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 ______	04/13/2006

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) COMPLETION DATE
F 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 1 of 11 sample residents, the facility did not immediately consult with the resident's physician when there was a	F 157	F157 The Director of Nursing has reviewed the current condition of resident # 8 to determine if the resident has had any change of condition, wherein proper notification would have been placed should the resident had a change. The Director of Nursing has met with every licensed nurse employed at the facility and has reminded all of their required duty to inform the resident's physician of any changes to every residents condition. To ensure that the facility continues to inform the appropriate party regarding a resident's change of condition, the licensed nurses will complete a 24 hour report each day. All change of conditions will be reported to the attending physician and resident's responsible party. Contact will be documented in resident's chart. Random audits will be conducted by Nursing Administration.	

5/23/06 POC acceptable & addendum completion date 6/1/06 (Brenbacher)

Utah Department of Health
755857
MAY 09 2006
Bureau of Health Facility Licensing, Certification and Resident Assessment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carriyn P Sears | TITLE: Administrator | (X6) DATE: 5-8-2006

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are 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 ______	04/13/2006

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) COMPLETION DATE
F 157	Continued From page 1 significant change in the resident's physical status. Specifically, throughout the night of 2/18/06, resident 8 exhibited signs and symptoms of gastrointestinal bleeding. The nurse did not notify the resident's physician or any other physician of these findings. Resident 8 was transferred to the hospital by the day nurse and was found to have a hematocrit of 16, a critical laboratory value. Resident 8 received two units of blood within 70 minutes of her arrival and was transferred to the intensive care unit. Findings included: Resident 8 was an 83 year old female who was initially admitted to the facility on 2/2/06. One of her admitting diagnoses was a history of gastrointestinal bleeding. During interview with resident 8 on 4/13/06, the resident stated that there had been a night "a few months ago" when she had been vomiting blood and having bloody stools through the night. The resident stated that she felt the night nurse had not assessed her as she should have. The medical record of resident 8 was reviewed on 4/13/06. Nurses notes, dated 2/18/06, documented the following: The night nurse documented at 3:00 AM - "HS (evening) cares given. C/o (complains of) nausea et (and) vomiting. Phenergan given X (times) 1. Medicated for pain X 2. Call light within reach." The day nurse documented at 10:00 AM - Res.	F 157	The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator "Change of Condition" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ______	04/13/2006

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) COMPLETION DATE
F 157	Continued From page 2 (resident) with coffee ground emesis et (and) sticky black stools thru -out noc (night) according to noc (night) nurse et (and) res. (resident). Res. has extreme pallor, abd (abdomen) slightly distended et (and) tender to palpation. BS (bowel sounds) AX4 (active times four) quads (quadrants). Cont (continues) to c/o (complain of) nausea. Unable to take AM (morning) meds, given phenergan IM (intramuscular) X 1 with minimal relief of nausea. Res. sent to ER (emergency room) via ambulance for eval (evaluation) et (and) tx (treatment)." The emergency room/hospital record for resident 8 was obtained from the hospital on 4/13/06. The physician's "critical care progress note", dated 2/18/06, documented the following: "The patient is an 83-year-old female who recently was hospitalized for an anterior septal myocardial infarction. She apparently had a GI (gastrointestinal) bleed...The patient has returned to the emergency department today for evaluation of melena (blood in the stools) and hematemesis (vomiting blood), which began earlier today. The patient was found to have a hematocrit (measures percentage of red blood cells in blood) of 16, she has been transfused with two units of packed red blood cells and she apparently was hypotensive in the emergency department. She was transferred to the intensive care unit in essentially stable condition..." The hospital laboratory was called on 4/25/06 and asked to define their reference range for a hematocrit on an adult female. The hospital's laboratory reference values for a normal	F 157		

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 ____	04/13/2006

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) COMPLETION DATE
F 157	Continued From page 3	F 157		

hematocrit in an adult female were 36 to 46%. The laboratory staff person stated that for an adult female, anything below 20 or above 60% is a "critical" value.

The nurse who worked the night shift of 2/18/06 was interviewed via telephone on 4/13/06 at 9:01 AM. The nurse was asked to describe the events of the night of 2/18/06 in regards to resident 8. The nurse stated that resident 8 was having "dark, coffee looking stools" and had been vomiting. The nurse added "I wasn't sure if it was anything or not." The nurse was asked if she performed a guiac on the stools. The nurse responded, "What's that?" (The term guiac is a common nursing term used to describe the test that identifies the presence of occult blood in a persons stool. The nurse places a small amount of stool on a special testing card and adds a drop of a reagent.)

This night nurse was then asked if she called the physician as there was no documentation in her notes for resident 8 for the night of 2/18/06 that she attempted to notify the physician of these signs and symptoms of a gastrointestinal bleed. The nurse stated that she tried to call the physician but "got no response back."

There was no documentation in the medical record of resident 8 to evidence that the nurse who worked the night of 2/18/06 performed a thorough assessment of the resident, including vital signs. There was no documentation of resident 8 having episodes of bloody stools or that she had been vomiting blood. There was no documentation to evidence that the nurse was aware of the meaning of these symptoms.

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 ______	04/13/2006

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) COMPLETION DATE
F 157	Continued From page 4 There was no documentation that the nurse attempted to notify the physician of the bloody stools or of the blood in resident 8's vomit. Resident 8 did not arrive at the hospital until 10:08 AM where she was found to have a hematocrit of 16, a critical laboratory value. The physician wrote orders for "2u (units) type specific blood stat." Resident 8 was then transferred to the intensive care unit.	F 157		

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 ____	04/13/2006

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) COMPLETION DATE
F 164 SS=E	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on comments made during the confidential group interview and additional confidential resident interviews, it was determined that the facility did not provide privacy during times when personal cares were being provided.	F 164	F164 The Social Worker has spoken to all members of the resident Council and has informed each one of them that personal privacy during shower times has been addressed to all staff and will no longer be a concern for residents being viewed by other staff members not involved in the giving of the showers. The Director of Nursing and Assistant Director of Nursing will conduct an in-service to all employed staff of the privacy rights of the residents while being showered and that the shower door will continue to always be closed while giving a shower and that the shower curtain are always pulled to enclose the person being showered. In addition, once the shower door is closed, it will not be open unless an appropriate reason merits opening the door, such as an emergency.	

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 ______	04/13/2006

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) COMPLETION DATE
F 164	Continued From page 6 Findings included: A confidential group interview was held on 4/11/06. Six residents were present in the interview and all six participated. When asked about privacy, 3 of the 6 residents stated that other staff members had come into the shower room when they were being showered or assisted to shower. The residents stated that the other staff saw them without clothes on. One of the six residents stated that this made him feel "embarrassed". All 3 residents agreed that this had happened more than once. During an additional confidential resident interview on 4/12/06, the resident stated that other staff had come into the shower room while he/she was being showered and this had happened more than once.	F 164	To ensure that the facility continues to provide all residents with their right for personal privacy during shower times, it will be asked during the monthly resident council meeting if the facility is respecting the rights of the residents for such privacy and any responses will be reported on the resident council minutes The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:	
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of 5 employee personnel records, it was determined that the facility did not develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and	F 226	Under the quality assurance program, the form indicator "Resident Rights" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ___	04/13/2006

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) COMPLETION DATE
F 226	Continued From page 7 misappropriation of property. Specifically, the facility did not complete Back Ground Criminal Information screening for 4 out of 5 employees hired and two of two nurses' licenses were not checked for restrictions or abuse prior to their hire date. Findings include: On 4/11/06 facility employee files and the facilities policy and procedure for prohibiting abuse were reviewed. Review of the facilities policy and procedure for prohibiting abuse revealed a section for the screening of staff. The following is the procedure the facility operationalizes to identify and prevent abuse: "- All potential employees will be screened as part of the application process to determine if there is a history of abuse, neglect, or mistreatment of individuals. This will include completion of the Criminal Background Form, which will be sent to the Department of Health and registry if applicable. -..... - Screening will also include contact with the appropriate licensing board at Division of Occupational and Professional Licensing or the Nursing Assistant Registry. -.... - If screening process indicates any history of abuse or misappropriation of property, the individual will not be hired. - Continued employment is contingent upon information obtained from the background check."	F 226	F226 The Assistant Director of Nursing pulled the same 5 employee files that were reviewed during survey and has conducted Back Ground Criminal Information screening on the remaining 4 employees. In addition, the two Licensed Nurses who's licenses were not check, have now been verified. The Assistant Director of Nursing will audit all other employees and verify that all have received Back Ground Criminal Information screenings. In addition, the files for all other licensed nurses will be verified that the facility has checked for active and good licensure standing. To ensure that the facility continues to use proper screening of all employees that are considered for hire, all hiring managers will follow facility written policies and procedures wherein all employees will be properly screened through Background criminal Information checks and all licensed nurses will not be hired until confirmation has	

