		ND HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	\G			C 3/2007
	OVIDER OR SUPPLIER	I		1	REET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST	12/0	5/2001
	T ALTA				SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 155 SS=D	483.10(b)(4) NOTICE SERVICES	OF RIGHTS AND	F	155	5		1/11/08
	by: Based on interview a determined that for 1 (Resident 1) that the the resident the right Findings included: Resident 1 was admi 10/20/98 with diagnor retardation. Interviews on 11/14/0 Certified Nursing Ass revealed that on 10/2 allowed the right to re CNA 14 stated that the told them resident 1 h	tted to the facility on					
	help. CNA 13 and CNA 14 resident 1 refused to the DON to communi a shower. CNA 13 a DON told them he wo CNA 14 stated that th	hould come to the DON for stated that on 10/29/07, shower and that they went to cate that resident 1 refused nd CNA 14 stated that the build help them. CNA 13 and he DON went to resident 1 1 by holding resident 1's					

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 01/16/2008

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.

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 155	arms and assisted re- room. CNA 13 and C 1 was screaming, "N 14 stated that at that CNA 14 began remove while the DON held re- resident 1 from hitting CNA 14 stated that re- striking out, and kicki On 11/19/07 at 10:30 interviewed. The sur- residents' rights and it refuse a shower. The on the cognitive abilit DON further stated the dementia or can not re- themselves, I would to shower in the most co- stated that everybody shower, however, if a odor that was too offer infringe on other reside continued that others meal, in the dining ro- environment. The DO where body odor infri- rights. On10/29/07, to CNAs came to his offer resistant to getting infi- thought the resident as shower. The DON st the DON for his assiss CNA s, "Let's go give stated that as he app- resident walked past got closer to resident	sident 1 into the shower CNBA 14 stated that resident lo, No." CNA 13 and CNA time Nurse 1, CNA 13 and ving resident 1's clothing esident 1's arms to prevent g the staff. CNA 13 and esident 1 was screaming, ng. AM, the facility DON was veyor asked the DON about if a resident had the right to e DON replied, "It depends ies of the resident." The hat if a resident had make wise decisions for rry to give them a bath or omfortable way. The DON y has the right to refuse a a resident were to have body ensive to others, it would dents' rights. The DON had the right to enjoy their om, and enjoy their ON stated there was a point nges on other residents' he DON stated that two fice, and said resident 1 was to the shower, and that he said she did not want to ated the two CNAs asked stance and he told the two e her a shower." The DON roached resident 1 the him. He stated that as he 1, he guided her from er room. The surveyor	F	- 15			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 A APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONSTRUCTION		(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WINC	3			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 4035 SOUTH 500 EAST SALT LAKE CITY, UT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	R'S PLAN OF CORRECTI ECTIVE ACTION SHOUL ENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 155	comments. The DON resisting, agitated, ar they (CNA 13, CNA 1 to remove resident 1' resident 1 tried to hit resident's wrists. Review of written rep from staff involved in 11/19/07. This review statements revealed that resident 1 was a (shower). Cross Reference F-2 483.10(f)(2) GRIEVA A resident has the rig facility to resolve grie have, including those of other residents. This REQUIREMENT by: Based on interviews, facility grievance log, of 11 sample residen resident for facility did resolve the resident's identifiers 2, 3, 19, 32 Findings included: 1. Resident 2 was a to the facility, on 8/11 included infantile cere	<ul> <li>A replied that resident 1 was ad yelling. The DON stated 4, Nurse 1 and himself) tried is clothing. The DON stated the CNAs, so he held the</li> <li>orts and written statements, the incident, was done on w of these written report and that there was no evidence llowed to refuse treatment</li> <li>23.</li> <li>NCES</li> <li>with respect to the behavior</li> <li>T is not met as evidenced record review, and review of it was determined that for 3 tand one supplemental d not promptly respond to grievances. Resident 2.</li> <li>56 year old female admitted /06, with diagnoses that ebral palsy, hypertension, tia with depressive features,</li> </ul>		166			1/11/08

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		465100	B. WI	NG _			C 03/2007
NAME OF PF	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 166	Continued From page	93	F	16	66		
	did not recall the exact theft occurred. Resid reported it to a facility reported the theft to the Services Worker). Re- approximately \$ 215.1 husband's locked dre- reported that she didr happened, the money reported that the polic to her about it. Resid from the facility had do or resolve the alleged On 11/21/07, the surv copy, by the facility se of resident 2's alleged written report indicate reported on Saturday investigation reopt ind CNAs was aware of w the money in the lock assisted in looking for money. The report do was never interviewe The report document been reported to the 10/29/07, but that no department came to the facility about the alleged indicated that the facility State Agency survey.	her allegation of A. Resident 2 stated that she ct date of when the alleged ent 2 stated that she first staff member, who then he facility SSW (Social esident 2 stated that D0 was stolen from her sser drawer. Resident 2 n't know when or how it a was just gone. Resident 2 ce never came out to speak ent 2 stated that no one one anything to investgate I stollen/missing money. Yeyor was provided a written bcial service worker (SSW), d theft investigation. The d that the alleged theft was , 10/27/07. The dicated that one facility where resident 2 had hidden ed drawer, and even r and reporting the missing bcumented that this CNA d during the investigation. ed that the alleged theft had ocal police department on one from the police he facility or called the					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/16/2008 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		465100	B. WIN	NG _		1	C 2/03/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 166	On 11/21/07, the Stati intake log was review that the facility reporter misappropriation of re 11/29/07, one month reported it. 2. Resident 3 was a admitted to the facility that included obesity, ulcers, dermatitis, and On 11/15/07, during t interviewed. Residen at a doctor's appointin power wheelchair wa Resident 3 stated that nothing to help him gr police to report the m 3 stated that he boug from his former room the wheelchair. Resident could not find the rect the former facility soc knew about the purch Resident 3 stated that discharged quite a fer shortly after his room his wheelchair just dis was at the doctor app that office staff and for knew about his purch 3 stated that he asker administrator to call th On 11/19/07, at 3:40	te Agency Entity Report red. There was no evidence ed this allegation of esident property until after the resident had 70 year old male resident y on 12/2/04, with diagnoses hypertension, infection, d urinary obstruction. the dayshift, resident 3 was at 3 stated that while he was nent at a local clinic, his s stolen or given away. t the facility staff has done et it back or call the local issing wheelchair. Resident th an electric wheel chair mate, and that he purchased as given a receipt for the t 3 stated that he currently eipt. Resident 3 stated that ial service worker (SSW) hase of the wheelchair. t his roommate was w months ago, and that mate had been discharged, sappeared one day while he bointment. Resident 3 stated ormer facility administrator ase of wheelchair. Resident d the office staff and former ne police and was told that	F	16			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SU COMPLE	TED
		465100	B. WI	NG .			C 03/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 166	former SSW stated the purchase of a power from his former room stated that she would facility and provide a recall regarding the s the room mate to res On 11/26/07, the cur written investigation of wheelchair. The repo 3's roommate (seller discharged on 4/19/0 reported that his whe couple of weeks after discharge, most likely stated that the Maintek know something about On 11/19/07 at 3:15 If Supervisor was intervi- anything about the m Maintenance Supervi- approximately two we roommate was discha- the room mate and a facility and pick up th Maintenance Supervi- room mate came to the wheelchair. On 11/21/07 the curre- surveyor with a writter regarding Resident 3 report documented the facility Administrator to his room to report wheelchair from his p	hat she was aware of the wheelchair by resident 3 mate. The former SSW I be willing to come into the summary of what she could ale of the wheel chair from ident 3. Trent facility SSW provided a of resident 3's missing/stolen ort documented that resident of the wheelchair) was 7 and that resident 3 elchair was stolen/missing a that the roommate's 7 in May 2007. Resident 3 enance Supervisor might ut the missing wheelchair. PM, the facility Maintenance viewed to see if he knew issing wheelchair. The sor stated that eeks after resident's 3 arge, the facility staff called sked him to come to the e power wheelchair. The sor stated that the former he facility and picked up the ent facility SSW provided the in "Formal" investigation 's stolen wheelchair. The nat Resident 3 had called the and Maintenance Supervisor	F	- 1ε	66		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 A APPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUF COMPLET	ED
		465100	B. WIN	4G _			C 3/2007
NAME OF PF	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	٦IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 166	that Maintenance Sup 3's wheelchair had not for a few months. The Resident 3's roomma since 4/19/07. The res SSW called a local F officer come out and documented that an e up in resident 3's root that this was the chai documented that the resident 3 about the e in his room and he sta chair provided by the documented that the police had been calle take a report and resi from the police department to a different police ag to investigate the alle documented that the office that reason for likely probably occurr department did not res send out an officer. The police officer took department is now inv On 12/3/07, the local contacted reagrding F wheelchair. The polic that the facility reports on 11/20/07.	bervisor stated that Resident of been in Resident 3's room e report documented that the had been discharged eport documented that the olice Department to have an take a report. The report electric wheelchair showed m and the SSW assumed r in question. The report SSW later questioning electric wheelchair currently ated that this was a new hospital. The report resident was told that the d and asked to come out to dent 3 stated that no one tment has been out to speak documented that she called t again and was transferred gency that had the authority ged theft. the report bliceofficer came to the f the SSW's call. The report facility was told by the police delay in responding most ed when the other police lay to their department to 'he report documented that a report and the police vestigating the alleged theft.	F	16	36		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/16/2008 ORM APPROVED 3 NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI				E SURVEY IPLETED
		465100	B. WIN	NG_			C 12/03/2007
NAME OF PF	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	۶IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 166	conducted with the impolice department. The second of the	vestigating officer from the The office stated that commate is suspected of B's wheelchair, but that the is been unable to locate the puestion him. The officer ortunate that this theft and if the alleged theft had is time the wheelchair was alleged perpetrator would boate, as it is now, they are for questioning. Agency Entity Report intake the review revealed that lity did not report this nisappropriation of Resident State Agency until 11/29/07. wheelchair was reported 2007, but was not stolen/missing by the facility It was noted that the Supervisor had direct ent 3's former roommate hair at the request of facility e Maintenance Supervisor, <i>N</i> , the former facility	F	16	56		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	ED
		465100	B. WIN	NG_			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
INFINIA A	T ALTA				SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 166	that included diabetes depression, and asthu On 11/14/07, the fact surveyor that resident money stolen and that investigation. The SS that resident 19 might resident 19 had repor purse at a previous fa On 11/15/07 in the aff interviewed. Residen dicovered that she was the middle of October that she reported the (NA) 1. Resident 19 personal items are sto has been done by fac Resident 19 stated th money from her purse On 11/15/07 the facili Staff member with the investigation into the	s mellitus, Parkinson, ma. ility SSW informed the t 19 had reported some at she was doing an SW stated that she thought t be confused because ted theft of money from her acility. ternoon, resident 19 was at 19 stated that she as missing money around r 2007. Resident 19 stated theft to Nursing assistant reported that money and olen all the time, and nothing cility staff to prevent it. at she saw CNA 16 take the	F	<sup>7</sup> 16			
	facility SSW to come that time, Resident 19 7 dollars out of her pu documented that Res as CNA 16. The report asked CNA 16 come documented at the fa about the Resident 19 CNA 16 denied taking 19. The report docum taken off the schedule written statement. Th	down to her room and at 9 reported that a CNA took					

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/16/2008 A APPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION		(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_				C 3/2007
NAME OF PF	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULE APPROP	) BE	(X5) COMPLETION DATE
F 166	16 has stolen money done nothing about it that the SSW called in she had been working shift when Resident 1 stolen/missing money that NA 1 had the new returned to work, she facility SSW about the documented that the allegation of alleged in Agency on 11/14/200 that Resident 19's sto to "err" on the side of asked to come back to report documented the unable to substantiated misappropriation as in alleged theft to suppor Upon review of facility noted that the police of Protective Services) if allegation of misappropriation property. Additionally Entity Report intake for resident property on allegation of the theft staff in the middle of of On 11/15/07 at 3:15 F interviewed regarding 19's allegation of theft that she reported the on Tuesday 11/13/07 State cAgency staff of Wednesday, 11/14/07	afrom her and that NA 1 had . The report documented in NA 1 and she stated that g a Sunday night graveyard 19 hold her about the /. The report documented at day off and that when she had forgotten to tell the e allegation. The report facility reported the misappropriation to the State 7. The report documented ory has been consistent and caution CNA 16 was not to work at the facility. The hat the facility had been e the claim of the no one had witnessed the ort the claim. y written investigation it was department or APS (Adult had not been notified of this opriation of resident /, review of State Agency to g indicated that the facility on of misappropriation of 11/14/07, when the had been reported to facility October, 2007. PM, the facility SSW was g the investigation of resident t. The facility SSW stated allegation to State Agency at 4:40 PM, and that the	F	<sup>:</sup> 16	36			

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/16/2008 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI			(X	3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_				C <u>3/2007</u>
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE			
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E		(X5) COMPLETION DATE
F 166	theft. The SSW state 19 had informed a sta her. The SSW state with resident 19 and 1 investigation into the that she had no know of the missing money The SSW stated that immediately began at 4. Resident 32 was a 7/19/07 with diagnose obstructive pulmonar pain, hypothyroidism, irritable bowel syndro On 11/14/07 resident Resident 32 stated th complaints that had in Administration. Resid wasn't receiving her in food was too spicy, a lights were not being receiving ice water, a routinely cleaned by h On 11/26/07, a resid conducted. The resid stated that they had b that were not being a Administration. The in "smokers" at the facil non-designated smok the second hand smo as residents enter an On 11/26/07, the facil interviewed about this	ed that on 11/13/07, resident aff nurse who then informed aff nurse who then informed a that at that time she met began the facility's allegation. The SSW stated dedge that NA 1 was aware r since mid October, 2007. once she was informed she n investigation. admitted to the facility on es that included chronic y disease, joint and pelvis diabetes, hypertension, and me. 32 was interviewed. at she had multiple tot been addressed by facility dent 32 stated that she medications on time, the nd her mattress was old, call answered, she wasn't nd her room was not nousekeeping. ent group interview was dents in the group meeting prought up multiple concerns ddressed by facility staff and major complaint was that ity were smoking in sing areas, specifically that oke comes into the building d exit the facility.	F	· 16	56			

