		ND HUMAN SERVICES MEDICAID SERVICES					M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLET	IRVEY
		465100	B. WIN	IG _		12/0	03/2007
NAME OF PF	ROVIDER OR SUPPLIER		I	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 PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 155 SS=D	483.10(b)(4) NOTICE SERVICES The resident has the refuse to participate i and to formulate an a specified in paragrap This REQUIREMENT by: Based on interview a determined that for 1 (Resident 1) that the the resident the right Findings included: Resident 1 was admit 10/20/98 with diagnos	E OF RIGHTS AND right to refuse treatment, to n experimental research, dvance directive as h (8) of this section. is not met as evidenced nd record review, it was of 10 sample residents facility staff failed to allow to refuse a shower.		155	DEFICIENCY)		1/11/08
	Certified Nursing Ass revealed that on 10/2 allowed the right to re CNA 14 stated that the told them resident 1 h afternoon, and if they to shower that they sh help. CNA 13 and CNA 14 resident 1 refused to the DON to communi a shower. CNA 13 and DON told them he wo CNA 14 stated that the	7, during the dayshift, with istant (CNA) 13 and CNA 14 9/07 resident 1 was not ifuse a shower. CNA 13 and the Director of Nursing (DON) had to have a shower that had trouble persuading her hould come to the DON for stated that on 10/29/07, shower and that they went to cate that resident 1 refused hd CNA 14 stated that the build help them. CNA 13 and the DON went to resident 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: 01/29/2008

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: 01/29/2008 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
		465100	B. WIN	NG_		12/0	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 CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 155	arms and assisted rearoom. CNA 13 and C 1 was screaming, "N 14 stated that at that CNA 14 began remove while the DON held rearesident 1 from hitting CNA 14 stated that reast striking out, and kicking On 11/19/07 at 10:30 interviewed. The sum residents' rights and i refuse a shower. The on the cognitive abiliti DON further stated the dementia or can not reast themselves, I would the shower in the most constated that everybody shower, however, if a odor that was too offer infringe on other reside continued that others meal, in the dining roo environment. The DON where body odor infrin rights. On10/29/07, the CNAs came to his offer resistant to getting int thought the resident ses shower. The DON states the DON for his assist CNA s, "Let's go give stated that as he appiresident 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 a DON replied, "It depends ies of the resident." The hat if a resident had make wise decisions for 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 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 ther 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	55		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 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	
		465100	B. WIN	1G _		12/03/2007		
NAME OF PR	ROVIDER 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 TAG	٦IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 155 F 166 SS=E	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 resident 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	A replied that resident 1 was ad yelling. The DON stated 14, Nurse 1 and himself) tried s clothing. The DON stated the CNAs, so he held the orts and written statements, the incident, was done on w of these written report and that there was no evidence llowed to refuse treatment 23. NCES what to prompt efforts by the vances the resident may e with respect to the behavior T is not met as evidenced record review, and review of it was determined that for 3 t and one supplemental d not promptly respond to s grievances. Resident 2 56 year old female admitted /06, with diagnoses that ebral palsy, hypertension, tia with depressive features,		15			1/11/08	

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 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	
		465100	B. WIN	NG_		12/0	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	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 166	Continued From page	3	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 \$ 215.0 husband's locked dre- reported that she didr happened, the money reported that she didr happened, the money reported that the policitor to her about it. Resid from the facility had do or resolve the alleged On 11/21/07, the survice copy, by the facility set 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 interviewed The report documents been reported to the 1 10/29/07, but that no department came to the facility about the allege indicated that the faci police department age State Agency survey.	her allegation of A. Resident 2 stated that she ct date of when the alleged lent 2 stated that she first a staff member, who then he facility SSW (Social esident 2 stated that 00 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 lent 2 stated that no one lone anything to investgate d stollen/missing money. A theft investigation. The ed that the alleged theft was a, 10/27/07. The dicated that one facility where resident 2 had hidden led drawer, and even r and reporting the missing ocumented that this CNA d during the investigation. ed that the alleged theft had local police department on one from the police the facility or called the					

Facility ID: UT0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		465100	B. WI	NG_		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 8410		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	FIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 166	On 11/21/07, the State 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 appointer power wheelchair was Resident 3 stated tha nothing to help him ge police to report the m 3 stated that he boug from his former room the wheelchair. Resident could not find the rece the former facility soc knew about the purch Resident 3 stated tha discharged quite a few shortly after his room his wheelchair just dis was at the doctor app that office staff and fo knew about his purch 3 stated that he askee administrator to call the On 11/19/07, at 3:40	e Agency Entity Report ed. There was no evidence ed this allegation of ssident property until after the resident had 70 year old male resident 70 year old male resident 70 year old male resident 70 n 12/2/04, with diagnoses hypertension, infection, d urinary obstruction. The dayshift, resident 3 was t 3 stated that while he was hent at a local clinic, his s stolen or given away. t the facility staff has done et it back or call the local sissing wheelchair. Resident that an electric wheel chair mate, and that he purchased as given a receipt for the 3 stated that he currently eipt. Resident 3 stated that ial service worker (SSW) ase of the wheelchair. t his roommate was w months ago, and that mate had been discharged, sappeared one day while he ointment. Resident 3 stated rmer facility administrator ase of wheelchair. Resident d the office staff and former he police and was told that	F	16	56		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/29/2008 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
		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 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	56		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 A APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		465100	B. WIN	1G _		12/0	3/2007
NAME OF PR	OVIDER OR SUPPLIER			SI	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 SHOUL CROSS-REFERENCED TO THE APPRO 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 re SSW called a local P officer come out and a documented that an e up in resident 3's roo that this was the chain documented that the a resident 3 about the e in his room and he sta chair provided by the documented that the police had been called take a report and resi from the police depart with him. The SSW the police department to a different police ag to investigate the alled documented that the office that reason for likely probably occurre department did not re send out an officer. T 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 to 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 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 timent has been out to speak documented that she called is again and was transferred gency that had the authority ged theft. the report bliceofficer came to the if 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 the report documented that a report and the police vestigating the alleged theft.	F	16	6		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	ED: 01/29/2008 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE COMPI	SURVEY
		465100	B. WIN	NG_		1:	2/03/2007
NAME OF PF	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 TAC	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 166	conducted with the in police department. The Resident 3's former re- the theft of Resident 3's police department has former roommate to co- stated that it was unfo- occurred so long ago it been reported at the missing, perhaps the have been easier to be unable to locate him fi On 12/3/07, the State log was reviewed. The indicated that the faci- allegation of alleged re- 3's wheelchair to the Resident 3's electric re- stolen/missing in May investigated as being staff until 11/20/2007. facility Maintenance S knowledge that reside picked up the wheelch staff. Additionally, the the former facility SSN Administrator, and we happened to Residern no documentation as or was currently doing obtaining his wheelch documentation that a communicated what he to Resident 3. 3. Resident 19 was a	vestigating officer from the The office stated that commate is suspected of 3's wheelchair, but that the s been unable to locate the question him. The officer ortunate that this theft and if the alleged theft had the time the wheelchair was alleged perpetrator would ocate, as it is now, they are for questioning. Agency Entity Report intake the review revealed that lity did not report this misappropriation of Resident State Agency until 11/29/07. wheelchair was reported v 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, W, the former facility	F	<sup>-</sup> 16	36		

