DEPARTMENT OF HEALTH AND HUM. SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 9/24/20
FORM APPROVE
2567

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 9/12/2002

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 221 SS=G	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, resident record reviews, facility policy review and facility staff interviews, it was determined that the facility failed to assess resident medical symptoms that would necessitate the implementation and use of physical restraints for 2 of 5 sample residents (residents 4,5) and 4 of 8 supplemental residents (residents 6,7,8 resulting in harm to 1 resident (resident 4). Findings include: Facility Policy The following information regarding restraint use was documented in the facility's "Nursing Policy Key Points" : 1."The least restrictive measure has been taken." 2."The patient/representative has been fully informed of the risks and benefits." 3. "A physician order has been obtained." 4."Visual observation of the patient is made every 30 minutes and documented on the restraint record." 5."The patient is released from restraints at least 2 hours following use and activity is documented on the restraint record." 6. Nursing diagnosis: risk for injury is enter on the Standard of Care and updated as needed." Resident Review	F 221	10/22/02 approved Residents 1-13 cited had the necessary assessments, T.O.'s, Careplan updates and proper documentation written in their charts. All resident records have been reviewed and received the same updates. From October 1st-10th, all residents were assessed for restraint use, by utilizing the the evaluation forms found in the Nursing Policies & Procedures. T.O.'s were obtained where needed and proper documentation completed by the IDT. The IDT has received training concerning restraint assessment and documentation on October 2, 2002. ⟶	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 10/14/02

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.

Utah Dept. of Health
Receipt 499959
OCT 2002
Bur. of Medicare/Medicaid Prog
Certification and Res. Assessment

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F 221	Continued From page 1 1. Resident 4 was admitted to the facility on 11/13/01 with diagnoses including Alzheimer's dementia, hypertension, right hip repair and hearing loss. The resident's medical record was reviewed on 9/10/02. The August physician re-certification orders, the most current in the medical record upon review, documented the following under restraints, "lap buddy as needed... dx [diagnoses]: for safety, waist restraint when out of bed as needed. Side rails when in bed as needed SR [side rails] x [times] 2 while in bed, release q [every] 2 hrs [hours] x [times] 10 min [minutes] for nursing cares". There were no documented dates for these restraint orders. The physician's orders did not document a medical symptom that would warrant the use of physical restraints for resident 4. Review of resident 4's quarterly MDS (minimum data set) assessments, dated 2/11/02, 5/6/02 and 7/28/02 documented the following: Section G, 6. Modes of Transfer: The resident was not assessed as using bed rails for mobility or transfer. Section P., Devices and Restraints: The resident was assessed as using full bedrails on all sides of the bed daily and a chair that prevents rising daily. Resident 4's care plans were reviewed. There was no documented care plan, including goals and interventions, addressing restraints. Resident 4 was observed in bed with both full side rails up on the following dates: 9/10/02 at 2:50 PM 9/11/02 at 1:50 PM 9/12/02 at 10:40 AM and 1:30 PM	F 221	Restraint assessments and monitoring of Incident reports will be reviewed during IDT meetings. Incident reports are looked at by the D.O.N., Medical Director, and administrator. The completed document is then stored in the Administrator office for safe keeping. The D.O.N. and A.D.O.N are responsible to ensure systems remain in place and functional.	10/11/02

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F 221	Continued From page 2 Resident 4 was observed to be in a wheelchair with a lap buddy in place on the following dates: 9/11/02 at 4:15 PM 9/12/02 at 12:05 PM On 9/10/02, a review of the facility incident reports was done. On 6/22/02, resident 4 had an incident report completed, which documented the following description of injuries, " CNA doing cares in A.M. pointed out bruise on resident's [left] cheek-states wasn't there yesterday. Poss [possibly] hit siderail". There was no documented evidence that the interdisciplinary team re-evaluated resident 4's use of full side rails while in bed. On 7/18/02, resident 4 had an incident report completed, which documented the following description of injuries, "noticed bruise on resident's chest poss. [possibly] caused by side rails." There was no documented evidence that the interdisciplinary team re-evaluated resident 4's use of full side rails while in bed. On 8/10/02, resident 4 had an incident report completed, which documented the following description of injuries, "around dinner time resident was found to have numerous bruises to face. Bruises on both cheeks. 3 on forehead, 1 on each forearm. No fall reported. Poss. [possibly] caused by side rail". There was no documented evidence that the interdisciplinary team re-evaluated resident 4's use of full side rails while in bed. On 9/11/02, the facility administrator in training and social worker were interviewed.	F 221		