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 ______	04/13/2006

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) COMPLETION DATE
F 226	Continued From page 8 On 4/11/06 5 facility employee files were reviewed. Review of these files revealed that 4 of 5 newly hired employees (employees A, C, D, and E) did not have a current Background Criminal Information form completed and sent to the Department of Health for approval. Review of the employee files revealed that 2 of 2 newly hired licensed nurses (employees B and C) were not screened or there license not verified through the Department of Occupational and Professional Licensing prior to their hire date.	F 226	been obtained to current and good standing licensure. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator "Abuse Prohibition" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Findings included: The following observations were performed on 4/10/06 at 6:05 AM: Please note that all measurements noted in this tag are approximated, not actual. . The carpet within the locked unit had numerous	F 253		

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 ____	04/13/2006

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) COMPLETION DATE
F 253	Continued From page 9 (more than 20) large stains. There was visible dust and debris on the carpet. The locked unit had an unpleasant odor. The dining room within the locked unit had a linoleum floor which appeared not to have been swept. There was a cotton ball on the floor with a dark red spot in the middle of it. There were popcorn fragments in the corner near the sink. The dining room tables had some dried food spills on them and some sticky cup rings. The heater unit in the dining room (to the left of the door) had the front panel hanging off and had dust build up on it. The kitchenette in the dining area had a missing wooden drawer. In the dining area on the floor near the sink, there was a plastic crate containing pvc tubing. The white tubes had multiple areas of a dried brown substance on them. The family/TV room on the locked unit had numerous stains on the carpet. This room had a very unpleasant odor. The wallpaper around the heater unit was ripped in several places. Continued observations from 4/10/06 and 4/11/06: Room 102: There was a 30 inch by 10 inch area on the wall across from bed A which was had been spackled but not painted. Room 106: There was an 8 inch by 10 inch area on the wall across from bed A, under the vent, which was	F 253	F253 During the survey process, the Administrator hand delivered a check off list to the survey team leader of the following housekeeping/maintenance areas that were fixed during their visit: Carpet within the locked unit was professionally steamed cleaned. The linoleum floor within the unit was swept and cleaned. The dining room tables were cleaned of any sticky substance. The heater unit panel face in the dining room was correctly fixed to fit appropriately. The kitchenette missing drawer was replaced with a new one. The plastic PVC tubing were cleaned or thrown away.	

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 ______	04/13/2006

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) COMPLETION DATE
F 253	Continued From page 10 unpainted. In the hallway, above the doorway for room 106, there was a 12 inch by 18 inch piece of ceiling tile missing. Vents and insulation were exposed. The tile next to this had a 12 inch by 18 inch water stain. The resident who resided in this room was interviewed on 4/11/06 at 7:10 AM. He stated that when it rained, the ceiling in his room leaked in several places. One leak he pointed out came down the wall across from bed A and very near (within 5 inches) an electrical outlet. Room 108: In the hallway, above the door for room 108, there was also a 12 inch by 18 inch piece of ceiling tile missing. In the Main Activity room (had the piano), there were cracked and dirty tiles in front of the exit door. Also in this Main Activity room, there was a ceiling vent which appeared to have water damage around it which measured 4 inches by 10 inches. The paint around this vent was peeling. In the Main Dining area, there was a ceiling vent which appeared to have significant water damage. The paint and main ceiling were gone, the underboard was exposed. There was a bucket under this vent with a large bath blanket next to it. Two residents who were sitting in the main dining area were interviewed on 4/10/06 at 7:15 AM. They were asked about the bucket and the bath blanket on the floor. The residents stated that the	F 253	Repairs completed in Room 102, 106, 108, 403, 409 and repairs/deep cleansing performed in the 100 hall shower room and locked unit shower room. Brand new weather stripping installed on the front entry doors. A few days after the survey team left, two full boxes of brand new ceiling tiles replaced old and stained ceiling tiles. The maintenance Supervisor performed a facility walk through to determine if there were any additional maintenance or housekeeping repairs that needed to be attended to.	

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 ____	04/13/2006

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) COMPLETION DATE
F 253	Continued From page 11 ceiling "leaks all over the place" and "it leaks every time it rains or snows." There were six ceiling tiles in the hallway near the nurse's station were water damaged. One of these six tiles appeared to have blackish-grey spotting in multiple places. On 4/10/06 at 12:35 PM, there were 13 live ants in the main dining area along the outer walls. On 4/10/06, at 12:40 PM, it was noted that the main entry doors were without weather stripping. Sunlight could be viewed under neath the doors at least .5 inches by the full length of the doors (6 feet). A gray bug was viewed coming inside the facility under these doors. The emergency exit in the main dining room did not appear to seal the bottom 6 or 7 vertical inches. Sunlight could be viewed coming through the side of the door. The central supply room ceiling had extensive water damage. One area of water damage was an area of 24 inches by 30 inches by 18 inches which partially surrounded a light fixture. There were water stains running down the wall to the baseboards and the floor. A ceiling vent in this room had water damage around it which measured 36 inches by 18 inches. During interview on 4/12/06, the central supply staff person verified that the ceiling leaked when it rained. Shower room in 100 hall: The shower room in the 100 hall had water	F 253	To ensure that the facility provides housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, the Administrator or the Maintenance Supervisor will perform a facility walk through weekly and document it on the facility walk through report that requires 50 specific questions to be answered with a performance score and follow up to be conducted on any low scores. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator "Maintenance Repairs/Reports" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ______	04/13/2006

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) COMPLETION DATE
F 253	Continued From page 12 damage to the wall next to the shower. The paint on the wall was peeling and rippling. There were holes in the paint. The total area of water damage was 3 feet by 8 inches. The light fixture on the ceiling was falling away from the ceiling approximately 1 to 1.5 inches at the end closest to the wall. This room also had a blue wire container which held a box of gloves. The blue wire was covered in a yellowish soap residue. The shower chair sitting within the shower stall had brownish and yellowish streaks on it. Room 403: The bathroom for this room had a white bar of soap sitting on the side of the sink. The bar of soap appeared very dirty with a brownish substance embedded in it. This bar of soap was observed in this bathroom on 4/10/06 and 4/11/06. During interview with a resident from room 403, she stated that she had asked staff multiple times to clean the brown substance off the bathroom floor which was visible around the metal piping. This was visible to surveyors on 4/11/06. Room 409: In the bathroom for this room, there was a 10 inch by 18 inch area on the wall which had been spackled but not painted. There was a 1.5 inch by 2 inch area next to the soap dispenser where the wall board was exposed. The putty behind the sink was cracked. Shower room on locked unit:	F 253		

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 ______	04/13/2006

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) COMPLETION DATE
F 253	Continued From page 13 The shower room within the locked unit had brownish smears on the floor of the shower. The remainder of the shower floor appeared to be a greyish-yellow color. There was a round bar of dirty soap on the floor next to the shower. There was also a container of lotion which had several splotches of lotion on the floor next to it. Near the shower, there was a blue lap buddy that had a brown chunk on it.	F 253		
F 275 SS=D	483.20(b)(2)(iii) RESIDENT ASSESSMENT-WHEN REQUIRED A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview with the facility Minimum Data Set (MDS) Coordinator and review of resident medical records, it was determined that for 1 of 11 sample residents, the facility did not complete an annual assessment. Resident identifier: 2 Findings include: Resident 2 was admitted to the facility on 8/12/00. The facility completed an annual assessment for Resident 2 on 3/31/05. Per review of resident 2's medical record, the resident has resided in the facility continuously since 8/12/00. The facility completed the following quarterly MDS assessments for resident 2 since 3/31/05: 6/26/05, 9/21/05, 12/20/05.	F 275	F275 The MDS Coordinator, along with the Interdiscipinary Team, will schedule with resident # 2, a time to meet and hold an annual assessment. The MDS Coordinator will review all current charts of the residents to verify that all annual assessments are current. To ensure that the facility continues to conduct annual resident assessments, a schedule will be sent out to team members and followed according to assessment due date.	

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 ________	04/13/2006

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) COMPLETION DATE
F 275	Continued From page 14 An interview was held the the facility MDS Coordinator on 4/11/06 at 2:00 PM. The MDS Coordinator stated she was new to the position, starting in March 2006. She stated that she was trying to catch up, and that some MDS assessments were past due. When asked by the surveyor, the MDS Coordinator stated that resident 2's annual MDS assessment was due 3/16/06 and that it had not yet been completed.	F 275	The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator "Comprehensive Resident Assessment and Care Plan" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06
F 276 SS=E	483.20(c) QUARTERLY REVIEW ASSESSMENT A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and review of resident medical records, it was determined that for 2 of 11 sample residents, the facility did not assess the residents using the quarterly review instrument specified by the State and approved by CMS not less frequently then once every 3 months. Resident identifiers: 5, 10. Findings include: 1. The facility completed a quarterly assessment for resident 5 on 12/20/05. At the time of survey, 4/10/06 through 4/13/06, facility staff had not yet completed the next quarterly assessment which would have been due on or about 3/20/06. 2. The facility completed a quarterly assessment	F 276	F276 The MDS Coordinator, along with the Interdisciplinary Team will schedule with resident # 5 and #10 a time to meet and hold a quarterly assessment. The MDS Coordinator will review all current charts of the residents to verify that all quarterly assessments are current. To ensure that the facility continues to conduct quarterly resident assessments, a schedule will be sent out to team members and followed according to assessment due date.	