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		465100	B. WIN	NG_		12/0	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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 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 The report document	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 rted 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. tat she saw CNA 16 take the	F	<sup>7</sup> 16			
	that time, Resident 19 7 dollars out of her pu documented that Res as CNA 16. The repo 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	9 reported that a CNA took					

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/29/2008 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		465100	B. WIN	٩G _			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 LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(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>7</sup> 16	36		

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM A	01/29/2008 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) [	DATE SURVI	EY
		465100	B. WIN	NG.			12/03/2	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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(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 in 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 to been addressed by facility dent 32 stated that she nedications 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	F	16	36			

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & M					FOR	D: 01/29/2008 M APPROVED D. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
	465100	B. WING			12/0	3/2007
NAME OF PROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107	·	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C 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
and mentioned that the problem.On 11/27/07, the currer Grievance log was revis sheets of paper. The lo the above concerns, bu The facility grievance lo of the complaint, just th There was no document residents to make sure the outcomes.F 223 SS=J483.13(b), 483.13(b)(1) SS=JThe resident has the rig sexual, physical, and m punishment, and involu The facility must not us or physical abuse, corp involuntary seclusion.This REQUIREMENT i by: Based on facility direct administrative staff inte interviews, facility docu medical record review, 1 of 10 sampled resident from	e action plan for the approached SA Surveyor "smoke" was still a ht copy of the facility ewed. The log was four og documented some of it not all of the concerns. og did not address the date e month of the complaint. thation as to prompt efforts o correct the complaint (s), tation of follow up with the they were satisfied with o(i) ABUSE ght to be free from verbal, nental abuse, corporal intary seclusion. e verbal, mental, sexual, ioral punishment, or is not met as evidenced care staff, as well as rviews, resident mentation review, and it was determined that for its, the facility failed to		223			1/11/08

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLETI	RVEY
		465100	B. WIN	√G_		12/0	3/2007
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
	ſ 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	ΞIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	Continued From page	÷ 12	F	22	3		
	administrative nurse, coersion to shower re addition to the four sta participated in this ind administrative person incident and failed to The facility's failure to abuse was determine risk to the health and therefore determined Findings include: Resident 1 was a 67 y to the facility on 10/20 moderate mental reta and cardio vascular a Resident 1's quarterly assessment, dated 9/ facility RN (Registered indicated that residen with set-up assistance dressing.	cident, two other intervene. b protect its residents from ed to constitute an serious welfare of the residents, and to be Immediate Jeopardy. year old female admitted to D/98, with diagnoses of irdation, seizure disorder, inccident. y MDS (minimum data set) /12/07, and signed by a d Nurse) on 9/13/07, it 1 required supervision, e, for ambulation and					
	(CNA) 13 was intervie CNA 13 about resident treatment, including the CNA 13 stated, on the on 10/29/07, she was which resident 1 was shower. CNA 13 state between 2:00 and 4:00 13 stated she went to	PM, certified nurse aide ewed. The surveyor asked nts' rights to refuse he right to refuse a shower. e Monday before Halloween, a involved in an incident in not allowed to refuse a ted the incident occurred 00 PM. On that day, CNA o the Director of Nursing him that resident 1 did not					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUF COMPLET	RVEY
		465100	B. WIN	NG_		12/0	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 CORRECT (EACH CORRECTIVE ACTION SHOU 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 wi CNA 14, would provid CNA 13 stated the re opportunity to refuse member would comp resident 1 responded shower. The residen went to the dining roc DON instructed me to CNA 13 stated the Ac the DON was providin 13 stated, at some tir facility Social Service 1 to shower, to which 13 stated she was in room when she obse resident 1, holding the pushing the resident 1 w 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 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 t 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 me during the afternoon, the e Worker also asked resident or resident 1 said, "No." CNA	F	÷ 22			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 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 COMPLET	JRVEY
		465100	B. WIN	NG_		12/(	03/2007
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 TAG	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF 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 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 se NO shower. Asked he D.O.N. She went in t no shower and he sa today is the day. so y [CNA 13] or [CNA 14] one. Went to Dr (din 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: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		465100	B. WIN	NG_		12/0	3/2007
NAME OF PR	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 TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 223	brought into bathroom her holding her arms Nurse 1] to take off he screaming let me go. bathroom. tring [sic] to she was undressed s apologetic saying to e honney [sic]. She was document was signed On 11/1407 at 2:00 P The surveyor asked O rights to refuse treatm refuse a shower. CN involved in an incident allowed to refuse a sh incident occurred the between 2:00 and 4:0 DON, Administrator, a resident 1 had to sho DON approached res and forcibly took her to 14 stated the DON wa providing the resident CNA 14 stated that as to the shower room, s Leave me alone!" CN attempting to bite, scr 14 stated that, in the resident 1 continued to Leave me alone!", str bite, as the staff undre 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 o bite scratch kick When he 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 at in which resident 1 was not nower. 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 ident 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! ike out, and attempted to essed her. CNA 14 stated the twant to force resident 1 to	F	÷ 22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLETI	RVEY
		465100	B. WIN	NG _		12/0	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D 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 occer reprimanded for refuse 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 olete. CNA 14 stated once ssed, the resident stopped IA 14 stated the cial Worker were in the area n as resident 1 was being wer. 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 ', to any one. CNA 14 stated the incident and her e facility CNA Coordinator. eyor clarified with CNA 14, dent involving resident 1 on d during the interview on statement, provided by CNA and given to surveyors on eted. CNA 14 documented were told, by the DON, that	F	: 22			