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F 221	Continued From page 3 On 9/11/02, at 2:00 PM, a nurse's aide familiar with resident 4's care was interviewed. The aide stated that staff members often observe resident 4 trying to get out of bed. The aide also stated that resident 4 often rolls around in the bed and almost daily rolls into the side rails. On 9/12/02 at 1:30 PM, a nurse familiar with resident 4's care was interviewed. She stated that resident 4 used side rails while in bed because she moved around in bed a lot and would often try to get up. She further stated that resident 4 used the side rails and lap buddy for safety. Review of resident 4's medical record and incident reports documented injures on 6/22/02, 7/18/02 and 8/10/02 which the facility attributed to the resident hitting the side rails. Review of resident 4's medical record evidenced that no restraint assessments had been completed which addressed the use of full side rails as a restraint or as an aid to bed mobility. There was no documented evidence that a restraint assessment had been completed which addressed the use of a lap buddy as a restraint or as an aide to prevent falls or for postural support. There was no documented evidence that resident 4 was assessed for the need of side rails or a lap buddy restraint prior to their implementation. There was no documented evidence that a consent form authorizing the use of restraints was signed by the resident or family member as required by facility policy. There was no documented evidence that the interdisciplinary team assessed the use of physical restraints or identified a medical symptom that would warrant the use of physical restraints for resident 4. On 9/11/02 and 9/12/02, the facility DON (director of nursing) and the facility administrator in training were	F 221		

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F 221	Continued From page 4	F 221		

asked to provide the survey team any restraint assessment information they might have regarding resident 4. No information was provided prior to exit,and, as of 9/17/02, no information had been provided.

2. Resident 5 was admitted to the facility on 2/1/01 with diagnoses including dementia, general anxiety disorder, chronic obstructive pulmonary disease and hypertension.

The resident's medical record was reviewed on 9/12/02. The August physician re-certification orders documented the following under restraints, "lap buddy when out of bed Q [every] shift used for patient positioning and safety due to dementia while up in w/c [wheelchair]. Side rails up x [times] 2 every shift... up d/t [due to] dx [diagnosis]: dementia...". There was no documented date for the lap buddy order. The side rail order was ordered upon admission. The physician's order did not document a medical symptom that would warrant the use of physical restraints for resident 5.

Review of resident 5's annual MDS assessment, dated 1/14/02 and quarterly MDS' dated 4/8/02 and 6/30/02 documented the following:

Section G, 6. Modes of Transfer: The resident was assessed as using bed rails for mobility or transfer.

Section P., Devices and Restraints: The resident was assessed as using full bedrails on all sides of the bed daily and a chair that prevents rising daily.

Resident 5's care plans were reviewed. There was no documented care plan, including goals and interventions, which addressed restraints.

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F 221	Continued From page 5 A review of resident 5's IDT meeting notes dated 1/16/02, 4/10/02 and7/3/02 which were signed by the care plan team, was completed. On 1/16/02, 4/10/02 and 7/3/02, the interdisciplinary team did place a check mark by the box marked physical restraints as though it had been reviewed. There was, however, no documented evidence that the use of physical restraints was reviewed or that a medical symptom was identified that would warrant the use of physical restraints for resident 5. There was a care plan which identified as a problem the need for resident 5 to be in a chair that prevents rising due to falls, leaning forward and the diagnosis of dementia with restlessness. A documented intervention was to evaluate every 3 months for continued need or less restrictive restraint. Resident 5 was observed in bed with both full side rails up on 9/11/02 at 4:15 PM On 9/12/02, at 1:35 PM, a nurse familiar with resident 5's care was interviewed. She stated that resident 5 is very active and restless in bed and does move around quite often. When asked the medical symptom used to justify the use of side rails she stated they were used for safety because the resident would try to crawl out of bed. On 9/12/02, at 1:37 PM, the DON (director of nursing), resident 5's daughter, was interviewed. She stated that resident 5 would move around in the bed and used the side rails to prevent her from getting out of bed. They further stated that the lap buddy was also used as a safety measure as the resident would try to stand up unassisted. A review of resident 5's medical record evidenced that no restraint assessments had been completed which	F 221		