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY ED
	465100	B. WIN	G		C 3/2007
NAME OF PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z 4035 SOUTH 500 EAST SALT LAKE CITY, UT 8410	IP CODE	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
problem.On 12/4/07, a resid and mentioned that problem.On 11/27/07, the cd Grievance log was sheets of paper. T the above concerns The facility grievan of the complaint, ju There was no docu offered by the facilit there was no docu offered by the facilit there was no docu residents to make a the outcomes.F 223483.13(b), 483.13(b) SS=JF 223The resident has th sexual, physical, an punishment, and in The facility must no or physical abuse, involuntary seclusionThis REQUIREMEND by: Based on facility di administrative staff interviews, facility of medical record revi 1 of 10 sampled revi	ctive action plan for the dent approached SA Surveyor the "smoke" was still a urrent copy of the facility reviewed. The log was four he log documented some of s, but not all of the concerns. ce log did not address the date st the month of the complaint. mentation as to prompt efforts ty to correct the complaint (s), mentation of follow up with the sure they were satisfied with b)(1)(i) ABUSE he right to be free from verbal, nd mental abuse, corporal voluntary seclusion. th use verbal, mental, sexual, corporal punishment, or		223		1/11/08

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		465100	B. WIN	NG _			C 3/2007
NAME OF PR	OVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 223	administrative nurse, coersion to shower re- addition to the four st participated in this ind administrative person incident and failed to The facility's failure to abuse was determined risk to the health and therefore determined Findings include: Resident 1 was a 67 to the facility on 10/20 moderate mental reta and cardio vascular a Resident 1's quarterly assessment, dated 9/ facility RN (Registere indicated that residen with set-up assistance dressing. On 11/14/07 at 2:30 F (CNA) 13 was intervie CNA 13 about residen treatment, including th CNA 13 stated, on the on 10/29/07, she was which resident 1 was shower. CNA 13 state	ff members, including an used physical force and sident 1 against her will. In aff members who cident, two other anel were witness to the intervene. b protect its residents from ad to constitute an serious welfare of the residents, and to be Immediate Jeopardy. year old female admitted to 0/98, with diagnoses of ardation, seizure disorder, accident. MDS (minimum data set) (12/07, and signed by a d Nurse) on 9/13/07, t 1 required supervision, e, for ambulation and PM, certified nurse aide ewed. The surveyor asked	F	22			
		the Director of Nursing him that resident 1 did not					

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	TALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 223	want to shower. CNA resident 1 into the DC resident to choose wh CNA 14, would provid CNA 13 stated the re opportunity to refuse member would compl resident 1 responded shower. The resident went to the dining roc DON instructed me to CNA 13 stated the Ac the DON was providin 13 stated, at some tim facility Social Service 1 to shower, to which 13 stated she was in room when she obset resident 1, holding the pushing the resident 1 v CNA 13 stated she ob behind the DON. CN taken into the shower Nurse 1, CNA 14 and CNA 13 stated the DC arms while the three CNA 13 stated resident 13 stated resident 1 as tating, "NO, you're g stated resident 1 ask to let me go." CNA 1 "Will you cooperate?" replied, "No!" CNA 1 resident 1 and would she told the DON, "SI CNA 13 stated the DC	A 13 stated she had taken DN's office in order for the hich CNA, either CNA 13 or de the resident a shower. sident was not afforded the the shower, only which staff lete the task. CNA 13 stated that she did not want a t left the DON's office and om. CNA 13 stated the o get the shower room ready. dministrator was present as ng these instructions. CNA ne during the afternoon, the Worker also asked resident resident 1 said, "No." CNA	F	÷ 22			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	IRVEY TED
		465100	B. WIN	√G_			C )3/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
INFINIA A	TALTA				SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	was holding resident saying, "I can't breath stated that she knew wrong and wanted to when resident 1 was stopped yelling and s that because she knew water, she held a tow and that the resident stated the DON rema entire time. CNA 13 s that they had forced r shower and that she to participate. On 11/26/07 at 1:30 F re-interviewed. The s she had reported the occurred on 10/29/07 that she had reported concerns to NA 1, the At that time, the surve the details of the incid 10/29/07, as reported 11/14/07. A review of a written 13, dated 11/15/07, a 11/19/07, was comple "I was told [resident 1 today. I asked her set NO shower. Asked h D.O.N. She went in t no shower and he sai today is the day. so y [CNA 13] or [CNA 14] one. Went to Dr (dini bathroom ready. Car	1 down, resident 1 was he, I can't breathe". CNA 13 what they were doing was leave. CNA 13 stated that undressed, resident 1 triking out. CNA 13 stated ew resident 1 was fearful of rel over the resident's face seemed okay. CNA 13 ined in the shower room the stated that she was upset resident 1, against her will, to (CNA 13) had no choice, but PM, CNA 13 was surveyor asked CNA 13 if showering incident, which ', to any one. CNA 13 stated	F	22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	TALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 223	brought into bathroom her holding her arms Nurse 1] to take off h screaming let me go. bathroom. tring [sic] t she was undressed s apologetic saying to a honney [sic]. She was document was signed On 11/1407 at 2:00 F The surveyor asked O rights to refuse treatm refuse a shower. CN involved in an incider allowed to refuse a sl incident occurred the between 2:00 and 4:0 DON, Administrator, a resident 1 had to sho DON approached res and forcibly took her 14 stated the DON w providing the residem CNA 14 stated that a to the shower room, s Leave me alone!" CN attempting to bite, sc 14 stated that, in the resident 1 continued Leave me alone!", str bite, as the staff undr that she, as well as C DON that they did no shower. CNA 14 state	n by DON he was behind told us [CNA 13, CNA 14, er clothes She was please I have to go to the to bite scratch kick When the was fine She was very everyone I am sory [sic] as fine" This written d by CNA 13. PM, CNA 14 was interviewed. CNA 14 about residents' nent, including the right to A 14 stated she was nt in which resident 1 was not hower. CNA 14 stated the Monday prior to Halloween, D0 PM. CNA 14 stated the and SSW all told her that wer. CNA 14 stated the sident 1, in the dining room, to the shower room. CNA alked behind resident 1, not t the option of not showering. s resident 1 was being taken she was yelling, "No! No! NA 14 stated resident 1 was ratch, and was kicking. CNA shower room, the DON held CNA 13, Nurse 1, and CNA ident. CNA 14 stated to kick, scream "No! No! rike out, and attempted to ressed her. CNA 14 stated CNA 13 and Nurse 1 told the t want to force resident 1 to	F	· 22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/16/2008 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ETED
		465100	B. WI	NG_		12	C /03/2007
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	٦I	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	to." CNA 14 stated si exactly what Nurse 1 shower resident 1 eith DON remained in the 1's shower was comp resident 1 was undrest being combative. CN Administrator and So near the shower room forcibly taken to show the Administrator or Si leading CNA 14 to be it". CNA 14 stated the forced to shower on re- that on a previous occure reprimanded for refus when the resident has she was not comforta to shower, but felt she the DON told her she On 11/26/07 at 1:30 F re-interviewed. The sis she had reported the occurred on 10/29/07 that she had reported concerns to NA 1, the At that time, the surve the details of the incid 10/29/07, as reported 11/14/07. A review of a written si 14, dated 11/15/07, a 11/19/07, was complet that she and CNA 13 we had to shower residocumented that after	he was not able to quote said, but she did not want to her. CNA 14 stated the shower room until resident blete. CNA 14 stated once ssed, the resident stopped IA 14 stated the cial Worker were in the area n as resident 1 was being ver. CNA 14 stated neither Social Worker intervened, elieve they were, "Okay with at resident 1 had been more than one occasion, and casion a CNA had been sing to shower resident 1 d refused. CNA 14 stated able as they forced resident 1 e had to participate because had to. PM, CNA 14 was surveyor asked CNA 14 if showering incident, which f, to any one. CNA 14 stated the incident and her e facility CNA Coordinator. eyor clarified with CNA 14, dent involving resident 1 on I during the interview on statement, provided by CNA ind given to surveyors on eted. CNA 14 documented were told, by the DON, that	F	22	3		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 A APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		465100	B. WIN	NG _			3/2007
NAME OF PF	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR( DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 223	at which time the DOI have a shower. CNA instructed CNA 13 to he grabbed resident 1 to the shower room. DON held resident 1 CNA 13 and CNA 14 CNA 14 documented screaming, yelling, bi want a shower. CNA were able to get resid was still fighting and t shower room the who statement was signed On 11/15/07, followin pass, Nurse 1 was int asked Nurse 1 about treatment, including th Nurse 1 stated that re with showering, and t to shower once a wee her in there." Nurse occasion resident 1 h for the Social Service she (Nurse 1) could g side sometimes. Nur administered a PRN ( to resident 1. Nurse 1 "No! No! I don't want resident seemed to w her own will. Nurse 1 sta resident 1, with his ar hold. Nurse 1 stated	N told resident 1 she had to 14 documented the DON get the shower ready, and I from behind and took her CNA 14 documented the while the nurse (Nurse 1), undressed the resident. that resident 1 was hitting, ting, and saying she did not 14 documented that they ent 1 in the water while she hat the.DON stayed in the le time. This written 8 by CNA 14. g the morning medication rerviewed. The surveyor residents' rights to refuse her right to refuse a shower. esident 1 has had a problem hat staff wanted the resident ek. Nurse 1 stated, "we got 1 stated that on one ad refused to take a shower Worker (SSW), and that et on the resident's good se 1 stated she as needed) dose of Ativan recalled that resident 1 said to shower." but that the alk into the shower room on stated that, once in the tt 1 started batting her arms fressed of her three layers of ted the DON stood behind ms around her in a loose resident 1 would have been a that staff tried not to gang	F	22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG _			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A					4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 223	scratches to her arm, 1 stated that as staff resident 1's clothing, Nurse 1 stated the De that staff would not be The surveyor asked N capable of showering responded that the re- on to say that resider decisions and also th 1 had a legal guardia was appropriate to in because of the reside The SSW was intervi- on 11/26/07, at 10:10 respectively. The sur- residents' rights to re- right to refuse a show approximately two to and CNA 14 came to been refusing to show went to resident 1 an to get the resident to stated resident 1 beg "No!" The SSW state supervisor tried, also encourage resident 1 stated that because t shower, the DON, a f CNA 14 took the resi SSW stated the DON resident 1 toward the her, while CNA 13 an resident. The SSW s physically assisting th resident 1 was resisti you!" as well as obsc	during the incident. Nurse removed the last bit of the resident calmed down. ON held resident 1's arms so e injured by the resident. Nurse 1 if resident 1 was g herself., to which Nurse 1 esident could. Nurse 1 went at she did not think resident an. Nurse 1 stated she felt it sist resident 1 shower ent's health issues. ewed on 11/14/07 and again 0 AM and 2:35 PM, rveyor asked the SSW about fuse treatment, including the ver. The SSW stated that three weeks prior, CNA 13 her because resident 1 had wer. The SSW stated she d attempted, unsuccessfully, agree to shower. The SSW an screaming and said, ed the maintenance	F	÷ 22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI			(X3) DATE SU COMPLET	RVEY FED
		465100	B. WI	NG_			C 03/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	"popped" her head im on the resident and h "No! No!" The SSW s resident 1 verbally, as undressed by staff. T resident was in the sh ever since, showering The SSW stated, "Th that staff had a meeti showers get complete stated that CNAs nee residents more than o shower when the resi shower. The SSW st her employment at th bad and that resident done. A written statement, of dated 11/15/07, was 11/19/07. The SSW of asked to help with res her shower. She doo CNA 13 and CNA 14 shower as the DON v SSW documented that shower room) shortly documented that she the shower room) to r resident 1 swearing a documented that she to see if they needed documented she obse untangle all the neckl CNA13 and CNA 14 v clothes off. The SSW second time she "pop observed the resident	to the shower room to check leard resident 1 screaming, stated she reassured is the resident was being The SSW stated that once hower she was fine and that g has not been a problem. le CNA's are lazy here", and ing about the need to ensure ed as scheduled. The SSW eded to go back to the one or two times to offer a idents had refused to tated that when she began the facility, the facility smelled it showers were not being documented by the SSW, provided to the surveyors on documented that she was sident 1 and her refusal of cumented that she witnessed escort resident 1 into the walked behind them. The at Nurse 1 went in (the after. The SSW is stood outside the door (of monitor and that she heard and screaming. The SSW "popped" her head in twice	F	. 22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		465100	B. WING			12/0	03/2007
	NAME OF PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 223	room) shortly after an was being showered calm. This written sta SSW. On 11/19/07, the SSW with the facility's inve- resident 1. The SSW investigation findings the statements and th statements of the peo- that no abuse had oc- to hurt [resident 1]. A being a willful inflictio confinement, intimida resulted in harm, pain these apply to [reside screaming was not an [resident 1] in her reg witnessed by the soc Administrator after th the bathroom all parti were very pleased wi [Resident 1] was hap around showing ever hairstyle. This was n our policy due to the perceived the event t document was signed On 11/27/07 the facili was interviewed. Bas with the SSW, the su Maintenance Supervi instance when staff re when the resident ha Supervisor stated the	A came out (of the shower of reported that resident 1 now and seemed to be more atement was signed by the <i>N</i> provided the surveyors stigative report relative to <i>Y</i> documented the facility's as, " After reviewing all be inconsistency in the ople involved it was decided curred. There was no intent as the definition of abuse n of injury, unreasonable tion or punishment which n or mental anguish none of ent 1]'s situation. Her n unusual occurrence for ular behavior patterns. As ial worker and the e staff and [resident 1] left es looked pleased. Staff th how well the shower went. py and smiling. She went yone her new dress and her of reported to the state per fact that no one involved o be abusive." This d by the SSW.	F	22	23		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/16/2008 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		465100	B. WI	NG_		12	2/03/2007
NAME OF PR	OVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 223	Maintenance Supervissid, "No". The Maintenance Supervissid, "No". The Mainten he notified the Administer not want to take a shull supervisor stated that carpets, while listening device). The Mainten he was able to hear mean shower room that sheet A written statement, of Maintenance Supervisor was provided to the set Maintenance Supervisor unknown date, he was the West side and ob 1 if she would like a set He documented that 1 scream, "no no I'm document was signed Supervisor. On 11/27/07 at 11:25 interviewed at the rese began discussing, wit in which resident 1 wher will. Resident 43 being forced to show heard [resident 1] scr got up to see if she would interviewed. The sum residents' rights and it refuse a shower. The on the cognitive abilit DON further stated the statement of the statement of the statement of the set of th	hower, which he did. The sor stated that resident 1 tenance Supervisor stated istrator that resident 1 did ower. The Maintenance t he returned to cleaning ing to an iPod (music listening hance Supervisor stated that esident 1 screaming in the e did not want to shower. documented by the sor, and dated 11/15/07, surveyors on 11/19/07. The sor documented, on an is cleaning the carpets on served staff asking resident shower, which she declined. he was able to hear resident not going to shower". This d by the Maintenance AM, resident 43 was sident's request. Resident 43 th the surveyor, an incident as made to shower against stated, "It's true, [resident 1 er] I was laying in bed and I eaming bloody murder, and I as okay." AM, the facility DON was veyor asked the DON about f a resident had the right to e DON replied, "It depends ies of the resident." The	F	<sup>2</sup> 22			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 M APPROVED D. 0938-0391			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	ĒD			
		465100	B. WIN	NG_		C 12/03/2007				
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE					
INFINIA A	T ALTA			4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE			
F 223	shower in the most or stated that everybody shower, however, if a odor that was too offe infringe on other reside continued that others meal, in the dining ro- environment. The DO where body odor infri- rights. The DON stat staff to shower reside 10/29/07, he noticed been showered. The there was no docume received a shower for two CNAs came to hi was resistant to gettir he thought the reside shower. The DON stat the DON for his assis CNA s, "Let's go give stated that as he app resident walked past got closer to resident behind into the showe asked the DON if res comments. The DON resisting, agitated, an resident1 had an apro necklaces, jewelry an layers of clothing. The CNA 14, Nurse 1 and resident 1's clothing. tried to hit the CNAs, wrists. The DON stat and the CNAs were a The surveyor asked in	ry to give them a bath or omfortable way. The DON v has the right to refuse a resident were to have body ensive to others, it would dents' rights. The DON had the right to enjoy their om, and enjoy their DN stated there was a point nges on other residents' ed that he had asked the ent 1 on 10/27/07, and on that the resident had not DON stated, as of 10/29/07, entation that resident 1 had r a month. The DON stated s office, and said resident 1 ng into the shower, and that nt said she did not want to ated the two CNAs asked tance and he told the two her a shower." The DON roached resident 1 the him. He stated that as he 1, he guided her from er room. The surveyor	F	22						