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 ______	04/13/2006

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) COMPLETION DATE
F 276	Continued From page 15 for resident 10 on 12/27/05. At the time of survey, 4/10/06 through 4/13/06, facility staff had not yet completed the next quarterly assessment which would have been due on or about 3/27/06.	F 276	The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator “Comprehensive Resident Assessment and Care Plan” will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06
F 279 SS=E	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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 services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined that for 3 of 11 sampled residents the facility did not develop a comprehensive care plan that included measurable objectives and timetables to meet the	F 279	F279 The MDS Coordinator and the Director of Nursing has reviewed the charts of resident # 3, # 5 and #7 and has developed a comprehensive care plan for each resident that include measurable objectives and timetables to meet all of the resident’s needs. Resident # 7 now has a current comprehensive care plan in the chart. The Interdisciplinary Team has met and reviewed the charts of resident # 5 and Resident # 3. Both charts are now current and each comprehensive care plan describe	

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 ____	04/13/2006

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) COMPLETION DATE
F 279	Continued From page 16 resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. Specifically, resident 7's medical record contained no comprehensive care plan two months after the facility had completed a comprehensive assessment. Resident 5 had fifteen falls with multiple injuries before staff addressed this issue with a care plan. Resident 3 had 23 falls with multiple injuries before staff addressed this issue with a care plan. Findings include: 1. Resident 7 was admitted to the facility on 1/27/06 with diagnoses which included, Diabetes Mellitus, hypertension, cellulitis, Frost-bite, diabetic ulcers, and Bipolar Disorder. Resident 7's medical record was reviewed on 4/10/06. On 4/10/06, the review of resident 7's medical record revealed an initial comprehensive minimum data set assessment completed on 2/8/06. No documentation could be found in the medical record to show that a comprehensive care plan had been developed after the facility completed the comprehensive assessment on 2/8/06. On 4/11/06 the facilities Director of Nursing was interviewed about the missing care plan. She stated that she knew the staff member who completed the care plans was behind and that she would check with the staff member to see where the care plan was located.	F 279	the services that are to be furnished to attain or maintain the residents highest practicable condition. The MDS Coordinator and the Director of Nursing will review all other resident charts to determine that each resident has a current comprehensive care plan that is measurable. To ensure that the facility continues to provide each resident with an appropriate comprehensive care plan, the MDS Coordinator make sure that each resident upon admission, within the given time frame has a comprehensive care plan within their chart. In addition, the director of Nursing or Assistant Director of Nursing will obtain any incident reports from the previous night/ or weekend and bring to the daily stand up meeting, wherein a report will be give regarding all resident incidents, including falls. Upon doing so, the Interdisciplinary Team will schedule to meet and review the care plans for each resident reported of having an incident.	

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 ______	04/13/2006

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) COMPLETION DATE
F 279	Continued From page 17 On 4/11/06 a comprehensive care plan was placed into resident 7's medical record with the print date of 4/10/06. This care plan was placed in the chart 2 months after the facility had completed the comprehensive minimum data set assessment. 2. Resident 5 was a 47 year old male with diagnoses which included anoxic brain damage, brain injury and convulsions. Resident 5 was admitted to the facility on 9/9/05. From 9/23/05 through 12/5/05, resident 5 fell 15 times. Resident 5 suffered injuries during 9 of those 15 falls. Facility staff did not care plan the concern with his falls until 12/20/05. This was 88 days after his first fall. Injuries received by resident 5 included lacerations, abrasions, a hematoma, a swollen wrist, a skin tear and bruises. 3. Resident 3 was a 78 year old female with diagnoses that included anxiety disorder, hypothyroidism, bipolar disorder, osteoarthrosis, tremors and chronic obstructive pulmonary disease. Resident 3 was admitted to the facility on 6/4/04, and readmitted on 7/11/05, after a brief stay at an acute care hospital. From 7/20/05 through 4/11/06, resident 3 fell 35 times. Resident 3 suffered injuries during 14 of those 35 falls. Facility staff did not care plan the concern with her falls until 11/13/05. Resident 3's injuries included: lacerations and hematomas to her head; lacerations, abrasions, and bruises to both lower extremities; and a skin tear to her left	F 279	The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator "Comprehensive Care Plans" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ____	04/13/2006

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) COMPLETION DATE
F 279	Continued From page 18 arm.	F 279		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and review of medical records, it was determined that for 2 of 11 sample residents, the facility did not provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the comprehensive assessment and plan of care. Specifically, one resident (resident 8) exhibited signs and symptoms of gastrointestinal bleeding through the night and did not receive a physical assessment by a nurse to address these symptoms. There was no documentation that the nurse notified the physician. In the morning, the day nurse transferred the resident to the hospital where resident 8 was found to have a hematocrit of 16. Resident 8 was given two units of blood within 70 minutes of her arrival to the hospital and then transferred to the intensive care unit. The second resident (resident 11) was exhibiting signs and symptoms of a fecal impaction for 28 days and did not receive a thorough assessment by a nurse. Also, on the day resident 11 was	F 309	F309 Resident # 8 was transferred to the hospital based upon the medical assessment of the day-shift licensed nurse and according to the physicians orders. Resident # 11 was also transferred to the hospital according to the physicians orders. The Director of Nursing performed an in-service for all licensed nurses regarding assessment of all systems, wherein they are to be included in daily/weekly/monthly documentation. To ensure that the facility provides the necessary care and services to help residents attain or maintain their best overall health, Nursing Administration will perform random chart review on a weekly basis and provide administrator a written report once a month.	

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 ______	04/13/2006

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) COMPLETION DATE
F 309	Continued From page 19 transferred to the hospital, facility nurses documented that his leg was swollen, cold to the touch and that resident 11was unable to move his leg. No further assessment was performed. Upon arrival to the hospital, resident 11 was found to have a fecal impaction and a clot in his leg. Findings included: 1. Resident 8 was an 83 year old female who was initially admitted to the facility on 2/2/06. One of her admitting diagnoses was a history of gastrointestinal bleeding. During interview with resident 8 on 4/13/06, the resident stated that there had been a night "a few months ago" when she had been vomiting blood and having bloody stools through the night. The resident stated that she felt the night nurse had not assessed her as she should have. The medical record of resident 8 was reviewed on 4/13/06. Nurses notes, dated 2/18/06, documented the following: The night nurse documented at 3:00 AM - "HS (evening) cares given. C/o (complains of) nausea et (and) vomiting. Phenergan given X (times) 1. Medicated for pain X 2. Call light within reach." The day nurse documented at 10:00 AM - Res. (resident) with coffee ground emesis et (and) sticky black stools thru -out noc (night) according to noc (night) nurse et (and) res. (resident). Res. has extreme pallor, abd (abdomen) slightly	F 309	The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator(s) "Prevalence of Fecal Impaction & Change of Condition" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ___	04/13/2006

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) COMPLETION DATE
F 309	Continued From page 20	F 309		

distended et (and) tender to palpation. BS (bowel sounds) AX4 (active times four) quads (quadrants). Cont (continues) to c/o (complain of) nausea. Unable to take AM (morning) meds, given phenergan IM (intramuscular) X 1 with minimal relief of nausea. Res. sent to ER (emergency room) via ambulance for eval (evaluation) et (and) tx (treatment)."

The emergency room/hospital record for resident 8 was obtained from the hospital on 4/13/06.

The physician's "critical care progress note", dated 2/18/06, documented the following:

"The patient is an 83-year-old female who recently was hospitalized for an anterior septal myocardial infarction. She apparently had a GI (gastrointestinal) bleed...The patient has returned to the emergency department today for evaluation of melena (blood in the stools) and hematemesis (vomiting blood), which began earlier today. The patient was found to have a hematocrit (measures percentage of red blood cells in body) of 16, she has been transfused with two units of packed red blood cells and she apparently was hypotensive in the emergency department. She was transferred to the intensive care unit in essentially stable condition..."

The hospital laboratory was called on 4/25/06 and asked to define their reference range for a hematocrit on an adult female. The hospital's laboratory reference values for a normal hematocrit in an adult female were 36 to 46%. The laboratory staff person stated that for an adult female, anything below 20 or above 60% is a "critical" value.

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 ______	04/13/2006

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) COMPLETION DATE
F 309	Continued From page 21 The nurse who worked the night shift of 2/18/06 was interviewed via telephone on 4/13/06 at 9:01 AM. The nurse was asked to describe the events of the night of 2/18/06 in regards to resident 8. The nurse stated that resident 8 was having "dark, coffee looking stools" and had been vomiting. The nurse added "I wasn't sure if it was anything or not." The nurse was asked if she performed a guiac on the stools. The nurse responded, "What's that?" (The term guiac is a common nursing term used to describe the test that identifies the presence of occult blood in a persons stool. The nurse places a small amount of stool on a special testing card and adds a drop of a reagent.) This night nurse was then asked if she called the physician as there was no documentation in her notes for resident 8 for the night of 2/18/06 that she attempted to notify the physician of these signs and symptoms of a gastrointestinal bleed. The nurse stated that she tried to call the physician but "got no response back." There was no documentation in the medical record of resident 8 to evidence that the nurse who worked the night of 2/18/06 performed a thorough assessment of the resident, including vital signs. There was no documentation of resident 8 having episodes of bloody stools or that she had been vomiting blood. There was no documentation to evidence that the nurse was aware of the meaning of these symptoms. There was no documentation that the nurse attempted to notify the physician of the bloody stools or of the blood in resident 8's vomit. Resident 8 did not arrive at the hospital until	F 309		

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 ______	04/13/2006

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) COMPLETION DATE
F 309	Continued From page 22	F 309		

10:08 AM where she was found to have a hematocrit of 16, a critical laboratory value. The physician wrote orders for "2u (units) type specific blood stat." Resident 8 was then transferred to the intensive care unit.
Resident 11 was admitted to the facility on 10/10/95 with diagnoses which included Alzheimers, scoliosis, mental retardation, anemia and osteoporosis.