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 A APPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		465100	B. WIN	٩G _		12/0	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	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 223	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, bit 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 shower room, resider as she was being und clothing. 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 lent 1 in the water while she that the.DON stayed in the de time. This written to by CNA 14. g the morning medication terviewed. The surveyor residents' rights to refuse he right to refuse a shower. esident 1 has had a problem that 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 let 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 th 1 started batting her arms dressed of her three layers of ted the DON stood behind ms around her in a loose resident 1 would have been d that staff tried not to gang	F	· 22	23		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 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
		465100	B. WIN	NG_		12/0	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 ian screaming and said, ed the maintenance	F	÷ 22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
		465100	B. WIN	NG _		12/0	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 223	"popped" her head in 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 need residents more than of shower when the resis 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 st her shower. She doo CNA 13 and CNA 14 shower as the DON w SSW documented that shower room) shortly documented that she the shower room) to p resident 1 swearing a documented that she to see if they needed documented she obs- untangle all the neckl CNA13 and CNA 14 clothes off. The SSW second time she "pop observed the residen	to the shower room to check heard resident 1 screaming, stated she reassured s the resident was being The SSW stated that once hower she was fine and that g has not been a problem. He 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 he facility, the facility smelled t 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 e 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: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
		465100	B. WI	NG .		12/0	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 223	documented the DON room) shortly after ar was being showered calm. This written sta SSW. On 11/19/07, the SSW with the facility's inver resident 1. The SSW investigation findings the statements and the statements of the peo- that no abuse had out to hurt [resident 1]. A being a willful infliction confinement, intimidar resulted in harm, pain these apply to [reside screaming was not an [resident 1] in her reg witnessed by the soc Administrator after the the bathroom all parti were very pleased wi [Resident 1] was hap around showing even hairstyle. This was no our policy due to the perceived the event the document was signed On 11/27/07 the facil was interviewed. Bas with the SSW, the su Maintenance Supervision stated the state the Supervisor stated the	A came out (of the shower ad 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>I</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 yular 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 ot reported to the state per fact that no one involved o be abusive." This d by the SSW.	F	. 22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 A APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		465100	B. WI	NG _		12/0	3/2007
NAME OF PR	OVIDER 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 TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 223	Maintenance Supervisaid, "No". The Main he notified the Admin not want to take a shi Supervisor stated that carpets, while listenin device). The Mainten he was able to hear r shower room that she A written statement, of Maintenance Supervis was provided to the si Maintenance Supervis unknown date, he wat the West side and ob 1 if she would like a si He documented that 1 scream, "no no I'm document was signed Supervisor. On 11/27/07 at 11:25 interviewed at the resi began discussing, wit in which resident 1 w her will. Resident 43 being forced to show heard [resident 1] scr got up to see if she w 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 th	hower, which he did. The sor stated that resident 1 tenance Supervisor stated istrator that resident 1 did ower. The Maintenance it 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 6 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 vas okay."	F	223			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		465100	B. WI	NG _		12/0	3/2007
NAME OF PR	OVIDER 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 .SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	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 or 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 ON 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	23		

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DEPARTMENT OF HEALTH AND CENTERS FOR MEDICARE & ME					FORM	D: 01/29/2008 APPROVED D: 0938-0391
	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
	465100	B. WIN	NG_		12/0	3/2007
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA AT ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
out at staff, would it be a resident a shower? The the three days prior, resi been any different, and t used to not having to do stated that it was the CN residents that led to not g a consistent basis. The D residents were clean the NOTE: The DON compl dated 11/16/07, regardin resident 1 in which the D believe the manner in wh showered constituted ab On 11/14/07 and 11/26/0 PM, the facility Administr The surveyor asked the aware of an incident in w been showered against h Administrator reported al observed the DON walk guide her into the showe stated resident 1 was "sw Administrator could not r said. The Administrator "popped" into help. The a did hear resident 1 screat was in the shower room. stated the DON was in the	br something while sistive. The surveyor dent were resistive, with ng combative and striking a good time to give the e DON explained that for ident 1's behavior had not that the CNAs had gotten showers. The DON VAs' approach toward the getting showers done on DON stated that when ey were happy; better. leted a written statement, ng the incident involving DON indicated he did not hich resident 1 was ouse. 07, at 3:05 PM and 4:15 rator was interviewed. Administrator if she was which resident 1 may have her will. The in incident in which she behind resident 1 and er. The Administrator wearing" but the recall exactly what was stated the SSW Administrator stated she aming, while the resident . The Administrator he shower room to help, esident. The Administrator eft the area.	F	22			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/29/2008 DRM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		465100	B. WI	NG _		1	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 COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	stated that the facility habits, and that recent different standards, and On 11/14/07, during the interviewed regarding treatment, including the CNA 4 replied, that in past, staff were instru- aides have not been so they were expected to showered. CNA 4 states specifically mentioned be showered and " condition the way it we whatever necessary the surveyor asked CNA of resident 1 being for stated she had not with but that she had hear that resident 1 had be On 11/14/07 at 10:15 interviewed. The survive was familiar with resides stated resident 1 resist with staff when they and CNA 2 stated that a co meeting, the facility A resident 1 had to take no excuses. CNA 2 so instructed to inform the other resident refused On 11/15/07, during the interviewed regarding treatment, including the	CNA's had developed bad titly staff were being held to and that staff do not like it. The day shift, CNA 4 was residents' rights to refuse the right to refuse a shower. a meeting in the recent cted by the DON that nurse showering residents and that be ensure residents were ated that resident 1 was d by the DON as needing to with her [resident 1's] as, that we have to do o get her showered." The 4 if she had any knowledge reced into the shower. CNA 4 thessed any such incident, d, "through the grapevine" een forced to shower. AM, CNA 2 was veyor asked CNA 2 if she dent 1's care needs. CNA 2 sted showers, and fought tittempted to shower her. ouple of weeks ago in a Administrator and DON said e a shower, no refusals and datated that the CNA's were he DON if resident 1 or any d to shower A staff had a meeting the	F	22	23		

If continuation sheet Page 25 of 85

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
		465100	B. WIN	NG_		12/0	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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD 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 concern 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, " idents to shower). He bout twisting arms and t you are asking about is make her own bed, and she esses herself." 5 AM, nurse aide (NA) 1, the nator, was interviewed. The about residents' rights to luding the right to refuse a she had heard that a former sed to shower resident 1 and written up. NA 1 continued t, a CNA meeting was held fusal of showers had been ted she did not attend that for asked NA 1 if any facility ther with concerns about	F	= 22			