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 APPROVED D: 0938-0391
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_			C 3/2007
NAME OF PROV	VIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA AT A	ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
N reattorettbusierearen Ndrebsi CPTabAogsiAs:"Fdwisibs T	esident 1 was being asked the DON if a re- heir body language, I but at staff, would it b resident a shower? T he three days prior, r been any different, an used to not having to stated that it was the residents that led to n a consistent basis. The residents were clean NOTE: The DON cor dated 11/16/07, regar resident 1 in which the believe the manner in showered constituted On 11/14/07 and 11/2 PM, the facility Admin The surveyor asked the aware of an incident i been showered again Administrator reported baserved the DON was stated resident 1 was Administrator could no stated the DON was i bout did not shower the stated at that time, sho The Administrator sta	ed or something while resistive. The surveyor esident were resistive, with being combative and striking e a good time to give the The DON explained that for resident 1's behavior had not not that the CNAs had gotten do showers. The DON CNAs' approach toward the not getting showers done on the DON stated that when they were happy; better. mpleted a written statement, rding the incident involving e DON indicated he did not a which resident 1 was abuse. 26/07, at 3:05 PM and 4:15 histrator was interviewed. he Administrator if she was n which resident 1 may have est her will. The d an incident in which she alk behind resident 1 and ower. The Administrator "swearing" but the ot recall exactly what was tor stated the SSW he Administrator stated she creaming, while the resident om. The Administrator n the shower room to help, e resident. The Administrator	F	÷ 22			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLET	IRVEY TED
		465100	B. WIN	NG_			C )3/2007
NAME OF PR	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 223	stated that the facility habits, and that recer different standards, a On 11/14/07, during t interviewed regarding treatment, including tl CNA 4 replied, that in past, staff were instru- aides have not been s they were expected to showered. CNA 4 sta specifically mentioned be showered and " condition the way it w whatever necessary t surveyor asked CNA of resident 1 being fo stated she had not wi but that she had hear that resident 1 had be On 11/14/07 at 10:15 interviewed. The sur- was familiar with resid stated resident 1 resis with staff when they a CNA 2 stated that a c meeting, the facility A resident 1 had to take no excuses. CNA 2 s instructed to inform th other resident refused On 11/15/07, during t interviewed regarding treatment, including th	<ul> <li>CNA's had developed bad htly staff were being held to and that staff do not like it.</li> <li>the day shift, CNA 4 was gresidents' rights to refuse he right to refuse a shower.</li> <li>a meeting in the recent acted by the DON that nurse showering residents were ated that resident 1 was d by the DON as needing to . with her [resident 1's] vas, that we have to do to get her showered." The 4 if she had any knowledge rced into the shower. CNA 4 itnessed any such incident, rd, "through the grapevine" een forced to shower.</li> <li>AM, CNA 2 was veyor asked CNA 2 if she dent 1's care needs. CNA 2 sted showers, and fought attempted to shower her.</li> <li>couple of weeks ago in a Administrator and DON said e a shower, no refusals and stated that the CNA's were he DON if resident 1 or any d to shower</li> </ul>	F	: 22			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG _			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER		_	s	STREET ADDRESS, CITY, STATE, ZIP CODE		_
INFINIA A					4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 223	Administrator, and SS showers had to be do us were quiet. She s would not force the re- stated, during that me (Administrator) that re- water. CNA 7 stated 1's shower had to be resident would get ov Administrator respond 1 smelled so bad that CNA 7 stated, "Forci agree with it." She co started it (forcing resi- doesn't understand a forcing. The resident independent and can feeds herself and dre On 11/15/07 at 10:45 facility's CNA Coordir surveyor asked NA 1 refuse treatment, incl shower. NA 1 stated facility CNA had refus that CNA had been w that the following day and showers, and ref discussed. NA 1 state meeting. The survey CNA's had come to h residents being force responded that three her with such concerr when these CNAs ha her. NA 1 stated her and that she discusse residents to shower.	SW instructed that resident one. CNA 7 stated most of tated that we agreed we esidents to shower. CNA 7 eeting, she told her esident 1 was terrified of the DON said that resident done on a schedule, and the ver it. CNA 7 stated the ded by commenting resident t others were getting sick. ing is a problem. I don't ontinued that the DON, " dents to shower). He bout twisting arms and a you are asking about is make her own bed, and she esses herself." AM, nurse aide (NA) 1, the hator, was interviewed. The about residents' rights to uding the right to refuse a she had heard that a former sed to shower resident 1 and vritten up. NA 1 continued to a cNA meeting was held fusal of showers had been ted she did not attend that or asked NA 1 if any facility uer with concerns about	F	- 22			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	TALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 223	people to take a show replied to her that res stated she answered "rights". NA 1 stated have an obligation, at and that it was affecti stated that while she heard through the "gr been forced into the s morning meetings the resident 1 and the fac keep her on a showe asked NA 1 who atter to which NA 1 replied On 11/14/07 at 3:30 F interviewed. The sur residents' rights to rei right to refuse a show told me I had to show resident had not beer CNA 16 stated that sl "Okay, I will." CNA 1 DON that resident 1 v shower and that the r hit, and kick, but that stated the DON instru- needed to be done at before and that it sho 16 stated she told the another CNA to help CNA 16 stated she had another CNA to show following dinner. CNJ had been an agency shift, she and the oth- not "drag" resident 1 agency nurse, for fea	ver." NA 1 stated the DON sident 1 had to shower. NA 1 back that resident 1 had the DON replied that we nd that resident 1 smelled, ing other residents. NA 1 was not present, she had rapevine" that resident 1 had shower. NA 1 stated in e Administrator talked about ct that the facility staff had to r schedule. The surveyor nded the morning meetings, I all department heads. PM, CNA 16 was veyor asked CNA 16 about fuse treatment, including the ver. CNA 16 stated the DON ver resident 1 because the n showered in two weeks. he responded to the DON, 6 stated she informed the was tough to get into the resident would scream, yell, she would try. CNA 16	F	22			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 A APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY ED
		465100	B. WIN	NG _			C 3/2007
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 223 F 225 SS=J	that the DON talked a stated the DON expla someone to do a show done. CNA 16 stated down" in front of her p in that meeting I expla residents to shower. Resident 1 was interv 11/19/07. Resident 1 dragged her to the sh dragged to the shower like that." 483.13(c)(1)(ii)-(iii), (c TREATMENT OF RE The facility must not e been found guilty of a mistreating residents had a finding entered registry concerning at of residents or misapp and report any knowle court of law against a indicate unfitness for other facility must ensu- involving mistreatmen including injuries of un misappropriation of re- immediately to the ad to other officials in ac- through established p State survey and cert	here was a meeting, and bout showers. CNA 16 ined, when he instructed wer, he expected it to be she felt the DON, "put me beers. CNA 16 stated that ained that we could not force iewed on 11/14/07 and 's stated that one time staff ower. Referring to being r, resident 3 stated, "I didn't c)(2) - (4) STAFF SIDENTS employ individuals who have busing, neglecting, or by a court of law; or have into the State nurse aide ouse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or he State nurse aide registry s. The that all alleged violations it, neglect, or abuse, nknown source and esident property are reported ministrator of the facility and cordance with State law rocedures (including to the ification agency).		22	3		1/11/08
	The facility must have	e evidence that all alleged					

Facility ID: UT0002

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		ND HUMAN SERVICES				FC	TED: 01/16/2008 DRM APPROVED NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED C
		465100	B. WI	NG .		1:	2/03/2007
NAME OF PF	ROVIDER OR SUPPLIER		-	s	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 225	prevent further poten investigation is in pro The results of all inve to the administrator o representative and to with State law (includ certification agency) v incident, and if the all	phly investigated, and must tial abuse while the gress. estigations must be reported	F	22	25		
	by: Based on interviews of care staff and admini with a respresentative agency, reviews of fa the State Survey and records, it was deterr sampled residents plu the facility did not ens violations involving al resident property wer the Administrator, the Certification Agency, or Adult Protective Se violations were thoroo identifiers: 1, 2, 3, 19 Findings included: 1. Resident 1 was a to the facility on 10/20	<ul> <li>as 1 supplemental resident, sure that all alleged buse or misappropriation of re reported immediately to a State Survey and either local law enforcement ervices, and that all alleged ughly investigated. Resident</li> <li>67 year old female admitted 0/98 with diagnoses of ardation, seizure disorder,</li> </ul>					

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY FED
		465100	B. WI	NG_			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	On 10/29/07, facility s abused resident 1 wh shower against her w On 11/14/07, 11/15/0 11/27/07, surveyors of nurse aide (NA) 1, ce (CNA)s 2, 4, 7, 13, 14 Director of Nursing (E Social Service Worke Maintenance Supervi were interviewed to d in which resident 1 wa The following informat NA 1, the facility's Ce Coordinator- (intervie AM) - NA 1 stated that reported to her, conce forced to shower. In a had heard through the had been forced to sh reported this informat her own concern that forced to shower. NA was the facility's oblig and other residents, w CNA 2 - (interviewed CNA 2 stated that the instructed by the Adm resident 1 had to show not refuse and that th shower her. CNA 4 - (interviewed shift) - CNA 4 stated 1 were instructed by the naming resident 1 in p	staff physically and mentally een they forced her to fill. Cross-Refer F-223. 7, 11/19/07, 11/26/07 and conducted interviews with ertified nursing assistants 4, and 16, Nurse 1, the DON), the Administrator, the er (SSW), and the sor. These staff members letermine the circumstances as showered on 10/29/07. Ition was gathered: ertified Nurse Aide wed on 11/15/07 at 10:45 at three facility CNAs had erns about residents being addition, NA 1 stated she e "grapevine" that resident 1 nower. NA 1 stated she ion to the DON along with residents should not be A 1 stated the DON replied it gation to ensure resident 1, were showered. on 11/14/07 at 10:15 AM) - e nurse aide staff were ninistrator and DON that wer, that the resident could ere were no excuses not to on 11/14/07, during the day that the nurse aide staff e DON that all residents,	F	22	<sup>15</sup>		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WI	NG _			C 3/2007
NAME OF PR	OVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	٦IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	shift) - CNA 7 stated been instructed by th SSW that resident shi 7 stated she reported was terrified of water resident 1's shower h and that the resident stated the DON, "Sta residents to shower). about twisting arms a CNA 13 - (interviewer at 2:30 PM and 1:30 stated that on 10/29/0 DON, Nurse 1, and C to shower, after the re expressed that she d 13 stated that as resi screamed "No! No!" held resident 1's arm removed the resident that resident 1 was fil out, kicking, and scree me go?" CNA 13 sta resident 1 by saying, shower." CNA 13 sta incident to NA 1, her Nurse Aide Coordina CNA 14 - (interviewer at 2:00 PM and 1:30 stated that on 10/29/0 DON, Nurse 1, and C to shower, after the re expressed that she d 14 stated that as resi resident was yelling " attempting to bite, scr 14 stated the DON her	on 11/15/07, during the day that the nurse aide staff had e Administrator, DON, and owers had to be done. CNA I to the DON that resident 1 , to which the DON replied rad to be done on a schedule will get over it. CNA 7 rted it (meaning forcing He doesn't understand and forcing " d on 11/14/07 and 11/26/07 PM, respectively) - CNA 13 07, she participated with the CNA 14, in forcing resident 1 esident had clearly id not want to shower. CNA dent 1 was forced, she CNA 13 stated that the DON s as the three others 's clothing. CNA 13 stated ghting, trying to bite, striking aming "Will you please let ted the DON responded to "No, you're going to ated she reported this supervisor, the Certified tor. d on 11/14/07 and 11/26/07 PM, respectively.) - CNA 14 07, she participated with the CNA 13, in forcing resident 1	F	225			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
		465100	B. WI	NG _			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	Leave me alone!", str bite as staff undresse stated the Administra what was occuring to to intervene. Nurse 1 - (interviewe morning medication p resident 1 has had a to shower her and that to shower once a we shower, which occurr stated, "We got her in leading to resident 1's resident 1 was saying shower!" but that the the shower room on 1 that, once in the show batting her arms as th of her three layers of behind the resident wa a loose hold. Nurse appropriate to insist in the resident's health The SSW - (interview on 11/26/07, at 10:10 respectively) - The SS approximately two to resident 1 had refuse facility nurse, CNA 13 resident 1 was resisti you!" as well as obso taken to the shower in "popped" her head in on the resident and h "No! No!" The SSW	tinued to yell out "No! No! rike out, and attempted to ed the resident. CNA 14 tor and SSW were aware of resident 1, but did nothing d on 11/15/07, following the bass) - Nurse 1 stated that problem with allowing staff at staff wanted the resident ek. Referring to resident 1's red on 10/29/07, Nurse 1 n there." Nurse 1 recalled, s shower on 10/29/07, the g "No! No! I don't want to resident seemed to walk into her own will. Nurse 1 stated wer room, resident 1 started nree of the staff undressed clothing and the DON stood <i>v</i> ith his arms around hers, in 1 stated she felt it was resident 1 shower because of issues. ved on 11/14/07 and again 0 AM and 2:35 PM, SW stated that three weeks prior, because ed to shower, the DON, a 3, and CNA 14 took the wer. The SSW stated ve and screaming, "I hate enities as she was being room. The SSW stated she to the shower room to check ueard resident 1 screaming,	F	: 22	25		