Resident 11 was admitted to the hospital on 2/25/06 with diagnoses of Left lower extremity deep vein thrombosis, fecal impaction, and anemia.

Review of the hospital General ER (Emergency Room) Report dated 2/25/06 for resident 11 revealed the fecal impaction was, "quite impressive" and a surgical consult was initiated while the resident was in the emergency room.

Review of the hospital history and physical dated 2/25/06 revealed that resident 11 had been hospitalized in the past for a huge fecal impaction.

Resident 11's medical record was reviewed on 4/12/06.

Review of resident 11's medical record revealed an annual comprehensive minimum data set completed 3/24/05. Facility staff indicated in the assessment that resident 11's bowel elimination pattern was regular at least once every 3 days.

On 12/14/05 the facility completed a quarterly minimum data set for resident 11. Facility staff marked none of the above for the options under

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 ______	04/13/2006

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) COMPLETION DATE
F 309	Continued From page 23	F 309		

bowel elimination. Facility staff did not indicate on the assessment that resident 11 had regular bowel movements nor that he had an impaction.

Review of resident 11's comprehensive careplan revealed a careplan for altered elimination related to bladder and bowel incontinence. The goal of the careplan was for resident 11 to be clean, dry, odor free and have no skin breakdown until the next review. The approach section of the careplan indicated that staff should ensure adequate elimination by giving stool softeners.

No other careplan could be found in resident 11's medical record regarding constipation or for interventions or assessment for fecal impaction.

Review of the Activities of Daily Living (ADL) flow sheet for January 2006 through February 24, 2006 revealed that from January 28, 2006 through February 24, 2006, the day resident 11 was discharged to the hospital, resident 11 experienced 21 days of diarrhea. The ADL flow sheets indicated that resident 11 experienced 10 consecutive days of diarrhea, January 28, 2006 through February 6, 2006.

No documentation could be found in resident 11's medical record to indicate the facility assessed resident 11 during the 10 days of diarrhea or contacted the physician regarding the 10 consecutive days of diarrhea.

On 4/12/06 a telephone interview was conducted with a family member of resident 11. She stated that on February 24, 2006 resident 11 appeared to be nine months pregnant. She further stated that several weeks prior to the 24th of February

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 ______	04/13/2006

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) COMPLETION DATE
F 309	Continued From page 24	F 309		

she had told facility staff that resident 11's stomach was larger than normal and that resident 11 was complaining of being nauseated.

Additional information sent to the state survey agency on 4/18/06 provided nursing note documentation regarding resident 11. Review of the additional information revealed a nursing note dated 2/16/06 at 5:00 PM. A facility nurse documented in the nursing note, "... Spoke [with] res (resident) c/o (complains of) abd. (abdominal) discomfort. Abd. rounded [and] firm as usual. Bowel sounds sluggish but + (positive) X (times) 4 quads (quadrants)....Digital rectal exam revealed [no] stool in lower rectal vault; hard stool noted in upper rectal vault. Dr. Wood notified. Orders obtained for Fleet enema [and] MOM (Milk of Magnesia) PRN (as needed)....Fleet enema given....MOM given [with] prune juice....Incont. (incontinent) of sm. (small) hard BM (bowel movement) [one hour] [after] enema. Results pending for MOM [and] prune juice. [no] nausea...."

The following entry was documented in the nursing notes by the same facility nurse on 2/17/06 at 10:00 AM:
"Night shift reported res. was incontinent of BM during night. [no] diarrhea reported. Assessed res. again. Abd. still rounded [and] firm. Bowel sounds + (positive) X 4 quads....Incont. of large mushy green/black stool. Res. is taking iron..... 1500 (3:00 PM) ...Staff assisted to BR (bathroom). Again expelled lg. mushy BM green/black in color. Abd. still rounded. non tender. [no] distress noted."

No documentation could be found in resident 11's

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 ____	04/13/2006

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) COMPLETION DATE
F 309	Continued From page 25	F 309		

medical record to show facility staff re-assessed resident 11's bowel sounds, abdomen, or bowel movements after the initiated interventions on 2/16/06 (Fleet enema and MOM).

Review of resident 11's medical record revealed a nursing note dated 2/24/06. A facility nurse documented in the nursing notes, "Pt. (patient) [with] 2+ pitting edema in [left] leg, skin firm, pt. unable to move leg per norm, (normal) Pt. also appears to be SOB (short of breath)....MD paged, awaiting call back."

It was documented on 2/24/06 by a different facility nurse, " New orders MD, May send pt. to ER (Emergency Room) if family chooses to evaluate swollen [left] extremitie [sic]...."

On 4/12/06 at 2:10 PM the facility nurse who wrote the first entry in the nursing notes on 2/24/06 was interviewed. She stated that the certified nursing assistant (CNA) came and told her around 6:45 PM that resident 11's leg was swollen. She stated that resident 11's left leg was swollen and cold to the touch. She further stated that resident 11 was pale, a lot weaker and more short of breath the week prior to the 24th of February. The nurse stated that the last few days before resident 11 was discharged the CNA's were starting to push him around in his wheelchair due to weakness and shortness of breath. The nurse stated that resident 11's bowel movements were not regular, he smeared feces in his brief a lot and his stool was really hard. The nurse stated after being questioned about a bowel assessment on the 24th of February that his abdomen was round and firm feeling but she did not do an assessment of resident 11's bowel

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 ______	04/13/2006

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) COMPLETION DATE
F 309	Continued From page 26 sounds on the day of discharge. She further stated that she did not obtain vital signs on resident 11 after discovering the swollen extremity but, "I don't remember telling the CNA's to get vitals but I'm sure they did." No documentation could be found in resident 11's medical record to show facility staff assessed resident 11 in the week prior to resident 11 being discharged for a deep vein thrombosis of the lower extremity and a fecal impaction.	F 309		
F 312 SS=D	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that for 2 of 11 sample residents, the facility did not ensure that they provided the necessary services to maintain grooming and personal hygiene. Resident identifiers: 1 and 4. Findings included: Resident 1 was a 71 year old male. The MDS (minimum data set), a mandatory comprehensive assessment of the resident by qualified facility staff, was completed for resident 1 on 3/1/06 and documented that he needed	F 312	F312 The Assistant Director of Nursing instructed the C.N.A the morning of 4/12/06 of resident # 4 to attempt to comb her hair, as best possible, considering she usually resists. Resident # 1's soiled pants was changed on the morning of 4/11/2006. The Assistant Director of Nursing met with all of the C.N.A's and instructed them on Activities of Daily Living for our residents, especially those who are care planned to receive assistance and to be more attentive and watchful.	

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 ______	04/13/2006

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) COMPLETION DATE
F 312	Continued From page 27 assistance with personal hygiene. This assessment did not document that resident 1 was resistive to cares. The following observation was performed on 4/11/06 from 7:50 AM to 9:03 AM. At 7:50 AM, resident 1 was observed walking into the secured unit dining area wearing jeans that were wet around the peri area and down the left leg. Two nurse aides were present in the dining area and one of them approached resident 1 and guided him to a seat. At 8:12 AM, resident 1 was observed to be standing up in the dining area and moving away from the tables. He continued to wear the soiled jeans. At 8:29 AM, resident 1 was observed to be standing in his bathroom doorway with the door wide open and pulling at the front of his soiled jeans. At 8:30 AM, a nurse aide on the unit was interviewed while he was assisting to feed another resident. He was asked if he was the only nurse aide on the locked unit. The aide stated, "Yes. There's another aide who floats down here if I need help." It should be noted that 15 residents resided on the locked unit. From 8:29 AM until 8:51 AM, resident 1 was observed in the same position in his bathroom doorway. At 8:52 AM, an aide was observed to walk by the room for resident 1 and then stop. The aide was	F 312	To ensure that the facility continues to provide all of our residents who need assistance with activities of daily living, the Director of Nursing or Assistant Director of Nursing will conduct multiple daily rounds to observe that these residents needs are being met with assistance. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator "Activities of Daily Living" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ___	04/13/2006

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) COMPLETION DATE
F 312	Continued From page 28 then heard to say resident 1's name. The surveyor left the hallway and sat down in the secured unit dining area. At 8:54 AM, the same aide who stopped at the room of resident 1 appeared in the dining area of the secured unit. The surveyor got up and walked down the hallway and looked into resident 1's room. Resident 1 was still wearing the soiled jeans, but was then lying on his bed. Resident 1 remained on his bed until 9:03 AM when an aide helped him up and guided him into the shower room. Resident 1 wore soiled jeans for 73 minutes without receiving staff assistance to change. 2. Resident 4, who also resided on the secured unit, was observed on 4/10/06, 4/11/06 and 4/12/06 without having her hair combed. Her hair appeared pressed to the back of her head and then stood straight up in some areas. On 4/11/06 at 9:00 AM, resident 4 was observed sitting in her wheelchair in the secured unit TV room. There were chunks of food debris on her legs and around her peri area. The top of the lap buddy which was in place on her lap was very dirty and had multiple white smears on it.	F 312		