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F 221	Continued From page 6 addressed the use of full side rails as a restraint or as an aid to bed mobility. There was no documented evidence that a restraint assessment had been completed which addressed the use of the lap buddy as a restraint or as an aide to prevent falls or for postural support. There was no documented evidence that resident 5 was assessed for the need of side rails or a lap buddy restraint prior to their implementation. There was no documented evidence that a consent form authorizing the use of restraints was signed by the resident or family member as required by facility policy. There was no documentation that the facility assessed or evaluated resident 5 to determine the possibility of reduction or elimination of the restraint. On 9/11/02 and 9/12/02, the facility DON and the facility administrator in training were asked to provide the survey team any restraint assessment information they might have regarding resident 5. No information was provided prior to exit and, as of 9/17/02, no information had been provided. 3. Resident 6 was admitted to the facility on 6/8/02 with the diagnoses of Bell's palsy, paranoid schizophrenia, organic personality syndrome and osteoarthritis. Resident 6 was observed to reside in the Special needs Unit (SNU). On 9/10/02, at 3:15 PM, resident 6 was observed to be in his room lying in bed on his right side. He was observed to have full side rails up on both sides of his bed. Resident 6 was observed kicking his legs between the top side rail and the bottom side rail. On 9/11/02 at approximately 4:15 PM, resident 6 was observed lying in bed with full side rails up on both	F 221		

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F 221	Continued From page 7 sides of his bed. On 9/12/02 at 1:25 PM, resident 6 was observed lying in bed with full side rails up on both sides of his bed. A review of resident 6's medical record was completed on 9/11/02. A minimum data set (MDS) assessment completed by facility staff on 6/14/02 documented that resident 6 had short and long term memory problems and his cognitive skills for daily decision making were moderately impaired. The facility staff also documented that resident 6 wandered and had periods of altered perception or awareness of surroundings. The staff documented that resident 6 was able to transfer with limited assistance. The staff assessed resident 6 as requiring the use of 1/2 side rails or 1 side rail on a daily basis. There was no documented physician's order for resident 6 to have full side rails up on both sides of his bed. No documentation was found in resident 6's medical record that the interdisciplinary team had performed an assessment, attempted alternatives, determined the medical need for the restraint or identified the least restrictive device for resident 6, prior to initiating the use of side rails. A care plan, dated 6/14/02, documented that resident 6 "wanders with no rational purpose and seemingly oblivious to needs or safety frequently." One of the nursing interventions documented " if unsafe to ambulate independently, accompany him on a walk in/out of the facility at least one time every day." Resident 6 was also care planned for being at risk for	F 221		

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F 221	Continued From page 8	F 221		

falls. One of the nursing interventions documented "assist prn [as needed] with ambulation, transfers, ect. To minimize risk for falling."

There was no documented care plan, including goals and interventions, which addressed restraints.

A nurse aide was interviewed on 9/12/02 at 2:00 PM. The aide stated that he/she had observed resident 6's legs caught in his side rails once approximately 3 months ago. The aide stated that resident 6 was more alert 3 months ago.

A night shift nurse aide was interviewed on 9/12/02 at 2:10 PM. The aide stated that he/she had observed resident 6 "...stick his legs out in the side rail." The aide stated that resident 6 would try to get out of bed and would sometimes fall out of bed.

A nurse, familiar with resident 6's care, was interviewed on 9/12/02 at approximately 2:30 PM. The nurse stated she was unaware that resident 6 used side rails while in bed. The nurse also stated that resident 6 had experienced a change of condition over the past week and had been in bed during the day.

The DON was interviewed on 9/11/02 at 4:00 PM. The DON stated that the nurse who had been working on restraint assessments was not available. She stated that she was unsure where the restraint assessment information was kept.

The DON was interviewed on 9/12/02 at approximately 1:00 PM. The DON was able to contact the nurse responsible for completing the restraint assessments and stated that the restraint assessments should be in the chart. The DON also stated that she was aware that the facility was behind in completing some of the restraint assessments.

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F 221	Continued From page 9	F 221		

4. Resident 7 was admitted to the facility on 12/28/01 with diagnoses of chronic right hip fracture, edema of the right leg, and chronic arterial disease, depression and osteoarthritis. Resident 7 resides in the SNU unit.

On 9/11/02 at approximately 4:15 PM, resident 7 was observed in her room, lying in bed with full side rails on both sides of her bed.

On 9/12/02 at 2:00 PM, resident 7 was observed in her room, lying in bed with full side rails up on both sides of her bed.

Resident 7's medical record was reviewed on 9/11/02.

An MDS assessment, completed by facility staff on 6/13/02, documented that resident 7 had short and long-term memory problems and her cognitive skills for daily decision-making were moderately impaired. The facility also documented that resident 7 had periods of altered perception or awareness of surroundings. The facility staff documented that resident 7 was able to transfer with extensive assistance. Resident 6 was also assessed as requiring full side rails on all open sides of the bed on a daily basis.