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY IED
		465100	B. WIN	NG_			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	The DON - (interview - In reference to resid The DON stated that staff to shower the re- on 10/29/07, he notic been showered. The resident 1 from behin shower room. The D was resisting, agitate stated they (CNA 13, himself) tried to remo The DON stated reside that when residents w better. NOTE: The D statement, dated 11/2 involving resident 1 in he did not believe the was showered constit The Maintenance Sup 11/27/07) - Referring 10/29/07, the Mainter while he was cleaning his iPod (a music lister hear resident 1 screat that she did not want Administrator - (intervin 11/26/07, at 3:05 PM resident 1's shower of Administrator stated so behind resident 1 and The Administrator stated so resident 1 was being Administrator did not	red on 11/19/07 at 10:30 AM) dent 1's shower on 10/29/07, he had previously asked sident on 10/27/07, and that ed that the resident had not DON stated he guided d, leading her into the ON stated that resident 1 d, and yelling. The DON CNA 14, Nurse 1 and ve resident 1's clothing. dent 1 tried to hit the CNAs, nt's wrists. The DON stated vere clean they were happy; DON completed a written 16/07, regarding the incident n which the DON indicated e manner in which resident 1 tuted abuse. pervisor - (interviewed on to resident 1's shower on hance Supervisor stated that g carpets, while listening to ening device, he was able to ming in the shower room to shower. viewed on 11/14/07 and and 4:15 PM) - Referring to in 10/29/07, the she observed the DON walk d led her into the shower. ated resident 1 was dministrator could not recall d. The Administrator stated, V "popped" into help. The she left the area in which	F	÷ 22			

Facility ID: UT0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		465100	B. WI	NG_			3/2007
NAME OF PR	OVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	٦I	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 225	the facility's investigat resident 1. In addition investigative report, the with the written statem Nurse 1, the Maintena the SSW, and Admini statements were date after the incident.) and the facility, on 11/14/0 into allegations that re The SSW documente findings as, " After and the inconsistency people involved it was occurred. There was As the definition of ab of injury, unreasonabl or punishment which mental anguish none 1]'s situation. Her so occurrence for [reside patterns. As witnesse the Administrator after left the bathroom all p were very pleased witi [Resident 1] was hap around showing every hairstyle. This was no	V provided surveyors with the report relative to in to the results of the ne SSW provided surveyors nents of CNA 13, CNA 14, ance Supervisor, the DON, strator. Each of the these d 11/15/07 or later (17 days d after surveyors entered 07, to begin an investigation esident 1 had been abused. d the facility's investigation reviewing all the statements in the statements of the s decided that no abuse had no intent to hurt [resident 1]. use being a willful infliction e confinement, intimidation resulted in harm, pain or of these apply to [resident reaming was not an unusual ent 1] in her regular behavior ed by the social worker and r the staff and [resident 1] parties looked pleased. Staff th how well the shower went. by and smiling. She went yone her new dress and her ot reported to the state per	F	22			
	perceived the event to investigative report we by the SSW. On 11/29/07, the facil	as not dated and was signed ity submitted, to the State on Agency, an initial report					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/16/2008 M APPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
		465100	B. WI	NG _		12/	C 03/2007
NAME OF PR	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	reported that two num floor nurse (Nurse 1) Although the Adminis present to observe an resident 1 was being 10/29/07, they did no resident. Additionally reportedly brought to concerns of multiple should not be forced Administrator did not abuse of resident 1 to Certification Agency a Services and/or local allegation that reside 10/29/07 was not rep and Certification Age enforcement until 11/ and Certification Age investigation in to the after the incident had 2. Resident 19 was a admitted to the facility that included diabeted disease, depression, An interview was held 11/15/07. Resident 1 0/15/07, she had \$7 Resident 19 stated sh approximately two to 19 stated that she als money to the SSW of was upset because th reported it sooner. R	and of October. The facility se aides, the DON, and a forced resident 1 to shower. Atrator and SSW were and hear the manner in which forcibly made to shower on t intervene to protect the the Administrator, the CNA staff that residents to shower. The report the allegation of the State Survey and and Adult Protective law enforcement. The not 1 had been abused on orted to the State Survey nocy and local law 29/07; after the State Survey ncy had initiated it's own allegation, and 30 days occurred. a 71 year old female resident y on 8/1/07 with diagnoses s mellitus, Parkinson's and asthma.	F	22	25		

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUI COMPLET	RVEY ED
		465100	B. WI	NG_			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
INFINIA A	T ALTA				SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	Continued From page when she informed N		F	22	25		
	at 3:17 PM. The SSW aware of the allegation was stolen on 11/13/0 reported it to Nurse 7 reported the allegation SSW stated she had allegation of stolen m stated she reported th money to the State S Agency and Adult Pro- 11/16/07. On 12/3/07, the facilit Survey and Certificat investigative report re- that resident 19's mon- the investigative report re- that resident 19's mon- the investigative report re- that resident 19's mon- the investigative report from NA 1. NA 1 docume report, to the SSW, th stolen money. Per do- was unable to substa- money was stolen. 3. Resident 2 was a to the facility on 8/11/ include infantile ceret pain, anxiety, dementa- and mental retardation An interview was held 11/27/07. Resident 2 10/28/07, she noticed stolen from her locker	. The SSW stated Nurse 7 n to her on 11/13/07. The not received resident 19's oney from NA 1. The SSW he allegation of stolen urvey and Certification otective Services on by submitted, to the State ion Agency, a final egarding the the allegation ney was stolen. Included in rt was a written statement cumented that resident 19 that the resident had money ented that she forgot to he resident's allegation of bocumentation, the facility ntiate that the resident's 56 year old female admitted '06 with diagnoses that oral palsy, hypertension, tia with depressive features, in.					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLET	IRVEY TED
		465100	B. WIN	NG			C )3/2007
NAME OF PR	ROVIDER OR SUPPLIER		_	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	Continued From page money on 10/28/07.	≥ 36	F	22	25		
	The SSW stated resid money, more than \$2 stated, on 10/29/07 si believed was the app enforcement agency. not for another three law enforcement agent 10/29/07, was not the stated there were no investigation during th SSW stated on 11/21 correct law enforcement she was given a case name to contact. On 11/29/07, the facil allegation of misappro property, as well as th report, to the State State Agency. The facility of resident 2 and her hu missing. The facility of enforcement had bee Per documentation in which was undated, th was either \$75.00, or also included docume contacted the incorre- on 10/29/07, and ther enforcement agency of Resident 2 had report some money stolen fr on or around 10/27/07 contacted a local law	The SSW stated that it was weeks that she learned the ncy she contacted on e correct agency. The SSW law enforcement hat three week period. The I/07, she contacted the ent agency, at which time e number and an officer's lity reported both an initial opriation of resident he facility's final investigative urvey and Certification reported that on 10/28/07, usband alleged \$75 was reported that local law en contacted on 10/30/07. In the facility's final report, the amount of money missing rover \$200.00. The report entation that the SSW had cet law enforcement agency in the correct law					

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FOR	D: 01/16/2008 M APPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION		(X3) DATE SU COMPLET	ED
		465100	B. WIN	NG _				C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST	Ξ		
INFINIA A	T ALTA				SALT LAKE CITY, UT 84107			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOUL E APPRO	LD BE	(X5) COMPLETION DATE
F 225	Additionally, the facili allegation of misappriproperty, to the State Agency, until 11/29/0 the money was allege 4. Resident 3 was 70 admitted to the facility that included obesity, ulcers, dermatitis, and Beginning 11/15/07, if on several occasions electric wheelchair has away by staff, while h appointment. Reside believe facility staff h wheelchair back. Re purchased, with his of wheelchair, but that h Resident 3 stated that been discharged from months prior, and that roommate's discharg disappeared while he appointment. Resider facility staff to call the to do so. Resident 3 SSW would be able to purchase the electric had with his former room An telephone interviee former SSW on 11/19 SSW confirmed reside	ation into the allegation. ty did not report the opriation of resident Survey and Certification 7, more than 30 days after edly missing. 0 year old male resident, y on 12/2/04, with diagnoses hypertension, infection, d urinary obstruction. resident 3 was interviewed . Resident 3 stated his ad been stolen, or given he was at a doctor's ent 3 stated he did not ad done anything to get the sident 3 reported that he wn money, the electric ormer roommate. Resident ided a receipt for the ne was not able to locate it. It his former roommate had in the facility quite a few it shortly after his e, the electric wheelchair e was at a doctor's ent 3 stated he had asked e police, but that they refused stated the facility's former o verify the transaction, to wheelchair, that resident 3	F	22	25			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/16/2008 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WI	NG_			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 225	resident of the facility she would be willing to provide a summary of regarding the sale of room mate to residen On 11/19/07 at 3:15 F Supervisor was intervallegation that his ele missing. The Mainter resident 3's former ro and informed that he electric wheelchair for former roommate pick approximately two we On 11/21/07, the facil written "Formal Invest stolen wheelchair. The signed nor dated. The resident 3's roommate discharged on 4/19/07 [SSW] called the [name to have an Officer con An electric wheelchair room. I [SSW] assum question. After quest chair he said that this by the [payor of service asked if an officer have he said no that had no [name of city] Police of had explained the situ come out. The recep County Dispatch. An hour. The officer exp delay probably occurr	<ul> <li>The former SSW stated to come into the facility and f what she could recall the wheel chair from the t 3.</li> <li>PM, the facility Maintenance viewed regarding resident 3's ctric wheelchair was nance Supervisor stated that ommate had been called would have to remove his om the facility and that the ked up the wheelchair eeks after his discharge.</li> <li>lity's current SSW provided a tigation" of resident 3's nis document was neither is report documented that</li> </ul>	F	22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 A APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUI COMPLET	RVEY ED
		465100	B. WIN	IG _			C 3/2007
NAME OF PR	OVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From page	39	F	22	5		
	a representative of th department. Per this						
	Agency, Entity Intake 11/29/07. The facility Survey and Certification misappropriation of re-	reports was completed on did not report, to the State on Agency, an allegation of esident property, relating to electric wheelchair until					
	resident 3 had purchas purchased, an electric roommate and that the at the facility. Howeve the State Survey and this issue was initiate had not treated the re- allegation of misappro- and did not thorough allegations to required information that facilite with resident 3 to have The wheelchair was a September, 2007.	opriation of resident property y investigate and report the d agencies. There was no y staff were working working e the wheelchair returned. allegedly stolen in					
F 226 SS=J	The facility must deve policies and procedur	, and abuse of residents	F	220	5		1/11/08
	This REQUIREMENT	is not met as evidenced					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WI	NG _			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	T ALTA			1	4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	determined the facility policies and procedur residents and misapp property. The facility failed to p mental abuse of 1 of Resident identifier: 1. The facility failed to ir allegations of abuse a resident property for 3 plus 1 supplemental n Resident identifiers: 1 The facility failed to s employees in accorda policies and procedur Employee identifiers: CNA 20, CNA 21, CN Nurse 7. Findings included: On 11/26/07, the Adm versions of the Facility version titled "[Shared managment corporati Procedure". The ider version was, "Prohibi	d administrative staff v of facility policy and is employee files, it was y failed to implement written res that prohibit abuse of propriation of resident revent the physical and 10 sampled residents. Anvestigate and report and misappropriation of 3 of 10 sampled residents, residents. 1, 2, 3, and 19. Creen 9 of 14 sampled ance with their written res. CNA 9, CNA 16, CNA 17, IA 23, CNA 24, NA 1, and Anistrator provided two by Abuse Policies; first d name of facility and ion] Health Care Policy and iting Abuse" and second d name of facility and ion] Inc. Policy and ntified topic of the second	F	220			

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	0: 01/16/2008 1 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3)	DATE SUF	RVEY
		465100	B. WI	NG_				ے 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 226	<ul> <li>11/27/07. The Admir which version of abus currently being implet reviewed the policies "[Shared name of fac corporation] Health C Prohibiting Abuse" we procedures currently</li> <li>A review of facility en on 11/28/07. Copies titled "[Shared name corporation] Health C Prohibiting Abuse" we employee files with the indicate they had rea</li> <li>A review of the pod "[Shared name of fac corporation] Health C Prohibiting Abuse" we employee files with the indicate they had rea</li> <li>A review of the pod "[Shared name of fac corporation] Health C Prohibiting Abuse" we The following informate review:</li> <li>"It is the policy of [name abuse of its residents company seeks to pro- residents by providing environment. Every of free from verbal, sexual abuse, corporal punits seclusion."</li> <li>"Abuse: The willful ir unreasonable confine punishment with resumental anguish. This deprivation by an indi- of goods or services</li> </ul>	histrator was asked to clarify se policy the facility was mented. The Administrator and stated the first version, ility and managment are Policy and Procedure for ere the policies and being implemented. apployee files was completed of policies and procedures, of facility and managment are Policy and Procedure for ere noted to be in the ne employees' signature to d the facility abuse policy. licies and procedures, titled ility and managment are Policy and Procedure for as completed on 11/28/07. tion was obtained from this me of facility] to prohibit any regardless of source. This pomote the well-being of its g a safe and supportive resident has the right to be ual, physical, and mental shment and involuntary officition of injury, ement, intimidation, or liting physical harm, pain, or	F	22	6			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/16/2008 1 APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_			C 3/2007
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	Γ ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	Continued From page	: 42	F	22	26		
	abused resident 1 wh shower against her w 2. Further review of t procedures, titled "[S managment corporati Procedure for Prohibi section titled, "Investi Procedures". These following instructions "Any person who sus misappropriation of pr will immediately report facility administrator a "The administration w Protective Services o authority (and if staff the [former name of th Certification Agency]) care ombudsman." "The administration w process by interviewin having any knowledge immediately." "The Director of Nursi responsible parties ar incident."	ill. Cross-Refer F-223. he facility's policies and hared name of facility and on] Health Care Policy and ting Abuse" revealed a gation and Reporting procedures included the to staff: pects that abuse, neglect, or roperty may have occurred, rt the alleged violation to the and/or advocacy agencies." vill immediately notify Adult r local law enforcement abuse is alleged, also notify the State Survey and and the local long-term vill initiate the investigation ng all staff and residents e of the allegation ing will ensure notification of nd physician of the alleged les abuse by staff, the facility					
	further abuse. This m the staff member unti completed." "After the investigatio administration will doo findings as to whethe	cument a summary of its r the alleged abuse was findings to the agencies,					