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 ____	04/13/2006

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) COMPLETION DATE
F 323 SS=E	483.25(h)(1) ACCIDENTS 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, it was determined that the facility did not ensure that the resident environment remained free of accident hazards as was possible. Specifically, resident accessible areas within the facility had water temperatures that exceeded 120 degrees Farenheit. Findings included: Water temperatures were sampled on 4/11/06 from 7:20 AM through 7:49 AM and revealed the following: The water temperature in the beauty salon was 150 degrees. The door to the beauty salon was observed to be open at all times during 4/10/06 and 4/11/06 and was accessible to residents. The water temperature in the bathroom between rooms 102 and 104 was 142 degrees. The water temperature in the bathroom between room 101 and 103 was 136 degrees. The water temperature in the 100 hall shower room was 128 degrees. The water temperature at the secured unit kitchenette sink (accessible to all secured unit residents) was 136 degrees. The hot and cold faucets were mixed with the right faucet	F 323	F323 The Administrator instructed the Maintenance Supervisor to conduct a facility wide water temperature test to determine the range of temperatures throughout the facility. Upon doing so, he adjusted the main boiler and called and set up an appointment to repair service. The Maintenance Supervisor conducted water temperature multiple times daily until the repair service was performed. To ensure that the facility continues to provide facility wide water temperatures that do not exceed 120 degrees Fahrenheit, the maintenance supervisor will continue to conduct daily water temperature checks and document in the water temperature maintenance log book. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:	

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 ___	04/13/2006

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) COMPLETION DATE
F 323	Continued From page 30 producing hot water and the left faucet producing cold water.	F 323	Under the quality assurance program, the form indicator "Maintenance Repairs/Reports" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of medical records and facility unusual occurrence reports, it was determined that for 2 of the 11 sampled residents (residents 3 and 5), the facility did not ensure that residents received adequate supervision and assistance devices to prevent accidents. Specifically, from 9/23/05 through 12/5/05, resident 5 fell 15 times. Resident 5 suffered injuries during 9 of those 15 falls. Facility staff did not care plan the concern with his falls until 12/20/05. This was 88 days after his first fall. From 12/21/05 through 3/28/06, resident 5 fell an additional 9 times receiving injuries during all 9 of the falls. A care plan revision was written on 3/28/06, after which resident 5 had another fall. Resident 5 has had a total of 24 falls being injured 75% of the time due to the falls. Injuries received by resident 5 included lacerations, abrasions, a hematoma, a swollen wrist, a skin tear and bruises. Additionally, from 7/20/05 through 4/11/06, resident 3 fell 35 times. Resident 3 suffered	F 324	F324 The Care Plans for resident # 3 & resident # 5 have both been reviewed since each ones last incident and each care plans reflects adequate supervision and assistance devices to prevent accidents. The Director of Nursing will in-service all licensed nurses on incident reports/unusual occurrence charting. To ensure that the facility provides each resident with an adequate care plan that strives to prevent accidents, the Medical Records Designee will perform monthly audits based upon current incident reports/unusual occurrence reports and compare with specific resident	

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 ______	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 31 injuries during 14 of those 35 falls. Facility staff did not care plan the concern with her falls until 11/13/05. From 11/16/05 through 1/31/06, resident 3 fell an additional 12 times receiving injuries during 6 of the falls. On 1/31/06, facility staff implemented the use of a soft waist restraint on resident 3. Findings included: 1. Resident 5 was a 47 year old male with diagnoses which included anoxic brain damage, brain injury and convulsions. Resident 5 was admitted to the facility on 9/9/05. The medical record of resident 5 was reviewed on 4/10/06 through 4/13/06. A fall assessment was completed by a facility nurse on 9/9/05 and found resident 5 to have a score of 4. (The facility defined scores of 0 to 6 to be low risk and 7 or higher as high risk.) The MDS (a mandatory comprehensive assessment completed by facility staff) was completed for resident 5 on 12/20/05. This MDS documented the following: Resident 5's cognitive skills for daily decision making were severely impaired and that he had altered perception or awareness of his surroundings. Resident 5 also needed limited assistance or one person physical assistance during ambulation. The following is a summary of the nurse's notes contained within the medical record for resident 5 or information gathered from unusual occurrence	F 324	care plans to ensure adequate supervision and assistance devices to prevent accidents. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator "Falls/Prevention/Evaluation" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ____	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 32 reports regarding resident 5: Fall 1 9/23/05 - resident tripped, bumped his head, received a small abrasion, small skin tear and small hematoma Fall 2 10/9/05 - resident fell in the dining area, small laceration to rib area and right inner finger There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls. Fall 3 10/20/05 - resident fell to his knees, left knee abrasion There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls. Fall 4 11/6/05 - found on floor, left swollen wrist There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls. Fall 5 11/7/05 - fell, no injury There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls. Fall 6	F 324		

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 ______	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 33	F 324		

11/9/05 - fall, complaints of right arm pain

There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls.

Fall 7
11/10/05 - fall, scraped knee

There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls.

Fall 8
11/21/05 - fell in bathroom, no injury reported

There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls.

Fall 9
11/23/05 - fell on chair, hurt ribs

There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls.

Fall 10
11/25/05 - fall, bruise

There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls.

Fall 11
11/25/05 - fall, no injury

There was no documentation to evidence that

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 ____	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 34 staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls. Fall 12 11/29/05 - fell, laceration to forehead There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls. Fall 13 11/30/05 - fall, no injury reported There was no documentation to evidence that staff re-evaluated resident 5's risk for falls or initiated a care plan to address the falls. Fall 14 and 15 12/5/05 - "two falls this shift", no record of injury Facility staff did not initiate a care plan until 12/20/05, 88 days after resident 5's first fall. Also at this time, a second fall assessment, dated 12/05, was completed and scored resident 5 at an "8". This placed resident 5 in the high risk category for falls. After staff wrote the 12/20/05 care plan, resident 5 fell an additional 9 times receiving injuries with all 9 falls. A summary of the of those falls (as documented in the medical record or unusual occurrence reports) is listed below: Fall 16 1/1/06 - fall, left knee skin tear There was no documentation to evidence that staff re-evaluated the interventions of the care	F 324		

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 ___	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 35 plan or followed-up to ensure that the interventions were being implemented. Fall 17 1/10/06 - "fell face first to floor", 6 by 1.5 cm laceration to the left eyebrow There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 18 1/26/06 - fall, complaining of severe rib pain There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 19 2/14/06 - fell, stated he hit head, blood on right eyebrow There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 20 2/23/06 - fell outside, superficial abrasion to right cheek, right forehead and slight abrasion to right ear, scant bleeding has small hematoma to right forehead There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the	F 324		

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 ______	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 36	F 324		

interventions were being implemented.

Fall 21
3/9/06 - fell outside, unattended, reported by another resident, abrasion to left little finger

There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented.

Fall 22
3/17/06 - Other resident reported resident fell outside while smoking, abrasion to right upper cheek, steri strips intact.

There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented.

Fall 23
3/27/06 - fell outside, superficial abrasion 2 cm to mid back

On 3/28/06, staff updated the fall care plan to add two additional interventions which included to "monitor during times of unsteady gait" and "encourage use of w/c (wheelchair)."

On 4/13/06, the director of nurses was interviewed as to what was meant by the word "monitor". She was asked how and how often the staff were supposed to monitor resident 5. The director of nurses stated that the word "monitor" was very subjective.

On 4/13/06, a nurse aide in the secured unit

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 ____	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 37 where resident 5 resided was interviewed. The aide was asked what interventions he should be implementing to help avoid falls and injuries for resident 5. The aide responded "We're just supposed to watch him. If he gets unsteady, then we ask him to use the wheelchair." Fall 24 On 3/29/06, resident 5 again fell and sustained an abrasion to his back. 2. resident 3 was a 78 year old female with diagnoses that included anxiety disorder, hypothyroidism, bipolar disorder, osteoarthrosis, tremors and chronic obstructive pulmonary disease. Resident 3 was admitted to the facility on 6/4/04, and readmitted on 7/11/05, after a brief stay at an acute care hospital. The medical record of resident 3 was reviewed on 4/10/06 through 4/13/06. A fall assessment was completed by a facility nurse on 7/11/05 and found resident 3 to have a score of 8. (The facility defined scores of 0 to 6 to be low risk and 7 or higher as high risk.) The MDS (a mandatory comprehensive assessment completed by facility staff) was completed for resident 3 on 2/3/06. This MDS documented the following: resident 3's cognitive skills for daily decision making were moderately impaired . Resident 3 also needed limited assistance or one person physical assistance during ambulation.	F 324		

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 ______	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 38	F 324		

The following is a summary of the nurse's notes contained within the medical record for resident 3:

Fall 1
7/20/05 - Resident 3 tripped while pushing wheelchair, stuck back of head on door frame, causing laceration.