No documentation was found in resident 7's medical record that the interdisciplinary team had performed an assessment, attempted alternatives, determined the medical need for the restraint or identified the least restrictive device for resident 7, prior to initiating the use of full side rails on both sides of her bed.

There was no documented physician's order for resident 7 to have full side rails on all open sides of the bed.

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F 221	Continued From page 10	F 221		

A review of resident 7's fall care plan was completed. The care plan, dated 1/10/02, documented that resident 7 had "Inappropriate behavior: wandering, crying out, talking nonsensical r/t [related to] Alzheimer's disease and dementia." One of the documented nursing interventions was to protect resident 7 from injury but maintain her independence at a functional level.

Resident 7 was also care planned for having a loss of bone mass with brittle bones that were prone to fracture.

There was no documented care plan, including goals and interventions, which addressed restraints which included side rails.

A nurse's note, dated 7/2/02 documented, "....at 9 P [PM] res [resident] got arm caught in bed rail and got a V shaped skin tear much bleeding cried out in pain. Did not feel necessity for MD [medical doctor] call or call to home at this time of night. Tear was dressed [after] cleansing with wound cleanser and then covered with Kerlix. Hospice ntfd [notified] She slept well pp [pain pill] given. Ntfd [notified] tx [treatment] nurse so he can set up routine for treatment. Hospice nurse said she did not think it necessary to call MD [medical doctor]."

On 9/12/02, the administrator in training was asked for the incident report relating to the injury resident 7 received on 7/2/02 . The administrator could not provide an incident report for the 7/2/02 incident.

A nurse, familiar with resident 7's care, was interviewed on 9/12/02 at approximately 2:30 PM. The nurse stated that the side rails were used for resident 7's safety to prevent her from rolling out of the bed.

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F 221	Continued From page 11 5. Resident 8 was admitted to the facility on 4/5/02 with diagnoses of chronic obstructive pulmonary disease, chronic arterial disease, renal insufficiency, de-conditioning, hypertension, dementia with psychotic features, hyperlipidemia, and subdural hematoma. The physician's recertification orders for resident 8, dated August 2002, documented the following under restraints, "geri chair as need may use geri chair when oob [out of bed] for safety d/t [due to] fall risk. Siderails up x [times] 2 (both side rails) when in bed as needed. SR [side rails] x [times] 2 while in bed, release every 2 hrs [hours] x [times] 10 minutes for nursing cares." Resident 8 was observed to be residing in the SNU. He was observed to have a low bed and siderails were not being used. On 9/11/02, at approximately 4:15 PM, resident 8 was observed wearing a soft waist restraint while in his wheelchair. On 9/12/02, at 2:00 PM, resident 8 was observed, in his room sitting in a recliner with the footrest up, wearing a soft waist restraint. An MDS assessment completed by staff on 7/28/02, documented that resident 8 had a short and long term memory problem and his cognitive skills for daily decision making were moderately impaired. The staff also documented that resident 8 wandered. The facility staff documented that resident 8 was able to transfer with limited assistance and was able to ambulate with limited assistance. A care plan, dated 5/7/02, documented that resident 8 "needs a vest restraint for safety rt [related to]	F 221		

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F 221	Continued From page 12	F 221		

restlessness secondary to dementia with psychotic features." One of the documented interventions was to apply a vest according to the physician orders.

There was no documented physician order for a vest restraint.

There was a care plan, dated 5/19/02, which identified as a problem the need for resident 7 to use a soft waist restraint for safety related to restlessness secondary to dementia with psychotic features.

There was no documented care plan, including goals and interventions, which addressed the use of a geri chair.

Further review of resident 8's medical record documented the following nurse's notes and physician's orders

A nurse's note, dated 5/6/02, documented, "pt [patient] was placed in a low bed d/t [due to] falls risk."

A nurse's note, dated 5/7/02 at 10:45 AM, documented that resident 8 was found tipped over in his wheelchair on the floor. The nurse obtained a physician's order for a lap buddy and seat belt for his safety when he was in his wheelchair. The note also documented that resident 8 was sent out of the facility to be treated for a laceration.

A nurse's note, dated 5/7/02, documented that resident 8 returned to the facility and was placed in a low bed.

A physician's telephone order, dated 5/7/02, documented "may use lap buddy and seat belt as needed for safety to prevent fall."