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/16/2008 M APPROVED O. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TED
		465100	B. WIN	NG_		12/0	C 03/2007
NAME OF PR	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	Continued From page investigation."	9 43	F	<sup>:</sup> 22	26		
	including the Adminis Social Service Worke and Nurse 1 failed to in which resident 1 wa against her will on 10 caused the resident mathematic although CNA 13 and concerns to their super manner in which resid the shower, this information thorough investigation and was therefore no Cross-refer F-225. 3. Further review of the procedures, titled "[Step managment corporation Procedures, titled, "Screen procedures included the staff: "All potential employed of the application pro- a history of abuse, new individuals" "Screening will includ and known past empl "Screening will also in appropriate licensing professional licensing Assistant Registry."	al requirements, facility staff, strator, Director of Nursing, er, Maintenance Supervisor, recognize that the manner as forcibly taken to shower 0/29/07 was abusive and mental distress. Additionally, d CNA 14 expressed their rervisor, NA 1, relating to the dent 1 was forcibly taken to mation did not bring about a n by facility administration of reported as required. the facility's policies and Shared name of facility and ion] Health Care Policy and iting Abuse" revealed a ning of Staff". These the following instructions to ees will be screened as part cess to determine if there is eglect, or mistreatment of de contact with known current loyers." nclude contact with the board at [name of g agency] or the Nursing					

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	.DINC	PLE CONSTRUCTION G	(X3) DATE SU COMPLET	RVEY
		465100	B. WIN	G		12/0	3/2007
NAME OF PF	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 1035 South 500 East Salt Lake City, ut 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	21 was currently worl was no documentation her references had b CNA coordinator, war reference checks bei had called on CNA 2 had documented it or documentation was r NA 1's DOH was 8/20 working at the facility documentation in her references had been CNA 16's DOH was 8 11/20/07. There was employee file that he verified. CNA 17's DOH was 8 currently working at the documentation in his references had been CNA 9's DOH was 7 12/2/07. There was employee file that he verified. CNA 23's DOH was 8 terminated. There was employee file that he verified. CNA 24's DOH was 8 terminated. There was employee file that he verified. CNA 24's DOH was 8 terminated. There was employee file that he verified. CNA 20's DOH was 8 terminated. There was employee file that he verified. CNA 20's DOH was 8 terminated. There was employee file that he verified. CNA 20's DOH was 8 terminated. There was employee file that he verified. CNA 20's DOH was 8 on 12/1/07. There was	<ul> <li>a of hire) was 10/24/07. CNA king at the facility. There on in her employee file that een checked. NA 1, the s interviewed regarding ng done. NA 1 stated she 1's reference, and that she n a notepad but that the not in the employee's file.</li> <li>0/07. NA 1 was currently the model of the theter of the employee file that her verified.</li> <li>8/15/07. CNA 16 terminated is no documentation in her references had been</li> <li>8/21/07. CNA 17 was he facility. There was no employee file that his verified.</li> <li>7/6/07. CNA 9 terminated on no documentation in her references had been</li> <li>8/10/07. CNA 23 has as no documentation in her references had been</li> <li>8/10/07. CNA 24 has as no documentation in her references had been</li> <li>8/14/07. CNA 20 terminated as no documentation in her references had been</li> </ul>	F	226			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 APPROVED D: 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	NG_			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A					4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	employee file that ind verified as active thro licensing agency. On 11/29/07, the Bus interviewed as to who checking references a stated that this respon by the Department Mi employee was hired. Coordinator was resp CNA references and was responsible for c and licenses. On 11/ coordinator was initially check references, and came on board, he st checks. On 11/29/07 interviewed about the checks. The facility D responsibility, but bec new employee), some was doing the referen DON stated that he h recently. The facility interviewed on 11/29/ reference checks bein Administrator stated to Business Office Mana- reference checks. Su employee files to the specifically if reference	no documentation in the licated her license was rugh the the professional iness Office Manager was o was responsible for and verifying licenses. She nsibility was to be completed anager for which the She stated that the CNA is stated that the CNA is stated that the DON hecking nursing references 29/07, the facility CNA viewed. She stated that y hired, she was asked to d that once the new DON arted doing the reference to the facility DON was e documentation of reference DON stated that this was his cause he was "new" (as a eone in the business office nce checks. The facility ad not been doing them until Administrator was '07 at 3:00 PM, regarding ng completed. The facility that she thought the ager had been doing the urveyors provided the CNA Administrator and asked	F	<sup>7</sup> 22			
F 240 SS=D	483.15 QUALITY OF	LIFE or its residents in a manner	F	24	40		1/11/08

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/16/2008 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	· · · ·	E SURVEY PLETED
		465100	B. WI	NG .			C 12/03/2007
NAME OF PR	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 240	maintenance or enha	e 46 ncement of each resident's	F	24	40		
	by: Based on observation review it was determi care for its residents i environment that pror enhancement of each 1 supplemental reside identifier 20 Findings included: Resident 20 was a 56 facility on 11/15/07 w limb amputations. Resident 20's medica 12/03/07. Resident 2 Resident 20 was cog and long term memor mentally independent decisions. Her mode person wheeled in wh dependent on staff fo Activities of Daily Livi Comments in chart: " showed good awaren was no bowel or blad medical record. Ther (minimum data set) a The complete assess medical record on 11.	r transfer and ADL( ng)'s and for toileting. Resident [Resident 5] uess of safety issues." There der assessment in the re was no admission MDS ssessment in the record. ument was due to be in the /28/07. The resident care					
	plan documented con	tinent of bowel and bladder. dicated resident needed					

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FOR	D: 01/16/2008 M APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	TED
	465100	B. WIN	NG_			C 03/2007
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
nursing assistants). T         indicated per resident         pain was found in the         plan.         On 12/03/07 at 9:00 A         Resident 20 was initia         she was in the facility         20 stated that when st         was continent. Reside         being at the facility for         get assistance with toi         bed and clothing seve         20 stated that the aide         brief to prevent soiling         Resident 20 stated that         and bowel) for 20 min         from facility staff to ge         just release due to the         Resident 20 stated that         urinary accidents due         assistance from aides         laying in a urine soake         she used the incontine         from wetting her bed.         wear a brief was horril         felt humiliated.         On 12/03/07 at 3:15 F         12 was initiated in roo         present. CNA 12 state         short staffed. CNA 12         have two CNA's on the         however, have had on         one CNA that floats from         assist. He stated that	At with two CNA's (certified he schedule for toileting request. No care plan for temporary admission care M, an interview with ted. Resident 20 stated for rehabilitation. Resident he arrived at the facility she ent 20 stated that after a week, she was unable to leting and was soiling her ral times a day. Resident as offered for her to wear a her clothing and bedding. At after "holding it" (urine utes, without assistance t to the restroom, she would e pain of holding it. At she had fear of having to not getting timely to get to the toilet, and was ed bed. Resident 20 stated ence brief to protect herself Resident 20 stated that to oble and disgusting and she PM, an interview with CNA m 5 with Resident 20 ed that they have been e stated that usually they e east hall during the day, ily one CNA recently, and om west to east halls to	F	<sup>:</sup> 24			

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/16/2008 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		465100	B. WIN	NG _		12	2/03/2007
NAME OF PR	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 240	asked her to wait whil residents. He stated Resident 20's request restroom, and didn't r On 12/03/07 at 9:13 <i>A</i> initiated with resident she had received a pr narcotic pain medicat milligrams of acetami hours for pain. Resid had told her that she acetaminophen in a 2 to spread out her pain stated that she was n medication in a 24-ho under control and kee four grams Residen from 1 to 10 her pain A review of the nursin documented that Res pain in both upper exit that Resident 20 state hospital she was rece every 4 hours. It doct upset, and the nurse make a clarification to There was no docume indicating changes to to provide Resident 2 control without excee acetaminophen in a 2 On 11/16/07, the physician order that do clarification for Lortal	the he finished showering two that he forgot about that he forgot about about the second that rescription for Lortab ( a ion in combination with 500 nophen) 1-2 tabs every 4 ent 20 stated that the facility could not exceed 4 grams of 4-hour period and needed in medications. Resident 20 ot able to take enough ur period to keep her pain ep the acetaminophen under t 20 stated that on a scale level was at 9 or 10. In g notes, dated 11/16/07, ident 20 was complaining of tremities. It documented ed that while she was at the siving 2 Lortab instead of 1 umented Resident 20 was had called the doctor to the medication order. In the medication were made 0 with the appropriate pain ding the 4 grams of 4-hour period.	F	24	40		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 APPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI			(X3) DATE SURVEY COMPLETED	
		465100	B. WI	NG_			C 3/2007
NAME OF PR	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
INFINIA A	T ALTA				SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 240	Continued From page	÷ 49	F	24	40		
	-	lso documented that the not to exceed for grams in					
	documented that Res	g note, dated 11/17/07, ident 20 was still n the left upper stump.					
	documented that Res complaining of pain ir the pain as a 9 out of	n the left extremity, and rated 10. The note documented were being administered					
	The MDS coordinator have been encouragin pain medication out a hours so as not to ex- acetaminophen in a 2 coordinator stated that Resident 20 had com coordinator called in f coordinator stated that same pain relieving s the 4 grams acetamin	S coordinator was initiated. stated that the nursing staff ng resident 20 to spread the ind wait more than four					
	Resident 20 were rev dated 12/3/07, docum Lortab 10/500 had be order for Lortab 10/32 tablets every four hou been ordered.	iewed. A telephone order, nented that the medication, en discontinued and a new 25 milligrams one to two urs as needed for pain had					
	On 12/03/07 at 9:13 A initiated with Residen	AM, an interview was t 20.  Resident 20 stated					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465100	B. WIN	IG _			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA			I	4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 240	that she was admitted room 5. Resident 5 st weeks she has had a room. Resident 5 st arms or legs she was may drop on the floor swept frequently the room. Resident 5 st graveyard nurses had evening because the bed. On 12/03/07 from 9:1 observed that Reside had ants in the room. be located on the floor Resident 20's bed. T eating the food partic observed that there w substance along one On 12/03/07 at 1:00 F Maintenance Supervi Maintenance Supervi control company had and sprayed the perin The Maintenance Sup documented that the sprayed the building about room 5, the Ma that room 5 was not s unaware there were a On 12/03/07 at appro Maintenance Supervi powdery substance were	d to the facility on 11/15/07 in stated that for the previous 2 nts crawling through her ited that since she has no a unable to pick up food that r, and when the room is not ants spread through the ited that one of the d to change her bedding one ants had migrated to her 3 AM to 3:30 PM, it was int 20's in room [Room 5] The ants were observed to be under and around the ants were observed to be les on the floor. It was vas a brown powdery of the baseboards. PM, an interview with the sor was initiated. The sor stated that the pest come out the previous week meter of the building for ants. pervisor provided a bill that pest control company had on 11/28/07. When asked intenance Supervisor stated sprayed, and he was	F	240			
F 241 SS=E	483.15(a) DIGNITY		F	24 <i>°</i>	1		1/11/08

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION		(X3) DATE SUF COMPLET	RVEY
		465100	B. WI	NG _				3/2007
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOUL E APPRO	_D BE	(X5) COMPLETION DATE
F 241	manner and in an envenhances each reside full recognition of his This REQUIREMENT by: Based on observation determined that for 1 4 supplemental samp not promote care for an environment that re each resident's dignit recognition of his or f 2, 8, 12, 19, 20. Findings included: Resident 20 was a 56 facility on 11/15/07 w limb amputation. Resident 20's medica 12/03/07. Resident 2 Resident 20 was cog and long term memor mentally independent decisions. Resident 2 other person wheeled was dependent on stat toileting. Comments good awareness of stat bowel or bladder asser record. There was not data set) assessment medical record. The	<ul> <li>anote care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.</li> <li>T is not met as evidenced</li> <li>and interview, it was of 11 sample residents and de residents the facility did residents in a manner and in maintained or enhanced y and respect in full there individuality. Residents:</li> <li>B year old admitted to the ith diagnoses including four</li> <li>all chart was reviewed on 20's evaluation indicated that intive with good short term ry, and was oriented, and a with consistent, reasonable 20's mode of locomotion was d in wheelchair. Resident showed afety issues." There was no essment in the medical the medical the admission MDS (minimum time the cord. The twas due to be in the</li> </ul>	F	24				

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		465100	B. WI	NG_			)3/2007
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 241	that Resident 20 request. On 12/03/07 at 9:00 A resident 20 was initial was in the facility for said that the aides to wear incontinence br had never worn briefs continent. Resident 2 having urinary accides assistance from aides 20 stated she had was came to answer her of minutes, she could no Resident 20 stated sh herself from wetting that to wear a brief w she felt humiliated. Resident 8 was admi 12/11/07 with diagno schizophrenia, hypoti failure, hypertension, On 11/15/07, Nurse 7 residents' right to be respect. Nurse 1 state Nursing (DON) had no 8 about her teeth and the tone of voice the tone. Nurse 1 stated comment had been in front of other staff me	Foileting care plan indicated aired ex tensive assistance ed nursing assistants). The indicated per resident AM, an interview with ted. Resident 20 said she rehabilitation. Resident She Id her two weeks ago to iefs. Resident 20 stated she is before because she is 20 stateed she had a fear of ents due to not getting timely is to get to toilet. Resident aited 20 minutes, and no one call light and after 20 of hold it any longer. The used the brief to protect her bed. Resident 20 stated as horrible, disgusting and tted to the facility on ses which included, hyroidism, congestive heart and alzheimer's disease. I was interviewed about the treated with dignity and ed that the Director of nade a comment to resident i breath. Nurse 1 stated that DON used was not a friendly that the DON made the nade at the nurses station in embers and residents. tesident appearred very	F	24			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/16/2008 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPLI	URVEY ETED
		465100	B. WI	NG_		12	C /03/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 241	On 11/19/07, Resider Resident 8 stated tha ago, the DON stated, teeth.". She indicated made in a tone that m Resident 8 also state made her feel bad wh Resident 8 stated, "T shouldn't be able to o also stated that her ro without her permissio (laundry soap) had be her permission. On 11/27/07 at 12:10 interviewed. Resider Administrator, Social DON had come to he searching rooms to "I that doesn't belong.". didn't know what was stated that when the drawer of Resident 19 stated, "That's my ur DON did not acknowl search through the dr Resident 19 stated th jar" (a jar to urinate in been provided) and tf jar" with out the room Resident 19 stated th when she had a fema Administrator, DON a roommate's dresser, things, but did not tak stated that this search	ht 8 was interviewed. It approximately two weeks "You need to brush your d that the comment was hade her feel "degraded". d that facility staff members hen she orders pizza. hey make me feel like I order pizza.". Resident 8 bom had been searched on, and that her woolite een taken from her without PM, Resident 19 was ht 19 stated that the facility Service Worker (SSW) and r room and said they were Make sure nothing's here Resident 19 stated that she s meant by that. Resident 19 DON searched the top 9's her dresser, Resident 19 hoderwear drawer," and the ledge her and continued to rawer without permission. It her roommate had a "pee h, because a urinal had not hat facility staff took this "pee	F	24			