Fall 2
7/22/05 - Resident 3 found outside by staff on her knees. .5 x 3 cm abrasion on left knee.

Fall 3
8/3/06 - Resident 3 fell by bed. No injuries noted.

Fall 4
8/5/05 - Resident 3 fell by bed. No injuries noted.

Fall 5
8/6/05 - Resident 3 tripped over herself and fell. Small hematoma on back of head.

Fall 6
8/8/05 - Resident 3 found sitting on floor by bed. No injuries noted.

Fall 7
8/11/05 - Resident 3 found on floor. No injuries noted.

Fall 8
8/21/05 - Resident 3 fell on floor. Denied injury.

Fall 9
9/6/05 - Resident 3 found sitting in doorway. No injuries noted. Physician notified.

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 ____	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 39	F 324		

Fall 10
9/13/05 - [Patient] voiced [no complaints of] pain [secondary to] yesterday fall. Has [small] abrasion to knee [and antibiotic ointment and] Band-Aid applied."

Fall 11
9/14/05 - Resident 3 slid to floor. Denies discomfort.

Fall 12
9/22/05 - Resident 3 found on floor in room. " complains of abrasion from old fall hurting... [patient] denies pain...message left with family...physician informed."

Fall 13
9/25/05 - Resident 3 found sitting on floor. Denies pain. No injuries reported.

Fall 14
10/1/05 - Resident 3 fell in hallway. No injuries noted. "Resident embarrassed about falling."

Fall 15
10/9/05 - Resident 3 found on floor. Small laceration to mid back. "...resident has had confusion over past weeks."

Fall 16
10/10/05 - Resident 3 fell on bathroom floor. "...I'm tired of sitting on the floor."

Fall 17
10/15/05 - Resident 3 slid to floor. No injuries noted. "[Complains of right] shoulder hurting."

Fall 18

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 ____	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 40	F 324		

Continued From page 40

10/28/05 - Resident 3 found sitting on the floor. "...told three different stories. Confused this evening. [Complains of right] knee pain. Small bruise noted." Physician and family notified.

Fall 19, 20, 21
10/29/05 - "Resident has fallen three times today...very unsteady. Family called...".

Fall 22
11/11/05 - Resident 3 tipped wheelchair over while outside smoking. Red mark with indent to right knee.

Resident 3 sustained 22 falls between 7/20/05 and 11/11/05, eight of which resulted in physical injuries. One fall resulted in resident 3 expressing mental anguish/embarrassment by having fallen. Nursing note documentation revealed that only 3 of the 22 falls had been reported to resident 3's physician.

Despite resident 3 having had 22 falls with multiple injuries, no interventions were implemented to protect resident 3 from sustaining further injury from falls.

On 11/13/05 a care plan was created for resident 3's risk for falling related to generalized debility and psychotropic drug use.

After staff wrote the 11/13/05 care plan, resident 3 fell an additional 11 times receiving physical injuries with five of those falls. A summary of the of those falls ,as documented in resident 3's medical record, is listed below:

Fall 23

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 ____	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 41 11/14/05 - Resident 3 found on floor. No injuries noted. There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 24 12/28/05 - Resident 3 fell from wheelchair. No injuries noted. There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 25 1/11/06 - Resident 3 found on floor. No injuries noted. There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 26 1/15/06 - Resident 3 attempted to ambulate, lost balance and fell. Abrasion to right thigh, skin tear to left elbow. There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 27 and 28 1/16/06 - Resident 3 found on floor on 2 separate	F 324		

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 ______	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 42 occasions. No injuries noted. There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Nurse's notes dated 1/18/06 documents "...small bruise noted on [right] outer thigh. [Small] bruise noted on [left] buttocks...". Fall 29 1/25/06 - Resident 3 found lying on floor. No injuries noted. "[Patient] asked that we don't bother her son about this, but this nurse explained that because it happens so frequently, it would be best to let him know." There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 30 1/26/06 - Resident found on floor. Complained of pain in left arm. There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 31 and 32 1/27/06 - Resident 3 found on floor at 6:45 AM. No injuries noted. Resident 3 found on floor again at 1:30 PM. Hit back of head, small laceration observed.	F 324		

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 ____	04/13/2006

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) COMPLETION DATE
F 324	Continued From page 43 There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 33 1/31/06 - Resident 3 fell on floor of room. Hit face on floor. Lesion on nose and bleeding from [right] nostril. Red area above [left] eye. Complains of [right] shoulder hurting. Complains of [right] knee hurting. Small abrasion on that knee. On 1/31/06, a soft waist restraint was ordered by resident 3's physician for use while in wheelchair. Resident 3 continued to have falls even though facility had implemented the above mentioned interventions. No evidence could be found, that the facility had reassessed or re-evaluated resident 3's need for further interventions to protect her from sustaining further injury from falls. Fall 34 3/21/06 - Resident 3 found on floor, in bathrrom, next to toilet. No injuries noted. There was no documentation to evidence that staff re-evaluated the interventions of the care plan or followed-up to ensure that the interventions were being implemented. Fall 35 4/11/06 - Resident 3 was placed on toilet and left unattended and fell to floor. No injuries noted.	F 324		

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 ____	04/13/2006

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) COMPLETION DATE
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility did not ensure that each resident maintained an acceptable parameter of nutritional status as evidenced by the following: Calculating weight loss percentages is done by subtracting the current weight from the previous weight, dividing the difference by the pervious weight and multiplying by 100. Significant weight losses are as follows: 5% in one month, 7.5% in 3 months and 10% in 6 months. (Reference guidance: Manual of Clinical Dietetics, American Dietetic Association, 6th edition, 2000) Findings include: 1. Resident 2, a 82 year-old female, was admitted to the facility on 8/12/00 with diagnoses of rheumatoid arthritis, hyperthyroidism, hypertension, osteoporosis, peptic ulcer, bipolar, dementia, arthropathy. A review of Resident 2's weight revealed the following: March 13, 2006 115 lbs. (pounds) March 20, 2006 111 lbs.	F 325	F325 The Director of Nursing has reviewed the current care plan of resident # 2 and has changed her care plan to ensure that the resident maintains acceptable parameters of nutritional status. The Weight Committee (DON, RD & ADON) will review all current weights and all care plans will be update for appropriateness if needed. In addition, on documentation of meal percentage and snack documentation was given to C.N.A's on 5/10/2006. To ensure that the facility continues to maintain acceptable parameters of nutritional status, the Weight Committee will meet twice a month and will show documentation of such meetings and will update and change care plans and interventions as appropriate. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:	

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 ____	04/13/2006

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) COMPLETION DATE
F 325	Continued From page 45 March 27, 2006 109.5 lbs April 3, 2006 106.5 lbs From March 13, 2006 to April 10, 2006 Resident 2 lost 9 lbs. (7.9%) which was significant. A review of Resident 2's medical record dietary notes revealed that no RD assessment addressing the weight loss had been completed for resident 2. Resident 2 had a nutritional assessment and care plan completed on 3/16/2006. The dietitian made no changes to resident 2's current diet plan; mechanical soft and SNP (special nutrition program). Dietary Progress notes on 4/2/06 revealed that RD was aware of resident 2's weight loss. No new nutritional assessments or nutritional care plan was made, and no change to resident 2's diet plan was made. A review of nurse's notes dated March 22, 2006 revealed that an IDT (interdisciplinary team) meeting was held on that day, with resident 2's daughter. Daughter states that she is concerned that her mother doesn't eat well. Nursing notes go on to say her weight is stable and to continue current plan. No further assessment or mention of resident's weight is found. A review of resident 2's ADL (activities of daily living) sheet for February 2006, revealed that resident 2 had no intake documented for 9 out of 28 day for breakfast, 14 out of 28 days for lunch, 12 out of 28 days for dinner, and 22 out of 28 days for evening snack.	F 325	Under the quality assurance program, the form indicator "Weight Loss, 5% within 30 days" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ______	04/13/2006

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) COMPLETION DATE
F 325	Continued From page 46 A review of resident 2's ADL sheet for March 2006, revealed that resident 2 had no intake documented for 16 out of 31 days, and 31 out of 31 days for evening snack	F 325		
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not ensure that for 1 of 11 sampled residents, the facility did not provide proper respiratory care and treatment. Resident identifier: 3 Findings included: Resident 3 was admitted to the facility on 10/07/04 with diagnoses that included; anxiety disorder, hypothyroidism, bipolar disorder, osteoarthritis, tremors, and chronic obstructive pulmonary disease. On 7/9/05 resident 3 was transferred to an acute care hospital emergency	F 328	F328 The Director of Nursing corrected resident # 3 care plan during the survey process to ensure proper treatment and care. The Medical Records Designee will conduct an audit on all resident charts for appropriate written orders and care plan implementation. To ensure that the residents receive proper treatment and care the Director of Nursing or Assistant Director of Nursing will review 24 hour report each work day for any condition/order changes and report in the daily managers meeting. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:	