A nurse's note, dated 5/8/02, documented "order

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	465065	A. BUILDING _____ B. WING _____	C 9/12/2002

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

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F 221	Continued From page 13 written to d/c [discontinue] lap buddy/seat belt restraints, may use geri chair instead." A physician's telephone, dated 5/8/02, documented "may use gerichair when oob [out of bed] for safety dt [due to] fall risk. D/C [discontinue] lap buddy, seat belt restraints." A nurse's note, dated 5/10/02, documented "...up in Geri chair with self release SWR [soft waist restraint] check q [every] min [minutes] release ever 2 [hours]... ". There was no documented physician's order for resident 8 to use a soft waist restraint after it had been discontinued on 5/8/02. A nurse's note, dated 5/23/02, documented "....vest restraint applied....no agitation noted." A nurse's note, dated 5/26/02, documented "...vest restraint applied...no agitation noted." A nurse's note, dated 5/30/02, documented "....Up in w/c [wheelchair] [with] vest restraint, also in geri chair for a time." A review of the physician's orders revealed that there was no documented physician's order for resident 8 to use a vest restraint. A nurse's note, dated 5/31/02, documented "...waist restraint on " A nurse's note, dated 6/7/02, documented that resident 8 had been moving about the SNU in a merry walker and he tipped over sideways in the merry walker. There was no documented physician's order for	F 221		

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F 221	Continued From page 14 resident 8 to use a merry walker. A nurse's note, dated 6/8/02, documented "...Resident was in hall in w/c [wheelchair]. Restraint on. Resident tried to stand up et [and] walk pulling w/c [wheelchair] over [with] him. Resident fell with glasses on nose. Abrasion above r [right] eye. Bruises noted on face. Resident bit tongue... lap buddy put on chair..". A nurse's note, dated 6/9/02, documented "up in gerichair-restraint on." A nurse's note, dated 6/20/02, documented "...restrained in w/c [wheelchair]". A nurse's note, dated 6/21/02, documented "amb [ambulated] [after] brkfast [breakfast], then in merry walker." A nurse's note, dated 6/26/02, documented resident "...up in wheelchair. Restraint on...". A nurse's note, dated 7/3/02, documented "...got out of chair unassisted x [times] 2 [released restraint]...". A nurse's note, dated 7/10/02, documented "....Res [resident] can walk but d/t [due to] falls and unsteadiness uses a w/c [wheelchair] with belt for safety...". A nurse's note, dated 7/14/02, documented "...Soft waist belt restraint when up." A nurse's note, dated 7/26/02, documented "...Soft restraint on. Leaning forward...". A nurse's note dated 9/5/02 documented "SWR [soft waist restraint] on for safety."	F 221		

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F 221	Continued From page 15	F 221		

A review of the nurse's notes documented that resident 8 had a fall history.

On 6/8/02, it was documented that resident 8 got up and slipped. It was documented that a nurse aide did break resident 8's fall.

On 7/13/02, it was documented that resident 8 climbed out of bed and received a skin tear.

On 7/15/02, staff had documented that resident 8 was found on the floor and received an abrasion above eyebrow from his fall.

On 7/22/02, staff documented that resident 8 was found on the floor by his recliner.

On 7/31/02, staff documented that resident 8 was found with a skin tear.

On 8/4/02, staff documented that a facility aide heard a crashing noise and found resident 8 on the floor with a skin tear.

On 8/6/02, staff documented that resident 8 bumped his head on the wheelchair when he slid to the floor.

On 8/17/02, staff documented that resident 8 fell through a curtain striking his arm on a bed.

No documentation could be found in resident 8's medical record that the interdisciplinary team had completed an assessment for a lap buddy, soft waist restraint, vest restraint, geri-chair or merry walker.

There were no documented physician orders for the lap buddy, soft waist restraint, vest restraint or merry walker.

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F 221	Continued From page 16 A facility aide was interviewed on 9/12/02 at 2:00 PM. The aide stated that resident 8 could understand when spoken to. The aide also stated that she had not observed resident 8 attempt to stand up and walk in his wheelchair with a restraint in place. The aide stated that resident 8 required the use of restraints because he leaned forward in his wheelchair and would try to get out of his wheelchair while in the dining room. She further stated that resident 8 did attempt to get out of bed at night. A facility nurse, familiar with resident 8's care, was interviewed on 9/12/02 at approximately 2:30 PM. The nurse stated the reason why resident 8 required restraints was that he was unsteady on his feet and would often fall.	F 221	Padding for bedrails 10/30/02 was assessed for residents who are at risk for bruising + measures taken to ensure safety by placing padding on bedrails. An incident report system was put into place on 10/2/02. Nurses were inserviced on 10/10/02 on the necessity of reporting "unknown origin" to the D.O.N. or administrator so investigations can take place and proper agencies notified timely. Incidents are reviewed at the IDT meeting weekly to look for any trends →	
F 225 SS=D	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the	F 225		