Facility ID: UT0002

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DEPARTMENT OF HEALTH A				FOR	D: 01/16/2008 APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	465100	B. WING	G	12/	C 03/2007
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	DE	
INFINIA AT ALTA			4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
<ul> <li>asked if she was aw she stated that she and belongings had</li> <li>On 11/20/07 a reside conducted. Resident they were treated by of residents present members treat them resident stated that language in from of what was meant by residents reported, <sup>10</sup></li> <li>On 11/20/07, during Resident 2 stated the shower. The survey private, to discuss the Resident 2 stated the had been here, the shower when you distated that the other she was supposed that she told the CN Resident 2 reported told over and over a shower, even thoug 2 stated, I told her "take a shower anyw 483.15(h)(1) ENVIR</li> <li>F 252</li> <li>The facility must procomfortable and how the resident to use for the extent possible</li> </ul>	ent 12 was interviewed and are of a room search, and was not aware that her room been searched. ent group interview was its in general were asked how y staff members. The majority complained that staff disrespectfully. One some of the aides use bad them. The surveyor asked "bad language" and the swear words". the resident group interview, at she was "forced" to take a fors met with Resident 2, in he events of the incident. at ever since the new DON CNA's made you take a dn't want to. Resident 2 day she didn't feel well, and o take a shower that day, and A she didn't want to. that she was "pestered" and gain, that she had to take a in she didn't want to. Resident no", and the CNA made me ay, and I just didn't feel good. ONMENT vide a safe, clean, melike environment, allowing is or her personal belongings		241		1/11/08

Event ID: 4L4L11

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 A APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		465100	B. WIN	NG _			3/2007
NAME OF PR	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	۶IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 252	by: Based on observation determined that the fa clean, comfortable an Specifically, repairing functionality, and repairing functionality, and repairing functionality, and repairing functionality, and repair resident room. Room Findings included: Resident 20 was a 56 the facility on 11/15/0 included traumatic an both legs, hypertension migraines. On 12/03/07 at 9:13 A initiated with resident she was admitted to the room 5. She stated the the faucet in room 5 of the blinds would fall of anyone would try to a she had mentioned the facility staff, and had work on the faucet, he dripping and keeping On 12/03/07 from 9:1 observed that the fau drip. The frames of the be balancing on the fau supporting brackets of On 12/03/07 at 1:00 F the Maintenance Sup Supervisor stated that dripping faucet, but the	a and interview it was acility did not provide a safe, d homelike environment. blinds for privacy and airing a dripping faucet in a a 5. a year old female admitted to 7 with diagnoses that putation of both arms and on, breast cancer, and AM, an interview was 20. Resident 20 stated that he facility on 11/15/07 in hat when she was admitted continuously dripped, and ff of the window when djust them. She stated that he Maintenance Supervisor owever, the faucet was still	F	25	52		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY TED
		465100	B. WIN	NG _			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE	ī	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 252 F 272 SS=B	that he had faxed a c replacement parts to waiting for approval of Maintenance Supervi broken blinds in room Supervisor stated tha were broken. The Ma that staff in the facility environmental concer- located at each nursh identified. The facility was asked bill for replacement par room 5, that was sub- office. The facility was of the bill. On 12/03/07 at 1:15 F maintenance log local station revealed that in needed for room 5's w 483.20, 483.20(b) CC ASSESSMENTS The facility must concer a comprehensive, accor reproducible assess functional capacity. A facility must make a assessment of a resid specified by the State include at least the for	opy of the bill for the corporate office and was on the purchase order The sor was asked about the a 5, the Maintenance t he was unaware that they aintenance Supervisor stated v are instructed to write rns in the maintenance logs ng station when a repair is d for a copy of the estimated arts to repair the faucet in mitted to the corporate as unable to provide a copy PM, a check of the ted at the east nursing no repairs were identified as window blinds. DMPREHENSIVE duct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the RAI e. The assessment must		25	52		1/11/08

Facility ID: UT0002

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/16/2008 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		465100	B. WI	NG _		12/	03/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	Continence; Disease diagnosis ar Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments ar Discharge potential; Documentation of suit the additional assess resident assessment Documentation of par This REQUIREMENT by: Based on record revit the facility did not hav accurate assessment functional capacity fo Residents: 2, 4, 11, Findings included: 1. Resident 2's medi 11/26/07. Resident 2's on 8/11/06 with diagr cerebral palsy, hyper dementia with depress retardation. Based on an annual f assessment with a re resident 2 triggered in	atterns; ing; and structural problems; and health conditions; I status; and procedures; mmary information regarding ment performed through the protocols; and rticipation in assessment. T is not met as evidenced ew, it was determined that ve complete, comprehensive, ts of each resident's r 3 of 11 sample residents. cal record was reviewed on 2 was admitted to the facility poses including: infantile tension, pain, anxiety, ssive features, and mental MDS (Minimum Data Set) ference date of 8/7/07, in the following areas of ent Assessment Protocol	F	27	72		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	ſED
		465100	B. WI	NG _			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	potential, Urinary inco behavioral symptoms dehydration/fluid maii pressure ulcers, and each triggered area ti and location of the as 2. Resident 4's medii 11/27/07. Resident 4 on 7/13/06 with diagr stenosis, cerebral vas UTI's (urinary tract in An annual MDS (Mini 5/31/07. No RAPS w MDS which meant the complete. 3. Resident 11's medii 11/29/07. Resident 1 on 8/1/99 with diagnor retardation, obesity a Based on an annual I assessment reference 11 triggered in the fol the Resident Assessi (RAPS): delirium, co communication, ADL functional/rehabilitation behavioral symptoms maintenance, pressu drug use. For each ti documented the loca as: "s/s (social servic summary, RAP docur ADL's (activities of da	Functional/Rehabilitation ontinence, mood state, a, nutritional status, intenance, dental care, psychotropic drug use. For here was no specific date assessment documentation. cal record was reviewed on a was admitted to the facility hoses including: spinal scular accident, recurrent fections), and lumbago. imum Data Set) was done vere included with the annual at the MDS was not dical record was reviewed on 1 was admitted to the facility bases including: mental nd hypothyroidism. MDS assessment, with an e date of 9/12/07, resident lowing areas of Section V, ment Protocol Summary gnitive loss/dementia, (activities of daily living) on potential, mood state, a, falls, dehydration/fluid re ulcers and psychotropic riggered area facility staff tion of the RAP assessment es) notes, Mo. (monthly) mentation, nurse assess.,	F	272			

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/16/2008 ORM APPROVED 3 NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION		E SURVEY IPLETED
		465100	B. WI	NG			C 12/03/2007
NAME OF PR	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA		4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272 F 273	no date indicated for specific entries in whi could be located for e identified. On 11/29/07 at 2:25 F MDS coordinator nurs asked about missing and dates of the RAP documentation. She filled out those asses the facility. 483.20(b)(2)(i) RESIE	ration record)." There was any of these. Therefore, the ch the assessment data each of these items was not PM, an interview with the se was initiated. She was RAPS, and missing location		: 27 : 27			1/11/08
SS=D	after admission, exclu there is no significant physical or mental co this section, "readmiss facility following a ten hospitalization or for the This REQUIREMENT by: Based on interview a determined that the fac comprehensive assess timely manner. Resident 20 Findings included:	dent within 14 calendar days uding readmissions in which change in the resident's ndition. (For purposes of sion" means a return to the nporary absence for therapeutic leave.) is not met as evidenced and record review, it was acility did not conduct a ssment of a resident in a					
		nitted from the hospital to the with diagnoses including					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED O. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI			(X3) DATE SU COMPLE	JRVEY TED
		465100	B. WING			12/	C 03/2007
NAME OF PR	OVIDER OR SUPPLIER	-		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 273	Continued From page recent quadrilateral a		F	27	73		
F 309 SS=G	on 11/29/07. There w Minimum Data Set (M the medical record as calendar days after a conduct a comprehen RAPS (Resident Asso Summary). An interview was initia Coordinator on 12/3/0 comprehensive MDS completed for residen 483.25 QUALITY OF Each resident must re provide the necessary or maintain the higher mental, and psychoso	dmission the facility must hsive assessment including essment Protocol ated with the nurse MDS 07. She confirmed that a assessment had not been ht 20. CARE eccive and the facility must y care and services to attain st practicable physical,	F	30	09		1/11/08
	by: Based on interview and determined that the far necessary care and s the highest practicabl psychosocial well-bei comprehensive asses	is not met as evidenced ind record review it was acility did not provide the services to attain or maintain le physical, mental, and ng, in accordance with the ssment and plan of carefor mple resident. Resident					

Facility ID: UT0002

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		ND HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 01/16/2008 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		465100	B. WIN	NG		12	C / <b>/03/2007</b>
NAME OF PF	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Resident 20 was a 56 facility on 11/15/07 w limb amputations. On 12/03/07 at 9:13 <i>A</i> initiated with resident she had received a p medication with aceta hours for pain. She s told her that she could acetaminophen in a 2 to spread out her pain stated that it was not medication in a 24-ho under control. She st to 10 her pain level w Resident 20's medica 12/03/07. Resident 2 Resident 20 was cog and long term memor mentally independent decisions. Her mode person wheeled in wh chart: " Resident sho safety issues." There the medical record. T MDS (minimum data assessment) assessr complete assessmen medical record on 11. pain was found in the plan. A review of the nursin documented that Res pain in both upper ex documented that Res	AM, an interview was 20. Resident 20 stated that rescription for Lortab (pain aminophen) 1-2 tabs every 4 tated that the facility had d not exceed 4 grams of 44-hour period, and needed n medications. Resident 20 able to take enough our period to keep her pain ated that on a scale from 1 as at 9 or 10. I chart was reviewed on 0's evaluation indicated that nitive with good short term y, and was oriented, and with consistent, reasonable of locomotion was other neelchair. Comments in wed good awareness of a was no pain assessment in There was no admission set/comprehensive resident nent in the record. The t was due to be in the (28/07. No care plan for temporary admission care	F	. 30	99		

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/16/2008 A APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	¢	(3) DATE SUF COMPLET	ED
		465100	B. WI	NG_				C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 309	Lortab instead of one documented that Res nurse had called the to the medication ord that the order was cla documentation was for changes to the medic the patient with the a without exceeding the a 24-hour period. A review of the physi revealed that, on 11/ clarifying the pain me order documented th Lortab 10/500 milligra mouth every four hou dcoumented the acet exceed 4 grams in 24 The nursing note, dat that Resident 20 was the left upper extremit The nursing note, dat that Resident 20 was the left extremity and 10. Pain medications doctor's orders. On 12/03/07 at appro- interview with the MD initiated. The MDS c nursing staff have be to spread the pain me exceed the 4 grams of 24-hour period. The today was the first dat	e very 4 hours. The note sident 20 was upset, and the doctor to make a clarification er. The note documented arified, however, no bound indicating what cation were made to provide ppropriate pain control e 4 grams acetaminophen in cian telephone orders 16/07, a telephone order edication was written. The at the resident could receive ams, one or two tablets, by urs as needed. The order aminophen was not to a hour period. ted 11/17/07, documented still complaining of pain in rated the pain as a 9 out of a were administered per eximately 1:15 PM, an PS coordinator nurse was oordinator stated that the en encouraging Resident 20 edication out so as not to of acetaminophen in a MDS coordinator stated that	F	30	9			

Facility ID: UT0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY ED
		465100	B. WI	NG_			C 3/2007
NAME OF PROVIDER OR SUPPLIER			·	S	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315 SS=G Bass rescind 24- A ru rev Lor for eve SS=G Bass res ind res cat whit treat infe fun F SS=G Bass res ind fun F SS=G Bass res cat whit treat cat so co co co co cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so co cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so cat so co co co co co co co co co co co co co	me pain relieving st ceed the 4 grams o -hour period. review of the physic vealed a physician of rtab 10/500 to be di Lortab 10/325 milli ery 4 hours as need e facility staff did no sidents pain and se manage Resident 2 o weeks, during wh ntinued to be in pain 3.25(d) URINARY I sed on the resident sessment, the facili sident who enters the welling catheter is sident's clinical cond theterization was ne to is incontinent of the atment and service ections and to restor action as possible. is REQUIREMENT sed on observation view, it was determination sure that a resident atment without a cli	v order. The MDS t the new order had the rength, but would not f acetaminophen in a ian telephone orders order dated, 12/03/07, for iscontinued and a new order grams, one or two tablets ded for pain. of properly assess the e apppropriate interventions 0's pain successfully for ich time the resident n. NCONTINENCE 's comprehensive ty must ensure that a ne facility without an not catheterized unless the dition demonstrates that ecessary; and a resident oladder receives appropriate is to prevent urinary tract ore as much normal bladder is not met as evidenced , interview and record ned that the facility did not who entered the facility nical urinary condition was not receive appropriate		30			1/11/08