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 ______	04/13/2006

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) COMPLETION DATE
F 328	Continued From page 47 room for exacerbation of chronic obstructive pulmonary disease. A review of resident 3 ' s physician orders was completed on 4/13/06. On 7/11/05 resident 3 was readmitted to the facility with orders for oxygen at 2 liters per minute via nasal cannula, Combivent every four hours and Albuterol SVN (small volume nebulizer) as needed for wheezing. On 7/12/05 a physician order was received to administer Singulair 10 mg every evening for asthma. The physician orders did not include specific orders for monitoring resident 3 ' s oxygen saturation levels. A review of nursing notes for resident 3 between 7/11/06 and 4/12/06 was completed on 4/13/06. Per nursing note documentation, facility nursing staff monitored resident 3 ' s oxygen saturation level, use of oxygen and respiratory status as follows: a. On 7/11/05 at 11:00 PM, " Res (resident) wheezing, coughing. (Oxygen at 2 liters) per NC (nasal cannula). . . . Lung sounds (all fields) have wheezes. " b. On 7/12/05 at 2:00 AM, " Resp (respirations) (increased) to 25-30, SaO2 (saturation of oxygen arterial blood) 82%, wheezing/SOB (shortness of breath) continues after bedtime, dose of Combivent given. SVN (small volume nebulizer) Tx (treatment) given; helped (decrease) wheezing, coughing and distress. SaO2 still 86%. O2 (oxygen) per NC at 2 liters. Sao2 (increased) to 88-89%. " c. On 7/12/05 at 3:30 AM, " Sats (saturation) 80% while pt (patient) sleeping. Does not have labored breathing or wheezing while asleep.	F 328	Under the quality assurance program, the form indicator "Clinical Management" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ______	04/13/2006

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) COMPLETION DATE
F 328	Continued From page 48 SaO2 (increased) to 86% at times. Continue to monitor. " d. On 7/12/05 at 6:00 AM, " SaO2 86%, SVN tx given. " e. On 7/12/05 at 1000 AM, " (Resident 3 ' s attending physician) ordered Singulair 10 mg po (by mouth) qHS (at the hour of sleep) secondary to asthma and dyspnea. Pt reported to be coughing (up) blood. " f. On 7/14/05 at 4:00 PM, " O2 on at 2 liters per nasal cannula " g. On 8/4/05, " Using O2 at 2 liters via NC when in room. " h. On 8/8/05 at 7:40 AM, " Was found (without) O2 on later in shift and could not remember why it was off. Very confused. " i. On 9/1/05, " O2 at 2 liters / NC. Throws on floor ½ the time. " j. On 9/25/05, " Saturation at 92%. " k. On 9/27/05, " O2/NC. Respirations are even and unlabored. " l. On 9/29/05, " O2/nasal cannula. Resp are even and unlabored. " m. On 10/2/05 at 3:00 AM, " O2/NC. " n. On 10/21/05, " O2 2 liters/NC. " A review of the medication record and treatment record between 7/11/05 and 4/12/06 revealed orders for oxygen at 2 liters per minute as needed. This was listed as " FYI " (for your information) on these records. Nursing staff did not document whether the oxygen was used for resident 3 or not on this from. There was no documentation of resident 3 ' s oxygen saturation on these records. Note: Resident 3 ' s medical record contained no documentation of resident 3 ' s oxygen saturation except as noted in the nursing notes on 7/12/05. On that date, the	F 328		

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 ____	04/13/2006

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) COMPLETION DATE
F 328	Continued From page 49 nursing staff documented resident 3 ' s oxygen saturation level was checked six times while on 2 liters or oxygen. Resident 3 ' s oxygen saturation level ranged from 80-89%. On 9/25/05, nursing staff documented resident 3 ' s oxygen saturation level to be 92%. The nurse did not document if this oxygen saturation level was obtained while resident 3 was receiving oxygen or on room air. Additionally, physician orders for resident 3 ' s oxygen therapy was continuous at 2 liters, not as needed as indicated on these records. A review of Minimum Data Set (MDS) assessments for resident 3 was completed 4/13/06. Facility staff completed quarterly MDS assessments for resident 3 on 8/14/05, 11/12/05 and 2/3/06. On each of these assessments, facility staff assessed that resident 3 was receiving oxygen. A review of the comprehensive care plan for resident 3 was completed on 4/13/06. Facility staff had not developed a care plan to address resident 3 ' s use of oxygen. On 4/10/06 at 3:15 PM, observation of resident 3 revealed that no oxygen was being used by the resident. It was also observed that there was no oxygen concentrator, or other devices to deliver oxygen, in resident 3 ' s room. In an interview on 4/11/06 at 10:15 AM, resident 3 stated that she did not use oxygen and had not for some time. She was not able to identify when she had stopped using the oxygen. On 4/11/06 at 12:45 PM, a nurse was asked to check resident 3 ' s oxygen saturation level. It	F 328		

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 ____	04/13/2006

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) COMPLETION DATE
F 328	Continued From page 50 was 86-88% while at rest. The Director of Nurses (DON) was interviewed on 4/11/06 at 1:00 PM. She stated that resident 3 ' s oxygen had been discontinued " a while back ", but she was unable to locate that order in the resident ' s medical record. On 4/11/06, following the surveyor ' s interview with the DON, the DON provided a copy of a physician telephone order, dated 4/11/06. The physician telephone order included instructions to discontinue oxygen, due to resident 3 ' s request. An interview was held on 4/11/06 at 1:30 PM, with a LPN. This LPN stated she was assigned to resident 3 on that day. The LPN stated that when a resident returned from the hospital with orders for oxygen PRN (as needed), staff were to check their oxygen saturation level twice a day, until the resident can be weaned from the oxygen. When asked about an oxygen order that was to be continuous, not PRN, the LPN stated that staff would not wean the oxygen or check the oxygen saturation level unless they had a physician order to do so.	F 328		
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation of two nurses and medical record review, it was determined the facility did	F 332		

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 ______	04/13/2006

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) COMPLETION DATE
F 332	Continued From page 51 not ensure that it was free of medication error rates of five percent or greater. Observation of 48 medication opportunities revealed 4 medication errors resulting in an 8.3% medication error rate. (Residents 2, 6, and 13) Findings include: On 4/11/06 RN 1 (Registered Nurse) was observed during morning medication pass. RN 1 was observed administering all 9:00 AM medications to resident 2 including Ferrex 50 mg (milligrams) and Levothyroxine 100 mcg (micrograms). Ferrex is a polysaccharide-iron complex and Levothyroxine is a thyroid hormone replacement. According to the Nursing 2006 Drug Handbook 26th edition, Lippincott Williams and Wilkins, page 882 under Drug-drug Interactions; Ferrex may inhibit thyroid hormone absorption therefore doses should be separated by 2 hours. On 4/11/06 RN1 was observed during morning medication pass. RN 1 was observed administering all 9:00 AM medications to resident 6 including 1 capsule of Omega 3 Fishoil. RN 1 did not administer Muccinex 600 mg to resident 6 during the medication pass. Review of resident 6's medical record revealed a physician's order written on 1/31/06 for resident 6 to receive 600 mg of Muccinex twice a day. No physician's order could be found in resident 6's medical record to show that resident 6 was to receive the capsule of Omega 3 Fishoil. On 4/11/06 RN 1 was observed during morning	F 332	F332 The Director of Nursing reviewed the medication errors for resident # 2, # 6, & # 13. Upon doing so, she personally spoke to the licensed nurse(s) who were observed during the survey process of passing resident medication. Their errors were explained in detail and proper medication passing was rehearsed. The Director of Nursing and Assistant Director of Nursing performed an evaluation of all routine medication dispensing time. All medications were reviewed for potential interactions with other meds dispensed in that time frame. Med pass administration times will be adjusted accordingly. Med pass in-service was given to all licensed nursing staff. To ensure that the facility is free of medication error rates of five percent of greater, Nursing Administration will perform random med passing observations on a monthly basis and proper education will be given as needed.	

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 ______	04/13/2006

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) COMPLETION DATE
F 332	Continued From page 52 medication pass. RN 1 was observed administering all 9:00 AM medications to resident 13 including Prilosec 20 mg and Atenolol 25 mg. After administration of the medications, resident 13 was observed to immediately begin eating his breakfast meal. According to the Nursing 2006 Drug Handbook 26th edition, Lippincott Williams and Wilkins, page 707 under patient teaching, "Instruct patient to take drug 30 minutes before meals."	F 332	The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following: Under the quality assurance program, the form indicator "Medication Room/Chart Review" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ______	04/13/2006

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) COMPLETION DATE
F 496 SS=E	483.75(e)(5)-(7) REQUIRED TRAINING OF NURSING AIDES 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 the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. 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 review of 5 employee personnel files it was determined that for 2 of 3 Certified Nursing Assistants hired, the facility did not receive registry verification that the individual has met	F 496	F496 The C.N.A. registry has been contacted for verification that the 2 individual's has met competency evaluation requirements. The Assistant Director of Nursing has reviewed all other C.N.A employee files and has verified that all employed C.N.A's have had C.N.A. registry verification. To ensure that all potential C.N.A's who desire employment meet requirements, none shall be hired until verification has been obtained through the C.N.A. Registry and that they have met competency requirements. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:	