If continuation sheet Page 26 of 85

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		465100	B. WIN	NG_		12/0	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 TAC	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 223	replied to her that res stated she answered "rights". NA 1 stated have an obligation, and 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 fact 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 ret right to refuse a show told me I had to show resident had not beer CNA 16 stated that st "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 and 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. CNA had been an agency shift, she and the oth- not "drag" resident 1 agency nurse, for feat	ver." NA 1 stated the DON ident 1 had to shower. NA 1 back that resident 1 had the DON replied that we nd that resident 1 smelled, ng other residents. NA 1 was not present, she had rapevine" that resident 1 had shower. NA 1 stated in e Administrator talked about of that the facility staff had to r schedule. The surveyor nded the morning meetings, 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 esident would scream, yell, she would try. CNA 16	F	. 22			

Facility ID: UT0002

If continuation sheet Page 27 of 85

STATE DIRVIN OF DEPICIPANCES AND PLAYS OF CORRECTION       (22) MULTIPLE CONSTRUCTION A BUILDING A BUILDING BWWD       (22) MULTIPLE CONSTRUCTION A BUILDING BWWD       (22) MULTIPLE CONSTRUCTION BWWD       (22) MULTIPLE BWWD       (22) MWWD (22) MULTIPLE BWWD       (22) MWWD (22) MULTIPLE BWWDD       (22) MULTIPLE BWWDD (22) MULTIPLE BWWDD (22) MULTIPLE BWWDD (22) MULTIPLE BWWDD (22) MULTIPLE BWWDDD (22) MULTIPLE BWWDDDD (22) MULTIPLE BWWDDDDDDD (22) MULTIPLE BWWDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDDD		-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391	
MARE OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         MODE         MODE <td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>l` í</td> <td></td> <td></td> <td>(X3) DATE SU</td> <td colspan="2"></td>	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l` í			(X3) DATE SU		
INFINA AT ALTA         add S SOUTH SOU EAST SALT LAKE CITY, UT SALOT SALT LAKE CITY, UT SALOT PRETIX TAG         SUMMARY STATEMENT OF DEFICIENCY INIST BE PRECEDED BY FULL RECAY DEPTICIENCY NUST BE PRECEDED BY FULL RECAY DEPTICIENCY NOT LSC DENTIFYING INFORMATION)         PD PRETIX TAG         PROVIDENS FLAND OF CORRECTION (EACH DEPTICIENCY NOT LSC DENTIFYING INFORMATION)         PD PRETIX TAG         PROVIDENS FLAND OF CORRECTION (EACH DEPRICEDENCY NOT LSC DENTIFYING INFORMATION)         PD PRETIX TAG         PROVIDENS FLAND OF CORRECTION (EACH DEPRICEDENCY)         COMPET DEFICIENCY)           F 223         Continued From page 27 stated the next day, there was a meeting, and that the DON tabled about showers. CNA 16 stated the DON explained, when he instructed someone to do a shower, he expected it to be done. CNA 16 stated she fielt the DON, "put me down" in front of her peers. CNA 16 stated that in that meeting I explained that we could not force residents to shower. Refering to being dragged to the shower, resident 3 stated, "I didn't like that."         F 225         1//11/08           F 225         TREATMENT OF RESIDENTS         F 225         1//11/08         1//11/08           SS=1         TREATMENT OF STEP ensidents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employe, which would indicate unfiltness for service as a nurse aide or other facility staff to the State nurse aide or other facility staff to the State nurse aide or other facility staff to the State nurse aide or other facility s			465100	B. WIN	1G _		12/0	3/2007	
INFINIA AT ALTA         SALT LAKE CITY, UT 84107           (P4) ID PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTION 4 ACTION SHOULD BE (EACH ORRECTION 4 CONTROLL ON LOUD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY WIST BE PRECEDED BO BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         P         PREFX TAG         PREFX (EACH CORRECTION 4 CONTROLL DE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY         COMPLET DEFICIENCY           F 223         Stated the next day, there was a meeting, and that the DON talked about showers. CNA 16 stated the DON explained, when he instructed someone to do a shower, he expected it to be down. CNA 16 stated she fith the DON, Typu the down" in front of her peers. CNA 16 stated that in that meeting I explained that we could not force residents to shower.         F 223         If a state she fith the DON, Typu the down" in front of her peers. CNA 16 stated that in that meeting I explained that we could not force residents to shower.         F 225         If a state she fith the DON, Typu the down" in front of her peers. CNA 16 stated that in that meeting I explained that we could not force residents to shower.         F 225         If a state she fith the DON, Typu the down" in front of her peers.         If a state is the state of the shower.         If a state she fith the DON, Typu the down" in front of her peers.         If a state is the state of the shower.         If a state is the state of the state of the state is the state of a state she state of the state is the state of a state of the s	NAME OF PR	OVIDER OR SUPPLIER			S				
Prefix TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)       PREFIX TAG       CROSS REFERENCED TO THE APPROPRIATE       COMPLET MATE         F 223       Continued From page 27 stated the next day, there was a meeting, and that the DON Nexplained, when he instructed someone to do a shower, he expected it to be done. CNA 16 stated the fit the DON, put me down' in front of her peers. CNA 16 stated that the the DN stated she tit the DON stated she fit the DON, put me down' in front of her peers. CNA 16 stated that are tilt by stated that we could not force residents to shower.       F 223       If the state she was a meeting, and that we could not force residents to shower.       If the state she the DON stated she fit the DON, put me down' in front of her peers. CNA 16 stated that are tilt be that."       F 225       If the state she shower.       If the state she she shower.       If the state she shower.       If the state she she shower.       If the state she she shower.       If the she she she she she she she she shower.       If the she she she she she she she she she s	INFINIA A	T ALTA							
stated the next day, there was a meeting, and that the DON talked about showers. CNA 16 stated the DON explained, when he instructed someone to do a shower, he expected it to be done. CNA 16 stated she felt the DON, "put me down" in front of her peers. CNA 16 stated that in that meeting I explained that we could not force residents to shower.         Resident 1 was interviewed on 11/14/07 and 11/19/07. Resident 1's stated that one time staff dragged her to the shower, resident 3 stated, "I didn't like that."       F 225         F 225       483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF SS=J       F 225         The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of resident sor misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility must for the State nurse aide registry or licensing authorities.       The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	٦I	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC	LD BE	COMPLETION	
including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	stated the next day, the that the DON talked a stated the DON explassomeone to do a shord done. CNA 16 stated down" in front of her p in that meeting I explaresidents to shower. Resident 1 was intervent 11/19/07. Resident 1 dragged her to the shower like that." 483.13(c)(1)(ii)-(iii), (contracted to the shower like that." 50(contracted to the shower like that." 50(contracted to the shower like that the shower like that." 51(contracted to the shower like that the shower like that." 51(contracted to the shower like that the shower like that." 51(contracted to the shower like that the shower like that." 51(contracted to the shower like that the shower like that."	here was a meeting, and about showers. CNA 16 ined, when he instructed wer, he expected it to be a 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 er, 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. ure that all alleged violations at, 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).			13		1/11/08	