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STATE DENT OF DEFICIENCIES       Implicit Providers Supplicit Auton Number:       Destination       Destination <t< th=""><th></th><th>-</th><th>ND HUMAN SERVICES MEDICAID SERVICES</th><th></th><th></th><th></th><th>FC</th><th>TED: 01/16/2008 DRM APPROVED NO. 0938-0391</th></t<>		-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/16/2008 DRM APPROVED NO. 0938-0391
Meter         Meter         Mater         Meter         Meter <th< td=""><td></td><td></td><td></td><td>l` í</td><td></td><td></td><td>· · ·</td><td>LETED</td></th<>				l` í			· · ·	LETED
Imprint A T ALTA         Constraints           CMU ID PRETIX TAG         SUMMARY STATEMENT OF DEFICIENCIES ISALT LAKE ENTY, UT 84107         Continued From page 64 continence and maintain normal bladder function on a boileting program for one supplemental sample resident. Lesident identifier: 20.         F 315         Continued From page 64 continence and maintain normal bladder function on a boileting program for one supplemental sample resident. Resident identifier: 20.         F 315         F 315           Resident 20 was a 56 year old admitted to the facility on 111/507 with diagnoses including four limb amputations.         F 315         F 315           Resident 20 was a 56 year old admitted to the facility on 111/507 with diagnoses including four limb amputations.         F 315         F 315           Resident 20 was a 50 year old admitted to the facility on 111/507 with diagnoses including four limb amputations.         F 315         F 315           Nome of locomotion was in a wheelchair with one person assistance. Resident 20 was oriented. and mentally independent with consistent. reasonable decisions. Resident 20 was oriented and contom in Resident 20 was oriented and excloant prevident advage appendent on staff for transfers and tolleting. The notes documented that Resident 20 was medical record. Three was no admitsion MDS (minimum data set/comprehensive resident assessment) use sessement in the resident 20 was of all record. Three was no admitsion MDS (minimum data set/comprehensive resident assessment) assessment in the resident 20 stated as the was initiated. Resident 20 stated she was onitient of bowel and bladder. Toileting are plan indicated resident resident 20 stated that whe she arrived at the facility the was continent of bowe			465100	B. WIN	NG.		1	
INFINIA AT ALTA         SALT LAKE CITY, UT 84107           (24) [0]         [24:01 BETCINKY WIST & PRECEDED BY LULL REGULATORY OR LS: DENTIFING INFORMATION)         ID PRETIX TAG         PROVIDER'S ALL OF CORRECTIVE ACTION SHOULD BE CROSS REFERENCE IN OF CORRECTIVE ACTION SHOULD BE CROSS REFERENCE IN OF CORRECTIVE ACTION SHOULD BE CROSS REFERENCE IN CONSTRUCT TO THE UPPROPRATE         0.001 CMU FINANCE           F 315         Continued From page 64 continence and maintain normal bladder function on a tolleting program for one supplemental sample resident. Resident identifier: 20.         F 315           Findings included:         Resident 20 was a 56 year old admitted to the facility on 11/15/07 with diagnoses including four limb amputations.         F 315           Resident 20 was congitive with good short term and long term memory. Resident 20 was oriented, and mentally independent with consistent, reasonable decisions. Resident 20 was oriented, and mentally independent with consistent, reasonable decisions. Resident 20 was dependent on staff for transfers and boleting. The notes documented that Resident 20 barced cond awareness of safety issues. There was no bowel or blader assessment fund in Resident 20 was dependent assessment low as the resident care plan documented out the resident care plan documented to the resident care plan documented net metally independent for tolleting indicated per resident request.         On 12/20307 Am an interview with Resident 20 was in the facility for rehabilitation. Resident 20 stated that when her antived at the facility sho was continent of bowel and bladder. Tolleting indicated per resident tered sho was in the facility for rehabilitation. Resident 20 stated that when her antived at the facility sho was continent of bowel and bladder. Tolleting indicated p	NAME OF PR	OVIDER OR SUPPLIER			s			
Prefry TAG         LEACH DEFICIENCY MORT BE PRECEDED BY FULL REGULTORY OR LISC DEPATIFYING INFORMATION)         PREFIX TAG         CEACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         COMMENTION DEFICIENCY           F 315         Continence and maintain normal bladder function on a tolleting program for one supplemental sample resident. Resident identifier: 20.         F 315         F 11         F	INFINIA A	T ALTA						
continence and maintain normal bladder function         on a toileting program for one supplemental         sample resident. Resident identifier: 20.         Findings included:         Resident 20 was a 56 year old admitted to the         facility on 11/15/07 with diagnoses including four         limb amputations.         Resident 20's medical chart was reviewed on         12/03/07. Resident 20's evaluation indicated that         resident 20 was cognitive with good short term         and long term memory. Resident 20's         mode of locomotion was in a wheelchair with one         person assistance. Resident 20 was opod         awareness of safety issues. There was no bowel         or staff for transfers and tolleting. The notes         documented that Resident 20 was depodent         or bladder assessment found in Resident 20's         medical record. There was no bowel         or bladder assessment was due to be in the         complete assessment was due to be in the         medical record on 11/28/07. The resident care         plan documented continent of bowel and bladder.         Toileting care plan indicated resident needed         extensive assist by two persons. The schedule         for toileting indicated per resident request.         On 12/03/07 at 9:00 AM, an interview with         Resident 20 was initilat	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	FIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
	F 315	continence and maint on a toileting program sample resident. Res Findings included: Resident 20 was a 56 facility on 11/15/07 w limb amputations. Resident 20's medica 12/03/07. Resident 2 resident 20 was cogn and long term memor oriented, and mentall consistent, reasonabl mode of locomotion w person assistance. R on staff for transfers a documented that Res awareness of safety i or bladder assessmen medical record. Ther (minimum data set/co assessment) assess complete assessmen medical record on 11. plan documented cor Toileting care plan ind extensive assist by tw for toileting indicated On 12/03/07 at 9:00 A Resident 20 was initia she was in the facility 20 stated that when s was continent of bow stated that after being	ain normal bladder function a for one supplemental sident identifier: 20. by ear old admitted to the ith diagnoses including four al chart was reviewed on 20's evaluation indicated that itive with good short term y. Resident 20 was y independent with e decisions. Resident 20's vas in a wheelchair with one esident 20 was dependent and toileting. The notes ident 20 showed good ssues. There was no bowel and toileting. The notes ident 20 showed good ssues. There was no bowel in found in Resident 20's te was no admission MDS omprehensive resident ment in the record. The t was due to be in the /28/07. The resident care tinent of bowel and bladder. dicated resident needed vo persons. The schedule per resident request. AM, an interview with ated. Resident 20 stated for rehabilitation. Resident the arrived at the facility she el and bladder. Resident 20 g at the facility for a week,	F	<sup>:</sup> 31			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY ED
		465100	B. WIN	NG _			C 3/2007
NAME OF PF	OVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315 F 334 SS=E	and was soiling her b times a day. Resider assistants offered inc resident to wear to pr and bedding. Reside "holding it" (urine and without assistance fro restroom, she would j of holding it. Resider urinary accidents due assistance from aides urine soaked bed. Re the brief to protect he Resident 20 stated th horrible, disgusting an On 12/03/07 at 3:15 12 was initiated in roo present. CNA 12 stat short staffed. CNA 12 have two CNAs on th however, they have ro on the east hall and o west to east halls. Cl ago he had responde and had asked her to showering two other r that he forgot about F assistance to the rest 483.25(n) INFLUENZ IMMUNIZATION The facility must deve that ensure that (i) Before offering the each resident, or the	ed and clothing several t 20 stated that the nursing ontinent briefs for the event soiling her clothing int 20 stated that after bowel) for 20 minutes, m facility staff to get to the ust release due to the pain int 20 had a fear of having to not receiving timely to get to toilet and laying in esident 20 stated she used rself from wetting her bed. at to wear a brief was and she felt humiliated. PM, an interview with CNA im 5 with Resident 20 ed that they have been 2 stated that usually they e east hall during the day, ecently had only one CNA, ne CNA that floats from VA 12 stated that two days d to Resident 20's call light, wait while he finished esidents. CNA 12 stated tesident 20's request for room and didn't return. A AND PNEUMOCOCCAL		· 31			1/11/08

Facility ID: UT0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 A APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		465100	B. WIN	NG.			3/2007
NAME OF PR	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 334	<ul> <li>(ii) Each resident is or immunization Octobe annually, unless the incontraindicated or the immunized during this (iii) The resident or the representative has the immunization; and</li> <li>(iv) The resident's me documentation that in following: <ul> <li>(A) That the resident</li> <li>(A) That the resident</li> <li>(B) That the resident</li> <li>(B) That the resident</li> <li>(C) The facility must deventation that</li> <li>(i) Before offering the immunization; each relegal representative rethe benefits and potentimmunization;</li> <li>(ii) Each resident is or immunization;</li> <li>(iii) The resident is or immunization;</li> <li>(iii) The resident is or immunization;</li> <li>(iii) The resident or the presentative has the immunization; and</li> <li>(iv) The resident or the representative has the immunization;</li> <li>(iii) The resident or the representative has the immunization;</li> <li>(iii) The resident or the representative has the immunization; and</li> <li>(iv) The resident or the representative has the immunization; and</li> <li>(iv) The resident is me documentation that imfollowing: <ul> <li>(A) That the resident</li> </ul> </li> </ul></li></ul>	fered an influenza r 1 through March 31 mmunization is medically resident has already been a time period; e resident's legal e opportunity to refuse dical record includes dicates, at a minimum, the t or resident's legal ovided education regarding ntial side effects of influenza t either received the m or did not receive the m due to medical efusal. Hop policies and procedures pneumococcal esident, or the resident's eceives education regarding ntial side effects of the fered a pneumococcal the immunization is ated or the resident has zed; e resident's legal e opportunity to refuse dical record includes dicated, at a minimum, the	F	33	34		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/16/2008 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SI COMPLE	JRVEY TED
		465100	B. WI	NG _		12/	C 03/2007
NAME OF PR	OVIDER OR SUPPLIER		Ĩ	s	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 334	the pneumococcal im contraindication or re (v) As an alternative, and practitioner recor pneumococcal immur years following the fir immunization, unless the resident or the re- refuses the second in This REQUIREMENT by: Based on interview a determined that the far resident's medical rea that indicated the res pneumococcal immur immunization was me the resident had alrea Additionally, the facili resident or resident's provided education re potential side effects immunization, and wh the pneumococcal im-	ntial side effects of nization; and t either received the nization or did not receive munization due to medical fusal. based on an assessment nmendation, a second nization may be given after 5 st pneumococcal medically contraindicated or sident's legal representative nmunization. ' is not met as evidenced nd record review, it was acility did not ensure that the cord included documentation ident was offered a nization, unless the edically contraindicated or ady been immunized. ty did not ensure that legal representative was egarding the benefits and of pneumococcal nether the resident received munization or did not occal immunization due to ion or refusal. for 5 of 11	F	. 33			
	Findings included:						

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		IPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY TED
		465100	B. WIN	IG _			C 3/2007
NAME OF PI	ROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE	Ī	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 334 F 367 SS=E	On 11/29/07, medical 4, and 29 were review documentation of pre- these residents in the other notebooks offer that included the date immunization was off There was no docum or their legal represen- regarding the benefits of pneumococcal imm An interview of the D was held. The DON where the pneumoco The medical records interviewed on 12/3/0 She was asked for he residents' pneumocod documentation. She documentation regard immunization. 483.35(e) THERAPE Therapeutic diets mu attending physician. This REQUIREMENT by: Based on observation medical record review facility did not provide prescribed by the atte sample residents:	records of residents 1, 2, 3, wed. There was no sumococcal immunization for ir medical records or in ed by facility staff for review the pneumococcal ered, given, or refused. entation that these residents intatives had been educated a and potential side effects nunization. ON on 11/29/07 at 4:00 PM stated that he did not know ccal information was. staff member was 7 at approximately 9:00 AM. elp in locating these ccal immunization was unable to provide ding pneumococcal UTIC DIETS st be prescribed by the f is not met as evidenced a, interview and resident y, it was determined that the e a therapeutic diet as ending physician for 3 of 11 1 supplemental sample		334	4		1/11/08

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 A APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY ED
		465100	B. WIN	NG _			C 3/2007
NAME OF PF	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
INFINIA A	T ALTA				SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 367	admitted to the facility diagnoses that include cerebral vascular acc hypertension, aphasia depression. On 11/14/07 resident reviewed. Resident 1 orders indicated that in LCS (no added salt, le mechanical soft diet. On 11/14/07 at 12:15 interview was conduce Resident 18 was obse eating a soft shell flou interviewed about his head and pushed his surveyor asked Resid chew the food. Resid food was difficult to ch 2. Resident 4 was a admitted to the facility that included spinal st accident, recurrent un hypokalemia, dehydra On 11/14/07, Residen reviewed. Resident 4 orders indicated that 1 Regular SNP (super n mechanical soft diet. On 11/14/07 at 12:20 made of Resident 4 e Resident 4 was serve lettuce. Resident 4 w	<ul> <li>v on 10/24/07, with ed diabetes mellitus, ident, cardiac dysrhythmia, a, hemiparesis, anxiety, and</li> <li>18's physician's orders were 8's November recertification resident 18 was on a NAS, ow concentrated sweets)</li> <li>PM, an observation and ted with Resident 18. erved attempting to be in taco. Resident 18 was noon meal, he shook his tray away, untouched. The lent 18 if they were able to lent 18 indicated that the new.</li> <li>69 year old female v on 7/13/06 with diagnoses tenosis, cerebral vascular inary tract infections, ation and lumbago.</li> <li>at 4's physicians orders were t's November recertification Resident 4 was on a nutrition program),</li> <li>PM, an observation was</li> </ul>	F	36	37		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/16/2008 RM APPROVED NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED
		465100	B. WI	NG _		12	C / <b>03/2007</b>
NAME OF PR	OVIDER OR SUPPLIER	·		s	STREET ADDRESS, CITY, STATE, ZIP CODE	Ē	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 367	Continued From page shell.	e 70	F	36	57		
	admitted to the facility that include infantile	56 year old female resident y on 8/11/06, with diagnoses cerebral palsy, hypertension, a with depression and					
	were reviewed. Resi	indicated that Resident 2					
	interview was conduct Resident 2 was obset hamburger sandwich not wearing her dentu observed to not receit	rved to be eating a regular on a bun. Resident 2 was ures. Resident 2 was ve taco meat on a bun. t although she could eat the					
	admitted to the facility that included chronic disease, joint pain, hy	a 65 year old female resident y on 7/19/07, with diagnoses obstructive pulmonary /pothyroidism, diabetes, table bowel syndrome.					
	were reviewed. Resi	indicated that Resident 32					
	interview was conduc Resident 32 was obs shell flour taco. Resi	D PM, an observation and sted with Resident 32. erved to be eating a soft dent 32 stated that the eat, and that the flour shell					

