, documented, "[NA] came to me et [and] said that they gave [resident 1] a shr.[shower] et that she was combative. [NA] said it had been five days since last shr."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING ______ B. WING ______	C 6/28/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT OGDEN	**524 EAST 800 NORTH OGDEN, UT 84404**

(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 223	Continued From page 5 An NA note for resident 1, dated 5/26/02 at 3:00 PM, documented, "Pt [patient] Refused Shower. Checked charted She had ref [refused] five Days. So client was put in Shower [with] 3 aides asst. [assist] became combative [with] staff. Shower given @ [at] her dislike....] A facility-nursing assistant (NA1) was interviewed by telephone on 6/26/02 at 10:30 AM. NA1 stated that resident 1 was given a shower on 5/26/02 in the afternoon. NA1 stated resident 1 wanted the shower until she was put into the shower, "then she just went ballistic." NA1 stated that she had reported the incident to the facility nurse before and after the shower. NA1 stated that the facility nurse, "told me to try and talk her into it, try to negotiate with [resident 1]." An interview was held with facility NA2, on 6/26/02 at 2:30 PM. NA2 stated that she was at the nurse's station when she over-heard the facility nurse say that resident 1 had refused her shower for so long that she needed to have one. NA2 stated that NA1 and NA3 took resident 1 into the 300 Hall shower room, "...kicking, screaming and biting." NA2 stated that resident 1 continued to exhibit the behaviors during the shower. NA2 stated that, "You could hear [resident 1] down the hall." NA2 stated that when the shower was completed for resident 1, NA1 went to the nurses' station. The facility nurse asked NA1 if that had been resident 1 yelling. NA1 stated that it was resident 1 and the facility nurse told NA1 to document that resident 1 had been yelling during her shower. An interview was conducted on 6/27/02 at 11:00 AM, with the facility nurse who had provided care for resident 1 on 5/26/02. The nurse stated that no other options, besides the shower, had been given to resident	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING ____ B. WING ____	C 6/28/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT OGDEN	**524 EAST 800 NORTH OGDEN, UT 84404**

(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 223	Continued From page 6 1. The nurse stated that she had been informed of resident 1's behavior, by the facility's NA's, after the shower. The nurse also stated that she could hear something in the shower room, "I didn't think anything of it." Review of an investigation, dated 6/5/02, completed by the facility social worker, revealed a statement written by NA 2. The statement documented, "I was in the shower room when (2) aides brought [resident 1] into the shower room. She was yelling and swinging her arms. I asked one of the aides why she was yelling. Aide stated she had asked resident if she wanted her shower and resident said no. The aide stated she checked her chart and she had refused her shower for five days. So she was told by the nurse that she needed to give her the shower. The resident continued to hit & kick...." Two surveyors interviewed nurse 1 on 6/27/02 at 11:00 AM. NA1 was interviewed on 6/26/02 at 10:30 AM. NA2 was interviewed on 6/26/02 at 2:30 PM. NA3 was interviewed on 6/26/02 at 10:50 AM. None of the facitly staff members reported giving resident 1 any alternative options for bathing, after resident 1 had stated she did not want a shower. Resident 1 was still given a shower. During a phone interview with NA1 on 6/26/02 at 10:30 AM, she stated she did not remember attending any inservices on abuse given by the facility, but had been inserviced on abuse during her certification class in June 2001. During an interview with NA2 on 6/26/02 at 2:30 PM, the surveyor asked if she felt that the incident on 5/26/02 was abuse. She stated that it was, but after so long the facility could not keep letting the resident refuse showers. NA2 stated she had attended an	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING B. WING	C 6/28/2002

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT OGDEN	**524 EAST 800 NORTH OGDEN, UT 84404**

(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 223	Continued From page 7 inservice on abuse and resident rights given by the facility approximately 1 month ago. During an interview with NA3 on 6/26/02 at 10:50 AM, she stated she did not remember attending an inservice on abuse given by the facility, but she had received a packet on abuse when she was hired, nine months ago. Nurse 1 was interviewed by telephone on 6/27/02 at 11:00 AM. When asked by the surveyor if nurse 1 felt the incident was inappropriate she stated, "yes," and that it should not have taken three people to shower resident 1. Nurse 1further stated, "[Resident 1] does have the right to refuse once a week." When asked who told her this, she told the surveyor, "No one told her, it is just understood. I heard it through the grapevine and social services told me." When the surveyor asked nurse 1 if she had attended any inservices given by the facility on abuse or resident rights she answered, "I think we just had one, but I did not attend." A review of an inservice dated 5/24/02 given by the facility to facility staff, two days prior to the incident in the shower, was done on 6/26/02. The topic was, "residents and their rights." A pamphlet was reviewed at the inservice entitled, "Domestic Mistreatment of the Elderly." It was printed by the AARP the American Association for Retired Persons. The three aides that were involved in the shower incident had signed that they had attended. The pamphlet defined physical abuse as, "physical coercion."	F 223		

July 17, 2002

Kelly J. Criddle, Manager
Complaint, Hospital and Ambulatory Care Section
Bureau of Medicare/Medicaid Program Certification and Resident Assessment
PO Box 144103
Salt Lake City, UT 84114-4103

RE: Infinia @ Ogden, SAC-362-02

Dear Mr. Criddle:

The following is our Plan of Correction for the above referenced complaint survey.

F151: An incident investigation has been conducted for Resident #1. The resident, family and Physician have been contacted regarding this. In addition, the necessary county and State agencies were notified. A new care plan has been developed with the area of bathing specifically addressed. A new policy and procedure has been developed to insure that residents are given numerous alternative options for care. All residents that have presented issues regarding refusal for cares shall be evaluated and a specific care plan developed to deal with their respective issues. These care plans will be reviewed as required. The Director of Nursing shall be responsible to insure that the care plans are appropriate with the assistance of the IDT team. An All-Staff in-service meeting was held on June 27th, 2002 regarding abuse and the new policy. Resident #1 will be met with weekly by Social Services to determine if her needs are being met. The Quality Assurance committee will review all incidents related to abuse allegations on a monthly basis. Responsible Party: Administrator, Social Services Coordinator, Director of Nursing. Date of Compliance: August 5, 2002.

F223: Please refer to F151.

If there is anything that needs to be amended or revised, please contact me at (801) 782-3740.

Sincerely,

Lin Neff
Administrator

Cc: Terry Lemmon, Director of Clinical Services
Jon Robertson, President
Jared Elliot, Vice President, Operations