Facility ID: UT0002

If continuation sheet Page 28 of 85

		ND HUMAN SERVICES					M APPROVED
STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		465100	B. WIN	IG		12/(	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 PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	prevent further potent 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	hly investigated, and must tial abuse while the gress. stigations must be reported	F	228	5		
	by: Based on interviews of care staff and administ with a respresentative agency, reviews of fa the State Survey and records, it was detern sampled residents plu the facility did not ens violations involving at resident property wer the Administrator, the Certification Agency, or Adult Protective Se violations were thorou 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 e reported immediately to 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 rdation, seizure disorder,</li> </ul>					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/29/2008

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 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
		465100	B. WIN	NG _		12/0	3/2007
NAME OF PF	ROVIDER OR SUPPLIER				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	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 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 w The following informat NA 1, the facility's Ce Coordinator- (intervie AM) - NA 1 stated that reported to her, conce forced to shower. In 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 sho not refuse and that th shower her. CNA 4 - (interviewed shift) - CNA 4 stated for were instructed by the naming resident 1 in showered. CNA 4 stated	staff physically and mentally nen they forced her to vill. 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 isor. These staff members letermine the circumstances as showered on 10/29/07. Attion 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 tion 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 here were no excuses not to on 11/14/07, during the day that the nurse aide staff e DON that all residents,	F	. 22			

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 465100 12/03/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST **INFINIA AT ALTA** SALT LAKE CITY, UT 84107 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 30 F 225 CNA 7 - (interviewed on 11/15/07, during the day shift) - CNA 7 stated that the nurse aide staff had been instructed by the Administrator, DON, and SSW that resident showers had to be done. CNA 7 stated she reported to the DON that resident 1 was terrified of water, to which the DON replied resident 1's shower had to be done on a schedule and that the resident will get over it. CNA 7 stated the DON, "Started it (meaning forcing residents to shower). He doesn't understand about twisting arms and forcing. . . " CNA 13 - (interviewed on 11/14/07 and 11/26/07 at 2:30 PM and 1:30 PM, respectively) - CNA 13 stated that on 10/29/07, she participated with the DON, Nurse 1, and CNA 14, in forcing resident 1 to shower, after the resident had clearly expressed that she did not want to shower. CNA 13 stated that as resident 1 was forced, she screamed "No! No!" CNA 13 stated that the DON held resident 1's arms as the three others removed the resident's clothing. CNA 13 stated that resident 1 was fighting, trying to bite, striking out, kicking, and screaming "Will you please let me go?" CNA 13 stated the DON responded to resident 1 by saying, "No, you're going to shower." CNA 13 stated she reported this incident to NA 1, her supervisor, the Certified Nurse Aide Coordinator. CNA 14 - (interviewed on 11/14/07 and 11/26/07 at 2:00 PM and 1:30 PM, respectively.) - CNA 14 stated that on 10/29/07, she participated with the DON, Nurse 1, and CNA 13, in forcing resident 1 to shower, after the resident had clearly expressed that she did not want to shower. CNA 14 stated that as resident 1 was being forced, the resident was yelling "No! No! Leave me alone!", attempting to bite, scratch, and was kicking. CNA 14 stated the DON held resident 1's wrists as the other three staff undressed the resident. CNA 14

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 01/29/2008

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		465100	B. WI	NG _		12/	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 TAC	FIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD 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 - (interviewer morning medication p resident 1 has had a to shower her and that to shower once a wer 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 h 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 r the resident's health in The SSW - (interview on 11/26/07, at 10:10 respectively) - The S approximately two to resident 1 had refuse facility nurse, CNA 13 resident 1 was resisti you!" as well as obsc taken to the shower r "popped" her head in on the resident and h "No! No!" The SSW 3	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 pass) - 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 on there." Nurse 1 recalled, as 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 pree of the staff undressed clothing and the DON stood with his arms around hers, in 1 stated she felt it was resident 1 shower because of ssues. red on 11/14/07 and again 0 AM and 2:35 PM, SW stated that three weeks prior, because d to shower, the DON, a 8, and CNA 14 took the ver. The SSW stated ve and screaming, "I hate enities as she was being oom. The SSW stated she to the shower room to check eard resident 1 screaming,	F	: 22			

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		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 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 APPR 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 notice been showered. The resident 1 from behin shower room. The Di- was resisting, agitated stated they (CNA 13, himself) tried to remo The DON stated resident that when residents we better. NOTE: The Di- statement, dated 11/1 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 scread 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 at one point, the SSW Administrator stated so resident 1 was being	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. <i>v</i> iewed 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. ted resident 1 was dministrator could not recall d. The Administrator stated, V "popped" into help. The she left the area in which showered. The discuss any intervention to	F	÷ 22	25			

Facility ID: UT0002

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 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
		465100	B. WIN	NG _		12/0	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	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	the facility's investigat resident 1. In addition investigative report, the with the written stater 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 witnesses the Administrator after left the bathroom all p were very pleased wit [Resident 1] was happ around showing every hairstyle. This was no our policy due to the file perceived the event to	V provided surveyors with tive 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 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] arties looked pleased. Staff h how well the shower went. by and smiling. She went yone her new dress and her of reported to the state per act that no one involved	F	22			
	by the SSW. On 11/29/07, the facil	ity submitted, to the State on Agency, an initial report					

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DEPARTMENT OF HEALTH AI CENTERS FOR MEDICARE &					FOR	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY
	465100	B. WI	NG _		12/0	3/2007
NAME OF PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA AT ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
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 diabeter disease, depression, An interview was held 11/15/07, 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	hd of October. The facility se aides, the DON, and a forced resident 1 to shower. Attrator and SSW were hd 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 nt 1 had been abused on orted to the State Survey ncy and local law 29/07; after the State Survey ncy had initiated it's own a 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			