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI			(X3) DATE SU COMPLET	RVEY TED
		465100	B. WI	NG_			C 3/2007
NAME OF PR	OVIDER OR SUPPLIER		ī	s	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 367	to eat as well. On 11/14/07, was pro	d, and was hard and difficult ovided the breakdown	F	36	57		
	November 14th indica who had mechanical received taco meat or						
		•					
F 371	kitchen workerwas int mechanical soft diets acknowledged that fo 11/14/07, the menu for not been followed.	The kitchen worker	F	37	71		1/11/08
SS=E		e, prepare, distribute, and itary conditions.					
	by:	is not met as evidenced is the facility did not store, od under sanitary					
	Findings included:						
		oximately 11:40 AM, the sobserved lying in an					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY TED
		465100	B. WI	NG _			C 3/2007
NAME OF PF	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	ī	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 371	Continued From page	e 72	F	37	71		
	orange and white foo covered with clear wr	d substance in a container ap in the fridge .					
	On 11/26/07 at 1:40 I had the following iten	PM, the walk-in refrigerator ns:					
	A one pound carton of cheese with expiration	of Cream O' Weber cottage n date of 11/5/07.					
		tover vanilla pudding, dated containers covered with clear					
	Jalapeno peppers in container.	brine in a single use yogurt					
	Ketchup in a single u	se sour cream container.					
	The walk in freezer concerned to the mark in freezer concerned to the second se	ontained two pie crusts with					
		crowave had pink/red drops a and the interior door was					
F 406 SS=E	hood, over the grill ar dust hanging from the 483.45(a) SPECIALIZ	covers under the range nd range that had greasy em. ZED REHABILITATIVE	F	40	06		1/11/08
	not limited to, physica	tative services such as, but al therapy, speech-language nal therapy, and mental					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/16/2008 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE : COMPL	ETED
		465100	B. WIN	NG _		12	C 2/03/2007
NAME OF PR	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 406	and mental retardation resident's comprehern must provide the required services from accordance with §483 provider of specialize	ervices for mental illness	F	<sup>-</sup> 40	26		
	by: Based on interview a determined that the fa SRS (specialized reh identified and care pla (inter-disciplinary teal and evaluating the se for habilitative care.	nd record review it was acility did not provide the abilitation services) as anned for by the IDT m). Specifically, not tracking ervices being implemented For 3 out of 11sample ple receiving SRS in the					
	to the facility on 10/20	67 year old female admitted 0/98 with diagnoses that ental retardation, seizure ular accident.					
	completed on 11/28/0 progress notes relate resident 1's SRS bind 2. Resident 2 was a to the facility on 8/11/ included mental retar palsy, hypertension, o	<ul> <li>I's medical record was</li> <li>D7. No SRS data tracking or d to SRS were found in der since September 2007.</li> <li>57 year old female admitted (06 with diagnoses that dation, infantile cerebral dementia, and depression.</li> <li>2's medical record was</li> </ul>					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/16/2008 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLET	RVEY ſED
		465100	B. WIN	NG_			C 3/2007
NAME OF PR	OVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 406 F 469 SS=D	<ul> <li>progress notes relateresident 2's SRS bind</li> <li>3. Resident 11 was a admitted to the facility that included mental in hypothyroidism.</li> <li>A review of resident 11 completed on 11/28/C progress notes relateresident 11's SRS bind</li> <li>On 11/27/07 at 4:30 F initiated with the facility asked about SRS serstated that residents at the facility had not be summarized since Ju 483.70(h)(4) PHYSIC CONTROL</li> <li>The facility must main control program so the and rodents.</li> <li>This REQUIREMENT by:</li> <li>Based on observation determined the facility effective pest control</li> </ul>	<ul> <li>b7. No SRS data tracking or d to SRS were found in ler since July 2007.</li> <li>a 82 year old female y on 8/101/99 with diagnoses retardation, obesity, and</li> <li>a 1's medical record was or No SRS data tracking or d to SRS were found in oder since July 2007.</li> <li>bM, an interview was ty social worker. When vices, the social worker receiving SRS services in en tracked or notes ly 2007.</li> <li>bAL ENVIRONMENT- PEST</li> <li>bAL ENVIRONMENT- PEST</li> <li>bAL ENVIRONMENT- PEST</li> <li>bAt the facility is free of pests</li> <li>b is not met as evidenced</li> <li>b and interview it was y did not maintain an program so that the facility i rodents. Specifically, an</li> </ul>		· 40			1/11/08
	rinaings included:						

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/16/2008 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		465100	B. WI	NG_		1	C 2/03/2007
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 469	Resident 20 was a 56 the facility on 11/15/0 included traumatic an both legs, hypertensio migraines. On 12/03/07 at 9:13 <i>A</i> initiated with resident she was admitted to the room 5. She stated the she has had ants craw stated that since she was unable to pick up floor and when the roo the ants spread throut that one of the gravey her bedding one ever migrated to her bed. On 12/03/07 from 9:1 observed that there we room (room 5). The a located on the floor up 20's bed. The ants we the food particles on the that there was a brow one of the baseboard On 12/03/07 at 1:00 F Maintenance Supervit control company had and sprayed the purity about room 5, the Maintenance Supervity on the food particles on the floor up control company had and sprayed the building of about room 5, the Maintenance Supervity on the floor of the state the sprayed the building of about room 5, the Maintenance Supervity on the floor of the state the sprayed the building of about room 5, the Maintenance Supervity on the floor state the state the sprayed the building of about room 5, the Maintenance Supervity floor state the	<ul> <li>a year old female admitted to 7 with diagnoses that putation of both arms and on, breast cancer, and</li> <li>AM, an interview was 20. Resident 20 stated that he facility on 11/15/07 in hat for the previous 2 weeks wing through her room. She has no arms or legs she o food that may drop on the om is not swept frequently gh the room. She stated vard nurses had to change ning because the ants had</li> <li>3 AM to 3:30 PM, it was vere ants in Resident 20's ants were observed to be nder and around resident ere observed to be eating the floor. It was observed in powdery substance along s.</li> <li>PM, an interview with the sor stated that the pest come out the previous week neter of the building for ants. pervisor provided a bill that pest control company had on 11/28/07. When asked intenance Supervisor stated sprayed and he was unaware</li> </ul>	F	. 46			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY ED
		465100	B. WIN	√G _			C 3/2007
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 469	Continued From page	₹76	F	46	9		
F 490 SS=J	Maintenance Supervia powdery substance w staff had placed in the 483.75 ADMINISTRA A facility must be adm enables it to use its re efficiently to attain or	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial	F	49	10		1/11/08
	by: Based on resident intra administrative staff interviews, and fi determined that the fa in a manner that ensu- abuse, and that allega misappropriation of re- immediately reported, and that employee sc required by federal re- policies and procedur and respond to the ab- residents, was determ immediate threat to re- Resident identifiers: 1 Employee identifiers: CNA 20, CNA 21, CN 1, and Nurse 7. Findings included: 1. Interviews were here	esident property were , thoroughly investigated, creening occurred as equirements and facility res. The failure to prevent buse of 1 of 10 sampled nined to present an esidents' health and safety.					

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/16/2008 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPL	ETED
		465100	B. WIN	NG_		12	C / <b>03/2007</b>
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 490	<ul> <li>(SSW), Maintenance</li> <li>Aide (CNA)13, and C</li> <li>and 11/27/07. Consisivas that resident 1 cl</li> <li>not want to shower of staff were utilized to estaff were utilized to estaff were don 10/29/0</li> <li>expressed that she d</li> <li>resident fought with the resident 1 continued</li> <li>want to shower as the removed her clothing</li> <li>Administrator and SS as the four staff mem to the shower and we cries for staff to stop,</li> <li>Also consistent from once undressed, resifed four facility staff mem Cross-refer F-223.</li> <li>Interviews were her 2, resident 3, resident 00N, current SSW, f Supervisor, Nurse Aid 14, and the Businesss interviewed between</li> <li>Although facility staff abuse to resident 1, a property of residents</li> <li>Administrator did not investigated thorough accordance with fede facility's own policies ensure that screening conducted in accordance</li> </ul>	Supervisor, Certified Nurse NA 14 between 11/14/07 stent from these interviews learly expressed that she did in 10/29/07; that four facility ensure resident 1 was 7, after she clearly id not want to shower; that he four facility staff members resident for her shower; that to yell out that she did not e four staff members and jewelry; and that the SW were within line of sight bers forcibly took resident 1 ere able to hear resident 1's while in the shower room. these interviews was that, dent 1 ceased fighting the abers and stopped yelling. eld with resident 1, resident t 19, the Administrator, former SSW, Maintenance de (NA)1, CNA 13, and CNA Office Manager were 11/14/07 and 11/27/07. had received allegations of and misappropriation of 2, 3, and 19, the ensure the allegations were hy, reported timely and in eral requirements and the and procedures, and to g of employees was	F	<sup>;</sup> 49			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/16/2008 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		465100	B. WIN	NG _		12	/03/2007
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514 SS=E	The facility must mair resident in accordance standards and practic accurately documente systematically organiz The clinical record mu information to identify resident's assessmen services provided; the preadmission screeni and progress notes. This REQUIREMENT by: Based on record revie the facility did not ma each resident in acco professional standard residents. (Residents 4, 2, 13, 3) Resident 4 Findings included: 1. Resident 4 was ac 7/13/06 with diagnose cerebral accident, rec infections and lumbag Resident 4's medical 11/27/07. The Augus (Minimum Data Set) w by the nurse coordina	tain clinical records on each e with accepted professional es that are complete; ed; readily accessible; and zed. ust contain sufficient the resident; a record of the ts; the plan of care and e results of any ing conducted by the State; is not met as evidenced ew it was determined that intain clinical records on rdance with accepted s for 4 of 11 sample 2) mitted to the facility on es including: spinal stenosis, urrent urinary tract jo. record was reviewed on t 2007 quarterly MDS vas not dated as completed tor. mitted to the facility on	F	51			1/11/08

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/16/2008 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY TED
		465100	B. WI	NG_		12/	C 03/2007
NAME OF PR	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 514	Continued From page	e 79	F	51	4		
	hypertension, pain, and men						
	reviewed. Resident 2 progress notes for the were reviewed. The	t 2 ' s medical record was 2 ' s Weekly skin evaluation e month of October, 2007 form had no nursing regarding resident 2 ' s skin,					
	10/5/07, with diagnos	admitted to the facility on es of diabetes mellitus al failure, hypertension, sophageal reflux.					
	administration record	13 ' s MAR (medication ) was reviewed. The were not documented as					
	Renagel, was not do administered on 11/2	5					
	Renaplex, was not do administered on 11/3. 11/10/07, 11/12/07, a	/07, 11/5/07, 11/6/07,					
		was not documented as n 11/2/07 and 11/23/07.					
	Prilosec, was not doc administered on 11/1	umented as being /07, 11/2/07 and 11/24/07.					
	Minoxidil, was not do administered on 11/2	-					
	Enalapril Maleate, wa administered on 11/2	is not documented as being /07.					

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		ND HUMAN SERVICES MEDICAID SERVICES				I	NTED: 01/16/2008 FORM APPROVED B NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION		IE SURVEY IPLETED
		465100	B. WIN	NG _			C 12/03/2007
NAME OF PR	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	٦I	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From page	e 80	F	51	4		
	Norvasc, was not doc administered on 11/2	•					
	Metoprolol, was not d administered on 11/2	-					
	Lipitor, was not docur administered on 11/1/ 11/4/07, 11/7/07, 11/8	/07, 11/2/07, 11/3/07,					
	Relagel, was not docu administered on11/23	Ū.					
	administered on 11/1	not documented as being 3/07 at 5:00 PM, 11/23/07 at /24/07 at 12:00 PM and 5:00					
	administered on 11/1	ot documented as being 2/07 at 5:00 PM and 8:00 at 5:00 PM and 8:00 PM.					
	Lantus Insulin, was ne administered on 11/1	ot documented as being 3/07 at 8:00 PM.					
	indicated that residen glucose checked AC bedtime). The followi documentation to indi blood glucose was tai 11/2/07 at 07:00 AM a PM. 11/10/05 at 5:00	an's orders dated 10/5/07 t 13 was to have his blood and HS (before meals and ng dates times there was no cated that resident 13's ken and documented on and 5:00 PM. 11/2/07 at 5:00 0 PM. 11/14/07 at 11:00 AM. 1. 11/24/07 at 11:00 AM, and t 5:00 PM.					
		admitted to the facility on es of chronic obstructive pint and pelvis pain,					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/16/2008 MAPPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	ĒD
		465100	B. WING			C 12/03/2007	
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA A	T ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 514	hypothyroidism, diabe and irritable bowel sy On 11/14/07 resident reviewed, including h (medication administr	etes mellitus, hypertension,	F	51	4		
		13/07, 11/20/07, 11/21/07, 1/24/07, 11/25/07, 11/27/07,					
		cumented as being 1/07, 11/22/07, 11/23/07, 1/27/07, 11/28/07, and					
	Prilosec, was not doc administered on 11/1 11/28/07.	umented as being 3/07, 11/14/07, 11/27/07 and					
		ot documented as being 0/07, 11/27/07 and 11/28/07.					
	administered on 11/2	s not documented as being 0/07, 11/21/07, 11/22/07, 1/25/07, 11/27/07, 11/28/07,					
F 520 SS=J	11/23/07, 11/24/07, 1 and 11/29/07. 483.75(o)(1) QUALIT	umented as being 0/07, 11/21/07, 11/22/07, 1/25/07, 11/27/07, 11/28/07, Y ASSESSMENT AND	F	52	20		1/11/08
22-1							

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/16/2008 MAPPROVED O. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		465100	B. WI	NG_		12/	C 03/2007
NAME OF PF	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	٦I	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	A facility must mainta assurance committee nursing services; a pl facility; and at least 3 facility's staff. The quality assessme committee meets at le issues with respect to and assurance activit develops and implem action to correct idem A State or the Secret disclosure of the reco except insofar as suc compliance of such c requirements of this s Good faith attempts to and correct quality de a basis for sanctions. This REQUIREMENT by: Based on interviews a it was determined that that the Quality prob corrective action plan identification of abuse a resident property; rep allegations of pain man incontinence cares. Resident identifiers: 1	in a quality assessment and e consisting of the director of hysician designated by the other members of the ent and assurance east quarterly to identify o which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies. tary may not require ords of such committee h disclosure is related to the ommittee with the section. by the committee to identify efficiencies will not be used as - is not met as evidenced and review of facility records, at the facility did not ensure ssment and Assurance lems and developed is in the areas of: e and misappropriation of porting and investigating and misappropriation of eening of employees; hagement; and provision of	F	52			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/16/2008 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		465100	B. WI	NG _		12/	03/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 520	<ul> <li>CNA 20, CNA 21, CN Nurse 7.</li> <li>Findings included: <ol> <li>The facility's Qual Assurance Committee intervened with reside promotes resident ch</li> <li>On 10/29/07, facility sabused resident 1 wh shower against her w</li> <li>Cross-refer: F-223.</li> <li>The facility's Qual Assurance Committee were able to identify of resident property; allegations of abusea resident property to a federal requirements procedures; and that to determine appropriaccordance with facil</li> <li>The facility failed to in allegations of abusea resident property for plus 1 supplemental</li> </ol></li></ul>	IA 23, CNA 24, NA 1, and ity Assessment and e did not ensure facility staff ents in a manner that oice and prohibits abuse. staff physically and mentally then they forced her to rill. ity Assessment and e did not ensure facility staff abuse and misappropriation that facility staff reported and misappropriation of the facility policy and employees were screened iateness of employment in ity policies and procedures. Investigate and report and misappropriation of 3 of 10 sampled residents, residents.	F	52			
	employees in accord policies and procedu Employee identifiers:	creen 9 of 14 sampled ance with their written					

Facility ID: UT0002

If continuation sheet Page 84 of 85

DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		465100	B. WING			C 12/03/2007	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA AT ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	ID PROVIDER'S PLAN OF C REFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH DEFICIENCY		ON SHOULD BECOMPLETIONE APPROPRIATEDATE	
F 520	Continued From page 84		F	520	0		
	Cross-refer: F-225 and F-226.						
	<ul> <li>3. The facility's Quality Assessment and Assurance Committee did not ensure that, for 1 of 10 sampled residents, facility staff provided the necessary cares and services for the resident to achieve pain relief. Resident identifier 20.</li> <li>Cross-refer: F-309.</li> <li>4. The facility's Quality Assessment and Assurance Committee did not ensure that, for 1 of 10 sampled residents, facility staff provided the necessary cares and services for the resident attain or maintain normal bladder function. Resident identifier 20.</li> </ul>						
	Cross-refer: F-315.						