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F 225	Continued From page 17 administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, medical record review, facility staff interviews, and review of the state survey and certification agency records, it was determined that the facility did not immediately report 2 injuries of unknown origin nor did the facility submit follow up notification to the state agency, within 5 working days of the results of it's investigation for 1 resident. Resident 4. Findings include: Resident 4 was admitted to the facility on 11/13/01 with diagnoses that included Alzheimer's dementia, hypertension and hearing loss. Resident 4 was placed on Hospice care in April 2002 secondary to failure to thrive. On 9/10/02, a review of resident 4's medical record, including review of all documented nurses' notes was completed.	F 225	and assure compliance with regulations. The "Hospice" company in question was notified that their physicians will see their patients timely, or discharge of the patient from the facility will take place. A.D.O.N. D.O.N., Administrator + Social Services will monitor. 10/14/02	

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F 225	Continued From page 18	F 225		

A review of facility incident reports for June 2002, July 2002 and August 2002 was completed.

On 7/18/02, resident 4 had an incident report completed, which documented the following description of injuries, "noticed bruise on resident's chest poss. [possibly] caused by side rails." There was no documentation in the nurses' note dated 7/18/02 about the bruise found on resident 4's chest.

On 8/11/02, the nurse documented the following, "AM cares given. Nurse noticed bruises on face [and] arms. Bruise on both cheeks, 3 on forehead [and] one on each forearm. No falls reported... poss. [possibly] caused by side rail. Will cont [continue] to monitor." On 8/10/02, at 5:00 PM, resident 4 had an incident report completed which documented the same information as the 8/11/02 nurse's note.

On 8/13/02, the Hospice nurse documented the following in the progress notes, "pt. [patient] has bruising on face [and] arms. Spoke with [nurse] [at] facility. She reported that bruises were found on 8/11/02 [and] stated that no one knew what happened."

On 9/11/02, the facility administrator in training and the facility social worker were interviewed. The social worker stated that the above injuries were not reported to the State Survey Agency because the bruises had been attributed to resident 4 attempting to get out of bed over her side rails. No documentation could be provided to indicate an investigation had been completed which showed resident 4's bruises were, in fact caused by her side rails.

Resident 4's injuries should have been immediately reported to the State Survey Agency, an investigation conducted, and the results submitted to this agency

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F 225	Continued From page 19 within 5 working days pursuant to federal long-term care regulations.	F 225		
F 246 SS=E	483.15(e)(1) QUALITY OF LIFE A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and medical record review, it was determined that the facility failed to provide services with reasonable accommodations of individual needs and preferences. Specifically, the facility failed to provide 1 of 5 sample residents and 3 supplemental residents with accessible call light cords. Resident identifiers: 3, 11,12,13. Findings include: 1. On 9/10/02 at 2:45 PM, observation of resident 4's room, revealed that the call light cord was lying on her bedside table. The resident was in a wheelchair approximately 6 feet from the bedside table. The call light was not accessible to the resident. A review of resident 4's quarterly MDS (minimum data set) assessment dated 7/28/02, documented that resident 4 required limited assistance with 2 person physical assist for transfers and had severely impaired cognitive skills for decision making. Two facility nurse aides and a family member of the resident stated that resident 4 could and would use the call light. Resident 4's family member stated that at times, even when the resident had access to the call light cord, the angle was such that she was not strong enough to pull it on.	F 246	Call light cords have been assessed for proper lengths and ability to be placed in accessable areas. Nursing staff have been inserviced on the need to be aware of residents ability to reach cords in bed and at bedside. A.D.O.N & D.O.N. and charge nurses to monitor. 10/14/02	