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
		465100	B. WIN	√G_		12/0	3/2007
NAME OF PR	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 TAG	ΞIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO 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 SSV aware of the allegatio was stolen on 11/13/0 reported it to Nurse 7 reported the allegatio SSW stated she had allegation of stolen m stated she reported th money to the State SI Agency and Adult Pro 11/16/07. On 12/3/07, the facilit Survey and Certification 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 doc had reported, to her, f stolen. 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 cereb pain, anxiety, dement and mental retardatio An interview was helo 11/27/07. Resident 2 10/28/07, she noticed stolen from her locked	<ul> <li>The SSW stated Nurse 7</li> <li>In to her on 11/13/07. The not received resident 19's toney from NA 1. The SSW the allegation of stolen urvey and Certification obtective Services on</li> <li>Ity submitted, to the State ion Agency, a final egarding the the allegation ney was stolen. Included in ort was a written statement sumented that resident 19 that the resident had money ented that she forgot to ne resident's allegation of occumentation, the facility intiate that the resident's</li> <li>56 year old female admitted for al palsy, hypertension, tia with depressive features, on.</li> </ul>					

Facility ID: UT0002

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 465100 12/03/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST **INFINIA AT ALTA** SALT LAKE CITY, UT 84107 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 36 F 225 money on 10/28/07. An interview with the SSW was held on 11/27/07. The SSW stated resident 2 reported stolen money, more than \$200, on 10/28/07. The SSW stated, on 10/29/07 she contacted who she believed was the appropriate local law enforcement agency. The SSW stated that it was not for another three weeks that she learned the law enforcement agency she contacted on 10/29/07, was not the correct agency. The SSW stated there were no law enforcement investigation during that three week period. The SSW stated on 11/21/07, she contacted the correct law enforcement agency, at which time she was given a case number and an officer's name to contact. On 11/29/07, the facility reported both an initial allegation of misappropriation of resident property, as well as the facility's final investigative report, to the State Survey and Certification Agency. The facility reported that on 10/28/07, resident 2 and her husband alleged \$75 was missing. The facility reported that local law enforcement had been contacted on 10/30/07. Per documentation in the facility's final report, which was undated, the amount of money missing was either \$75.00, or over \$200.00. The report also included documentation that the SSW had contacted the incorrect law enforcement agency on 10/29/07, and then the correct law enforcement agency on 11/21/07. Resident 2 had reported to the SSW that she had some money stolen from a locked dresser drawer on or around 10/27/07. Although the SSW contacted a local law enforcement agency, she did not follow-up when there was a lack of law

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/29/2008

		ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/29/2008 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI				(X3) DATE SUF COMPLET	RVEY
		465100	B. WIN	NG_			12/0	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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOUL	LD BE	(X5) COMPLETION DATE
F 225	enforcement investiga Additionally, the facilit allegation of misappro property, 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, r on several occasions electric wheelchair ha away by staff, while h appointment. Reside believe facility staff ha wheelchair back. Res purchased, with his o wheelchair, but that h Resident 3 stated tha been discharged from months prior, and tha roommate's discharge disappeared while he appointment. Reside facility staff to call the to do so. Resident 3 SSW would be able to purchase the electric had with his former ro	ation into the allegation. ity did not report the opriation of resident Survey and Certification 7, more than 30 days after edly missing. D year old male resident, y on 12/2/04, with diagnoses , hypertension, infection, d urinary obstruction. resident 3 was interviewed S. 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 own money, the electric ormer roommate. Resident ided a receipt for the he was not able to locate it. at his former roommate had in the facility quite a few at 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				

If continuation sheet Page 38 of 85

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M					FORM	D: 01/29/2008 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
	465100	B. WIN	√G _		12/0	3/2007
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA AT ALTA				4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
she would be willing to provide a summary of regarding the sale of t room mate to resident On 11/19/07 at 3:15 P Supervisor was intervi allegation that his elec missing. The Mainten resident 3's former roo and informed that he w electric wheelchair fro former roommate pick approximately two we On 11/21/07, the facili written "Formal Invest stolen wheelchair. Th signed nor dated. Thi resident 3's roommate discharged on 4/19/07 [SSW] called the [nam to have an Officer con An electric wheelchair room. I [SSW] assum question. After questi chair he said that this by the [payor of servic asked if an officer had He said no that had no [name of city] Police d had explained the situ come out. The recept County Dispatch. An hour. The officer expl delay probably occurre	The former SSW stated o come into the facility and what she could recall the wheel chair from the t 3. PM, the facility Maintenance iewed 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 ted up the wheelchair eks after his discharge. ity's current SSW provided a igation" of resident 3's nis document was neither is report documented that	F	22			

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 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
		465100	B. WIN	1G _		12/0	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	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	39	F	22	25		
	a representative of the department. Per this	one interview was held with e local (County) sheriff's representative, the facility of resident 3's missing 11/20/07.					
	11/29/07. The facility Survey and Certificati misappropriation of re	vey and Certification reports was completed on did not report, to the State on Agency, an allegation of esident property, relating to electric wheelchair until					
F 226	resident 3 had purchas purchased, an electric roommate and that th at the facility. Howev the State Survey and this issue was initiated had not treated the re allegation of misappro and did not thoroughly allegations to required information that facilit with resident 3 to hav The wheelchair was a September, 2007.	ppriation of resident property y investigate and report the d agencies. There was no y staff were working working e the wheelchair returned.	F	22	26		1/11/08
F 220 SS=J	The facility must deve policies and procedur	elop and implement written es that prohibit , and abuse of residents		22			1/11/00
	This REQUIREMENT	is not met as evidenced					

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 A APPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SUF COMPLET	RVEY
		465100	B. WIN	NG_		12/0	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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	by: Based direct care and interviews and review procedures, as well a 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 in allegations of abuse a resident property for 3 plus 1 supplemental r Resident identifiers: 1 The facility failed to se employees in accorda policies and procedur Employee identifiers: CNA 20, CNA 21, CN Nurse 7. Findings included: On 11/26/07, the Adn versions of the Facilit version titled "[Shared managment corporati Procedure". The ider version was, "Prohibit	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. Nestigate 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 ninistrator provided two cy 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	÷ 22			