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 ____	04/13/2006

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) COMPLETION DATE
F 496	Continued From page 54 competency evaluation requirements prior to their hire date. Findings include: On 4/11/06 five employee files were reviewed for abuse prevention, screening and training. The following revealed that 2 of 3 Certified Nursing Assistants (CNA) were not checked through the nurses aide registry prior to their hire date: 1. Employee A's hire date was 9/5/05. The CNA registry was contacted 9/13/05 to determine if competency requirements had been met or if the CNA had any abuse allegations against them. 2. Employee D's hire date was 10/21/05. The CNA registry was contacted 4/11/06 to determine if competency requirements had been met or if the CNA had any abuse allegations against them.	F 496	Under the quality assurance program, the form indicator "Abuse Prohibition" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview it was determined that for 2 of 11 sampled residents the facility did not provide or obtain laboratory services to meet the needs of its residents. Additionally, the facility is responsible for the quality and timeliness of the services.	F 502		

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 ______	04/13/2006

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) COMPLETION DATE
F 502	Continued From page 55 Residents 2 and 6. Findings include: 1. Resident 6 was admitted to the facility on 4/8/05 with diagnoses which included, Congestive Heart Failure, Diabetes Type II, hypertension, and osteoarthrosis. Resident 6's medical record was reviewed on 4/10/06. Review of resident 6's medical record revealed a physician's order written on 1/24/06. This order indicated that resident 6 was to have a lipid panel drawn in 6 weeks and report the results to the physician. According to the physician's order the lipid panel should have been drawn on 3/8/06. Review of the facilities lab requisition book revealed a lab requisition form filled out for the lipid panel to be drawn on 3/8/06. Review of resident 6's medical record revealed a lipid panel drawn on 2/8/06, two weeks after the physician order date. On 4/11/06 the Director of Nursing was interviewed. She stated that she researched the lab and discovered that the phlebotomist from the lab company mistakenly drew the lab on 2/8/06 instead of 3/8/06. Facility staff were unaware that the phlebotomist drew the lab on the wrong date therefore, not waiting the 6 weeks requested in the physician's	F 502	F502 The Director of Nursing reviewed the orders given by the physician for both resident # 2 & 6. The physician gave new orders to be followed with new dates. The Director of Nursing instructed the Medical Records Designee to perform an audit to determine if all given orders for other residents have been followed through as ordered. To ensure that the facility follow through with given orders by the physician, the Medical Records Designee will perform a weekly audit for physician orders and submit to the administrator and the Director of Nursing. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:	

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 ______	04/13/2006

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) COMPLETION DATE
F 502	Continued From page 56 order, until the Director of Nursing investigated why the resident had a lipid panel drawn on 2/8/06 without a physician's order and no lipid panel drawn on 3/8/06. This investigation was conducted after the surveyor asked the Director of Nursing where the lab could be located. 2. Resident 2 was admitted to the facility on 8/12/00 with diagnoses that included, rheumatoid arthritis, hypothyroidism, hypertension, osteoporosis, peptic ulcer disease, dementia, bipolar disorder, and arthropathy. A review of physician orders was completed on 4/11/06. On 9/20/01, resident 2's physician wrote orders for a complete blood count (CBC) and a complete metabolic profile (CMP) to be drawn every six months. These were to be drawn in September and March. A review of laboratory results for resident 2 was completed 4/11/06. Per documentation, facility staff had not obtained the CBC or the CMP in September 2005. Interviews were held with the Director of Nursing on 4/11/06 and 4/12/06 at 1:00 PM and 3:45 PM respectively. The DON was interviewed about the September 2005 CMP and CBC laboratory results for resident 2. The DON stated she was unable to locate the laboratory results for resident 2. On 4/12/06, the DON provided the surveyor a copy of a physician telephone order, for resident 2, dated 4/11/06. The telephone order was, "CBC/CMP due Sept/Mar done April/Jan - due next draw Sept/Mar".	F 502	Under the quality assurance program, the form indicator "Lab Work" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

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 ____	04/13/2006

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) COMPLETION DATE
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on review of medical records and facility unusual occurrence reports, it was determined that for 1 of 11 sample residents, the facility did not maintain clinical records in accordance with accepted professional standards and practices that were complete or accurately documented. Resident identifier: 5. Findings include: The medical record of resident 5 was reviewed 4/10/06 through 4/13/06. During this review, it was noted that between 9/9/05 and 4/13/06, 20 falls were documented in the nurse's notes. When the facility's unusual occurrence reports were reviewed, an additional four falls were found which had not been documented in the nurse's notes. These four falls had the following dates: 11/9/05, 11/25/05 at 2:55 AM, 11/25/05 at 1:00 PM and 1/1/06. Three of these four falls ended in injury.	F 514	F514 The medical record for resident # 5 has been reviewed by nursing administration and where appropriate reflects additional incidents that occurred. Nursing administration will review incident reports/unusual occurrence reports to determine appropriate documentation and care plan intervention. To ensure that the facility maintains clinical records in accordance with professional standards, the licensed nurses will complete a 24 hour report each day and pass onto the Nursing Administration to be reviewed for appropriate follow through. The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:	

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 ______	04/13/2006

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) COMPLETION DATE
			Under the quality assurance program, the form indicator "RAI/ Medical Records" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved.	06/01/06

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # **465065**	MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	DATE SURVEY COMPLETE: **4/13/2006**
NAME OF PROVIDER OR SUPPLIER **INFINIA AT OGDEN**	STREET ADDRESS, CITY, STATE, ZIP CODE **524 EAST 800 NORTH OGDEN, UT**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 286	483.20(d) RESIDENT ASSESSMENT - USE

A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.

This REQUIREMENT is not met as evidenced by:
Based on record review, the facility failed to maintain Minimum Data Set (MDS) assessments completed within the previous 15 months in the resident's active record for 1 of 11 sample residents.

Resident identifier: 3

Findings include:

Resident 3 was originally admitted to the facility on 6/4/04 and readmitted to the facility on 7/11/05 after a brei stay at an acute care hospital. Resident 3's diagnoses included, Anxiety disorder, hypothyroidism, bipolar disorder, osteoarthrosis, tremors and chronic obstructive pulmonary disease.

On 4/11/06 a review of Resident 3's medical record revealed quarterly MDS assessments dated 8/14/05, 11/12/05 and 2/3/06.

The facility fail to maintain at least 15 months of assessments in resident 3's active record.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

Amendment to Recertification Survey CMS-2567L, plan of correction.

Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur for the following tags:

309- To ensure that the facility provides the necessary care and service to help residents attain or maintain their best overall health, nursing administration will perform random chart review on a weekly basis and provide and provide administrator a written report once a month. *The 24 hour report will be reviewed by the Director of Nursing or the Assistant Director of Nursing and a verbal report will be given at the managers morning meeting, wherein appropriate communication/intervention can take place.*

324- To ensure that the facility provides each resident with an adequate care plan that strives to prevent accidents, the Medical Records Designee will perform monthly audits based upon current reports and compare with specific resident care plans to ensure adequate supervision and assistance devices to prevent accidents. *Should a resident have recurring falls, new assessment(s) will take place to ensure that the current care plan safely meets the residents needs.*

Indicate how the facility plans to monitor its performance to make sure solutions are sustained for the following tags:

226- The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:
Under the quality assurance program, the form indicator "Abuse Prohibition" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved. *A hiring checklist, which will include background check and licensure verification, will be presented to the administrator upon each hire, wherein the administrator can be assured that all working employees are in good hiring terms.*

275- The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:
Under the quality assurance program, the form indicator "Comprehensive Resident Assessment" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved. *The MDS Coordinator will present to the administrator on a monthly basis an MDS completion checklist, which will include all MDS's that have been completed and any MDS's that are due, if any.*

276- The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:
Under the quality assurance program, the form indicator "Comprehensive Resident Assessment" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved. *The MDS Coordinator will*

present to the administrator on a monthly basis an MDS completion checklist, which will include all MDS's that have been completed and any MDS's that are due, if any.

276- The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:
Under the quality assurance program, the form indicator "Falls/Prevention/Evaluation" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved. *Nursing Administration will perform multiple daily rounds to assure the safety and well being of all current residents. Nursing Administration will communicate daily with nursing staff to ensure resident care is optimal.*

496- The Administrator plans to monitor the facilities performance to make sure that solutions are achieved and sustained by developing a plan, which will consist of the following:
Under the quality assurance program, the form indicator "Abuse Prohibition" will be completed and presented at our QA meetings wherein a threshold of at least 90% must be achieved. *A hiring checklist, which will include C.N.A. registry Verification, will be presented to the administrator upon each hire, wherein the administrator can be assured that all working employees are in good hiring terms.*

Indicate how often the monitoring will be done for the following tags:

157- To ensure that the facility continues to inform the appropriate party regarding a resident's change of condition, the licensed nurses will complete a 24 hour report each day. All change of conditions will be reported to the attending physician and resident's responsible party. Contact will be documented in resident's chart. *Nursing Administration will review the 24 hour report daily, Monday thru Friday. Change of Condition audits will be performed twice a month to verify that all appropriate interventions were followed through.*

226-As stated above, monitoring will be performed once a month
275-As stated above, monitoring will be performed once a month
276-As stated above, monitoring will be performed once a month
496-As stated above, monitoring will be performed once a month

Please accept this amendment in conjunction with our original 2567 plan for correction.

Sincerely,

Carrey R. Beers, Administrator Infinia at Ogden