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F 246	Continued From page 20 2. On 9/10/02 at 2:50 PM and 4:15 PM and 9/11/02 at 1:10 PM, resident 11 was observed in his room lying in bed. The call light cord was dangling down the wall behind the bed curtain and was not accessible to the resident. A review of resident 11's quarterly MDS assessment dated 8/18/02 documented that resident 11 was independent with ambulation, transfers and bed mobility and had moderately impaired cognitive skills for decision making. However, if the resident were to have an emergency situation, the call light would not be accessible to call for assistance. The resident was able to verbalize the appropriate use of the call light. 3. On 9/10/02 at 2:47 PM and 4:15 PM, resident 12 was observed in her room lying in bed. The call light cord was lying on the floor underneath the leg of her bedside table. The call light was not accessible to the resident. On 9/11/02 at 1:08 PM, resident 12 was not in her room, however, the call light cord was still lying on the floor underneath the leg of her bedside table and would not be accessible for her to call for assistance. A review of resident 12's quarterly MDS assessment dated 6/17/02, documented that resident 12 required limited assistance with 2 person physical assist with transfers and had moderately impaired cognitive skills for decision making. The resident was able to verbalize the appropriate use of the call light. 4. On 9/10/02 at 3:00 PM, resident 13 was observed in her room sitting in a chair beside the bed. The call light cord was hanging from the wall down behind her bed. The call light was not accessible to the resident. A review of resident 13's quarterly MDS dated 8/4/02, documented that resident 13 was independent with mobility and transfers and had modified independence regarding decision making. However, if the resident were to have an emergency situation, the call light would not be accessible to call for assistance. The resident was able to demonstrate appropriate use of the	F 246		

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F 246	Continued From page 21 call light.	F 246		
F 323 SS=G	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 observation, record review and interview it was determined that the facility did not ensure that the resident environment was as free of accident hazards as possible as evidenced by 1 of 5 sampled residents experiencing injuries on at least 3 occasions that the facility related to the use of side rails. Resident identifier: 4. Findings include: Resident 4 was admitted to the facility on 11/13/01 with diagnoses including Alzheimer's dementia, hypertension, right hip repair and hearing loss. The resident's medical record was reviewed on 9/10/02. The August physician re-certification orders documented the following under restraints, "Side rails when in bed as needed SR [side rails] x [times] 2 while in bed, release q [every] 2 hrs [hours] x [times] 10 min [minutes] for nursing cares". Resident 4 was observed in bed with both full, unpadded side rails up on the following dates: 9/10/02 at 2:50 PM 9/11/02 at 1:50 PM 9/12/02 at 10:40 AM and 1:30 PM On 9/11/02, at 2:00 PM, a nurse's aide familiar with	F 323	This deficiency requires the same plan of correction as those cited in F221 and has been answered accordingly. The D.O.N. and A.D.O.N. are responsible to monitor 10/14/02	

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F 323	Continued From page 22	F 323		

resident 4's care was interviewed. The aide stated that staff members often observe resident 4 trying to get out of bed. The aide also stated that resident 4 often rolls around in the bed and almost daily rolls into the side rails.

On 9/12/02 at 1:30 PM, a nurse familiar with resident 4's care was interviewed. She stated that resident 4 used side rails while in bed because she moved around in bed a lot and would often try to get up.

On 9/10/02 at 3:45 PM, review of the facility incident reports was done and documented the following injury incidents:

a. On 6/22/02, resident 4 had an incident report completed, which documented the following description of injuries, " CNA doing cares in A.M. pointed out bruise on resident's [left] cheek-states wasn't there yesterday. Poss [possibly] hit siderail".

A note, dated 6/24/02, written by the social worker and provided to the survey team via fax on 9/13/02 documented the following, " [resident 4] has had some bruising on her face and chest. This bruising has been caused by her trying to get out of bed over the side rails. This was observed by Social Services while watching from the hallway."

b. On 7/18/02, resident 4 had an incident report completed, which documented the following description of injuries, "noticed bruise on resident's chest poss. [possibly] caused by side rails."

c. On 8/10/02, resident 4 had an incident report completed, which documented the following description of injuries, "around dinner time resident was found to have numerous bruises to face. Bruises on both cheeks. 3 on forehead, 1 on each forearm. No

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F 323	Continued From page 23 fall reported. Poss. [possibly] caused by side rail". On 9/11/02, the facility administrator in training and social worker were interviewed. The social worker stated that padding resident 4's side rails was recently discussed with one of her family members but nothing had yet been done. There was no documented evidence that following any of the injuries the interdisciplinary team re-evaluated resident 4's use of full side rails while in bed. There was no documented evidence that methods were discussed which would make resident 4's use of side rails less harmful or decrease the residents potential danger for injury.	F 323		
F 387 SS=D	483.40(c)(1)&(2) PHYSICIAN SERVICES The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that 1 of 5 sample residents was not seen by a physician at least every 60 days as required. Resident Identifier 4. Findings include: 1. Resident 4, a 97 year old female, was admitted to the facility on 11/13/02 with diagnoses including Alzheimer's dementia, hypertension, and hearing loss. A review of resident 4's clinical record documented	F 387	The Medical Record clerk and D.O.N. made efforts to notify the physician and remind him of timely visits. The physician chose not to comply. The Administrator upon hire let the hospice company know that this behavior was unacceptable	