Facility ID: UT0002

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STATEMENT OF DEFICIENCIES       (X1) PROVIDERISUPPLIERICLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         AND PLAN OF CORRECTION       465100       B. WING       12/03/2007         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       4335 SOUTH 500 EAST         INFINIA AT ALTA       SUMMARY STATEMENT OF DEFICIENCIES       STREET ADDRESS, CITY, UT 84107       0         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES       ID PREFIX       PROVIDERS PLAN OF CORRECTION 0 (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX       PROVIDERS PLAN OF CORRECTION 5 (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX       PROVIDERS PLAN OF CORRECTION 5 (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX       PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       0         740       Continued From page 41       TAG       PREFIX       F 226       F       11/27/07. The Administrator was asked to clarify which version of abuse policy the facility was currently being implemented. The Administrator reviewed the policies and procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedu		TMENT OF HEALTH AN RS FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 APPROVED D: 0938-0391
MARE OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       INFINIA AT ALTA     STREET ADDRESS, CITY, STATE, ZIP CODE       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     0 PREFIX (EACH ORRECTIVE ACTION OF CORRECTIVE ACTION (EACH ORRECTIVE ACTION OF CORRECTIVE ACTION (EACH ORRECTIVE ACTION OF CORRECTIVE (EACH ORRECTIVE ACTION (EACH ORRECTIVE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l` í			(X3) DATE SUF	RVEY
INFINIA AT ALTA       1013 South sout east SALT LAKE CITY, UT 84107       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION & CROSS-REFERENCED OT THE APPROPRIATE DEFICIENCY)     COMP       F 226     Continued From page 41 11/27/07. The Administrator was asked to clarify which version of abuse policy the facility was currently being implemented. The Administrator reviewed the policies and stated the first version, "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" were the policies and procedures currently being implemented.     F 226       A review of facility employee files was completed on 11/28/07. Copies of policies and procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" were noted to be in the employee files with the employees' signature to indicate they had read the facility abuse policy.     A review of the policies and procedures, titled     Identify abuse" were noted to be in the employee files with the employees' signature to indicate they had read the facility abuse policy.     Identify abuse       1. A review of the policies and procedures, titled     Identify abuse policy.     Identify abuse			465100	B. WIN	NG _		12/0	3/2007
INFINIA AT ALTA       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)           ID PREFIX TAG           PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           Continued From page 41             F 226           Continued From page 41           F 226           F 226           F 226             F (Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" were the policies and procedures currently being implemented.           F 226           A review of facility employee files was completed on 11/28/07. Copies of policies and procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" were noted to be in the employee files with the employees' signature to indicate they had read the facility abuse policy.           A review of the policies and procedures, titled "[Shared name of facility abuse policy.             I. A review of the policies and procedures to in the employee files with the employees' signature to indicate they had read the facility abuse policy.           I. A review of the policies and procedures, titled	NAME OF PF	ROVIDER OR SUPPLIER			S			
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       comp DEFICIENCY         F 226       Continued From page 41       F 226         11/27/07. The Administrator was asked to clarify which version of abuse policy the facility was currently being implemented. The Administrator reviewed the policies and stated the first version, "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" were the policies and procedures currently being implemented.       F 226         A review of facility employee files was completed on 11/28/07. Copies of policies and procedures, titled "[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" were noted to be in the employee files with the employees' signature to indicate they had read the facility abuse policy.       I. A review of the policies and procedures, titled         1. A review of the policies and procedures, titled       I. A review of the policies and procedures, titled	INFINIA A	AT ALTA						
11/27/07. The Administrator was asked to clarify         which version of abuse policy the facility was         currently being implemented. The Administrator         reviewed the policies and stated the first version,         "[Shared name of facility and managment         corporation] Health Care Policy and Procedure for         Prohibiting Abuse" were the policies and         procedures currently being implemented.         A review of facility employee files was completed         on 11/28/07. Copies of policies and procedures,         titled "[Shared name of facility and managment         corporation] Health Care Policy and Procedure for         Prohibiting Abuse" were noted to be in the         employee files with the employees' signature to         indicate they had read the facility abuse policy.         1. A review of the policies and procedures, titled	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	٦I	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETION DATE
<ul> <li>"[Shared name of facility and managment corporation] Health Care Policy and Procedure for Prohibiting Abuse" was completed on 11/28/07. The following information was obtained from this review:</li> <li>"It is the policy of [name of facility] to prohibit any abuse of its residents regardless of source. This company seeks to promote the well-being of its residents by providing a safe and supportive environment. Every resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion."</li> <li>"Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being."</li> </ul>	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 of corporation] Health C Prohibiting Abuse" we employee files with the indicate they had read 1. A review of the po "[Shared name of fac corporation] Health C Prohibiting Abuse" we employee files with the indicate they had read 1. A review of the po "[Shared name of fac corporation] Health C Prohibiting Abuse" wa The following informate review: "It is the policy of [name abuse of its residents company seeks to pro- residents by providing environment. Every of free from verbal, sexu- abuse, corporal punis seclusion." "Abuse: The willful in unreasonable confine punishment with resu- mental anguish. This deprivation by an indi- of goods or services to or maintain physical,</li> </ul>	histrator was asked to clarify se policy the facility was mented. The Administrator and stated the first version, ility and managment care Policy and Procedure for ere the policies and being implemented. hployee files was completed of policies and procedures, of facility and managment care 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 care Policy and Procedure for as completed on 11/28/07. to mas obtained from this me of facility] to prohibit any a regardless of source. This omote the well-being of its g a safe and supportive resident has the right to be ual, physical, and mental shment and involuntary efficition of injury, ement, intimidation, or iting physical harm, pain, or a also includes the ividual, including a caretaker, that are necessary to attain	F	22			

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	RVEY
		465100	B. WIN	٩G _		12/0	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 LSC 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	staff physically and mentally ien they forced her to ill. Cross-Refer F-223.					
	procedures, titled "[S managment corporati Procedure for Prohibi section titled, "Investi Procedures". These following instructions "Any person who sus misappropriation of pi will immediately repor facility administrator a "The administration w Protective Services o authority (and if staff the [former name of tl Certification Agency]) care ombudsman."	procedures included the to staff: pects that abuse, neglect, or roperty may have occurred, rt the alleged violation to the and/or advocacy agencies." <i>v</i> ill immediately notify Adult r local law enforcement abuse is alleged, also notify he State Survey and and the local long-term <i>v</i> ill initiate the investigation ng all staff and residents					
	"The Director of Nursi responsible parties ar incident." "If the complaint alleg will take steps to prote further abuse. This m the staff member unti completed." "After the investigatio administration will door findings as to whethe	cument a summary of its r the alleged abuse was findings to the agencies,					