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F 387	Continued From page 24 that she was seen by a physician on 2/12/02 and 3/20/02. Resident 4 should have been seen by a physician on or around 5/20/02 and 7/20/02. There was no documented evidence in the clinical record that resident 4 had been seen by a physician. The facility administration was asked by the survey team to provide documentation that resident 4 had been seen by a physician on or around 5/20/02 and 7/20/02. They were unable to locate any documentation to evidence that resident 4 had been seen by a physician in May 2002 or July 2002 for a 60 day review.	F 387	and that in the future if the physician did not respond timely and within regulatory time limits, the patient would be immediatly discharged because of neglegence of the physician. Monitoring by Medical Records, D.O.N and Administrator 10/14/02 9/25/02 - Inservice was done by D.O.N. and A.D.O.N. to Nurses on the locking and maintaining of the Med. Carts when left unattended. Monitoring done by A.D.O.N. and D.O.N., Administrator 10/14/02	
F 432 SS=D	483.60(e) PHARMACY SERVICES In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and physically testing the medication carts to assess whether their medication storage drawers were secure, it was determined that the facility did not always maintian drugs in a locked compartment.	F 432		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 432	Continued From page 25 The medication cart by the nursing station was physically tested on 9/10/02 at 2:30 PM and was found to be unlocked and unattended till 2:32PM. The director of nursing (DON) was interviewed at 9/10/02 at 2:30 PM. The DON stated that there should be one nurse on the floor. A nurse was observed to be walking the 100 hall on 9/10/02 at 2:45 PM. The nurse stated that she ran into a meeting to get handouts. The medication cart by the nursing station was observed on 9/10/02 at 3:58 PM to be unlocked. The medication cart was then physically tested and found to be unlocked and resident medications unsecured. There were 2 nurses present at the nursing station, however, neither were watching the medication cart. One nurse was talking on the phone and the other was charting in a resident medical record.	F 432		

October 17, 2002

Shilo N. Jackson
Utah Department of Health
Bureau of Medicare/Medicaid Program
Certification and Residient Assessment
P.O. Box 144103
Salt Lake City, UT 84114-4103

Dear Ms. Jackson,

Thank you for helping me complete the plan of correction for the complaint survey dated 9/12/02. I believe that all issues have been addressed in this addendum. If I have overlooked anything else, I will gladly work with you to correct it. You may reach me anytime on my mobile phone at 643-0167.

Sincerely,

Jeffrey L. Ruth
Administrator
Infinia Health Care of Ogden
524 E. 800 N.
Ogden, UT 84404
Provider #465065

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Provider # 465065

Addendum to POC dated 9/12/02

F221

1. The facility holds QA meetings quarterly, of which the next one is scheduled for 10/18/02. Restraint usage is monitored during this meeting.
2. Restraint audits are done quarterly during the IDT updates.
3. IDT meetings occur weekly.

F225

1. The facility looks at any identified abuse cases quarterly in the QA meetings.
2. Audits on identified abuse cases as performed by the D.O.N./ A.D.O.N. are to be done as soon as notification to them occurs. Incident reports are reviewed daily.

F246

1. Staff were inserviced on call light cord placement on 10/10/02.
2. During nursing rounds (12 hours), the nurses look for proper placement of cords. This is part of the "Rounds Check List". The D.O.N./ A.D.O.N. will monitor weekly.
3. Call light cord positioning will be monitored by CNA's and nurses on a shift by shift basis. QA will address identified systemic issues on a quarterly basis.

F323

1. Resident #4 had the necessary assessments, T.O.'s, careplan updates and documentation written in her chart. The resident was assessed for restraint use and the need for padding on siderails. Padding has since been ordered and put in place.
2. Incident reports are being reviewed in IDT weekly and hazards being addressed immediatley as found. Incident reports will be reviewed quarterly in QA.
3. Audits on hazards will be done quarterly in preparation for the QA meeting.
4. IDT meetings are held weekly.

F387

1. An agreement between the Facility and the Medical Director exists. The Medical Directror will be the primary physician in circumstances where the residents attending physician fails to perform his/her duty.
2. The facility will review situations where physicians fail to perform their duties in the quarterly QA meeting.
3. Audits on physician visits are done monthly by medical records.

F432

1. The monitoring of medicine cart locking is done PRN by the D.O.N./ A.D.O.N.. Problems are addressed immediately with nursing staff. Discussion of persistent problems will be addressed in quarterly QA meetings.
2. Audits are performed as addressed in #1 above.
3. Nurses were inserviced on the locking of Medicine Carts on 10/10/02.