Facility ID: UT0002

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/29/2008 RM APPROVED IO. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE S COMPLE	URVEY
		465100	B. WIN	NG _		12/	/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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	Continued From page investigation."	2 43	F	- 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 n although CNA 13 and concerns to their supe manner in which resid the shower, this inform thorough investigation and was therefore no Cross-refer F-225. 3. Further review of t procedures, titled "[S managment corporati Procedure for Prohibi section titled, "Screen procedures included t staff: "All potential employed of the application pro- a history of abuse, ne 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 vas forcibly taken to shower 0/29/07 was abusive and mental distress. Additionally, d CNA 14 expressed their vervisor, NA 1, relating to the dent 1 was forcibly taken to mation did not bring about a in 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 ocess 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 20/07, 14 facility employee 9 of the 14 employees files					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/29/2008 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU 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	ΞIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	procedures. CNA 21's DOH (date 21 was currently work was no documentation her references had b CNA coordinator, wa 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 t documentation in his references had been CNA 9's DOH was 8 currently working at t 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 20's DOH was 8 terminated. There was	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. 0/07. NA 1 was currently . There was no remployee file that her verified. 3/15/07. CNA 16 terminated a no documentation in her r references had been 3/21/07. CNA 17 was he facility. There was no employee file that his verified. //6/07. CNA 9 terminated on no documentation in her r references had been 3/10/07. CNA 23 has as no documentation in her r references had been 3/14/07. CNA 24 has as no documentation in her r references had been	F	22	6		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLET	RVEY
		465100	B. WIN	NG _		12/0	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	۶IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD 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 M 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 icated her license was ugh 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 ionsible for checking the licenses, and that the DON hecking nursing references 29/07, the facility CNA viewed. She stated that v 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 nee checks. The facility ad not been doing them until Administrator was 07 at 3:00 PM, regarding ng completed. The facility hat she thought the ager had been doing the urveyors provided the CNA Administrator and asked	F	22			
F 240 SS=D	483.15 QUALITY OF	LIFE r its residents in a manner	F	24	40		1/11/08

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 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
		465100	B. WIN	NG_		12/0	3/2007
NAME OF PR	ROVIDER 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 TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 240		e 46 incement of each resident's	F	- 24	40		
	by: Based on observatior review it was determi care for its residents environment that pro- enhancement of each 1 supplemental residu 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 plan documented cor						

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-		ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/29/2008 M APPROVED O. 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		465100	B. WI	NG_		12/	03/2007
NAME OF PROVIDER OR SU	PPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
PREFIX (EACH	I DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
nursing ass indicated p pain was fo plan. On 12/03/0 Resident 24 she was in 20 stated th was contine being at the get assistant bed and clo 20 stated th brief to prev Resident 24 and bowel) from facility just release Resident 24 urinary acc assistance laying in a she used th from wettin wear a brie felt humilia On 12/03/0 12 was initi present. C short staffe have two C however, h one CNA th assist. He	7 at 9:00 / 7 at 9:00 / 0 was initi- the facility for 20 min 5 staff to g 6 due to th 0 stated th for 20 min 5 staff to g 6 due to th 0 stated th for 20 min 5 staff to g 6 due to th 0 stated th dents due from aide urine soak ie incontir g her bed f was horr ted. 7 at 3:15 ated in roo NA 12 sta d. CNA 1 NA's on th ave had o nat floats f stated tha	AM, an interview with at ed. Resident 20 stated of for rehabilitation. Resident she arrived at the facility she lent 20 stated that after or a week, she was unable to bileting and was soiling her eral times a day. Resident es offered for her to wear a g her clothing and bedding. that after "holding it" (urine nutes, without assistance et to the restroom, she would e pain of holding it. that she had fear of having e to not getting timely s to get to the toilet, and was ed bed. Resident 20 stated that they have been 2 stated that usually they he east hall during the day, nly one CNA recently, and rom west to east halls to t two days ago he had int 20's call light, and had	F	<sup>7</sup> 24			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/29/2008 DRM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		465100	B. WIN	NG _		1	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 TAG	IX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 240	Continued From page	2 48	F	24	40		
	asked her to wait whil residents. He stated Resident 20's request restroom, and didn't r	t for assistance to the					
	she had received a prinarcotic 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	20. Resident 20 stated 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 n 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.					
	documented that Respain in both upper exit that Resident 20 state hospital she was rece every 4 hours. It document upset, and the nurse make a clarification to There was no document indicating changes to to provide Resident 2 control without excee acetaminophen in a 2 On 11/16/07, the physic Resident 20 were rev physician order that do clarification for Lortal	the medication were made 0 with the appropriate pain ding the 4 grams of 4-hour period. sician telephone orders for iewed. There was an					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				I	NTED: 01/29/2008 FORM APPROVED B NO. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		465100	B. WIN	NG_			12/03/2007
NAME OF PR	OVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
INFINIA A	ΓΑLΤΑ				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 SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 240	Continued From page	e 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 exe acetaminophen in a 2 coordinator stated tha Resident 20 had com coordinator called in f coordinator stated that same pain relieving st	S coordinator was initiated. stated that the nursing staff ng resident 20 to spread the and wait more than four					
	Resident 20 were rev dated 12/3/07, docum Lortab 10/500 had be order for Lortab 10/32	ician telephone orders for iewed. A telephone order, nented that the medication, ten 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: 01/29/2008 A APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	
		465100	B. WIN	۱G _		12/0	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 LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 240	room 5. Resident 5 st weeks she has had a room. Resident 5 sta arms or legs she was may drop on the floor swept frequently the a room. Resident 5 sta 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 Maintenance Supervi ontrol company had and sprayed the perin The Maintenance Sup documented that the sprayed the building of 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 w	d to the facility on 11/15/07 in tated that for the previous 2 nts crawling through her ted that since she has no unable to pick up food that and when the room is not ants spread through the ted that one of the d to change her bedding one ants had migrated to her 3 AM to 3:30 PM, it was nt 20's in room [Room 5] The ants were observed to or under and around he 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 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 ants in room 5. ximately 2:30 PM, the sor stated that the brown vas cinnamon that one of his	F	24			
F 241 SS=E	staff had placed in the 483.15(a) DIGNITY	e room to deter the ants.	F	24	11		1/11/08

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/29/2008 MAPPROVED 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_			12/0	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	ΞIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N 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 admission MDS (minimum time the medical the to be in the et was due to be in</li></ul>	F	24				

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 M APPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY	
		465100	B. WI	NG_		- 12/03/2007		
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 DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 241	that Resident 20 request. On 12/03/07 at 9:00 A resident 20 was initia was in the facility for said that the aides to wear incontinence bri- had never worn briefs continent. Resident 2 having urinary accide 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 diagnos schizophrenia, hypoth failure, hypertension, On 11/15/07, Nurse 1 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 no 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				FORM	D: 01/29/2008 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
		465100	B. WIN	NG_		12/0	3/2007
NAME OF PR	ROVIDER 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 TAG	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD 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	<sup>:</sup> 24			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 MAPPROVED D. 0938-0391
STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SUF COMPLET	
		465100	B. WIN	IG		12/0	3/2007
NAME OF PROVID	ER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA AT AL	ТА				1035 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
<ul> <li>On ask she and</li> <li>On contherers and</li> <li>SS=D</li> <li>The contherers and</li> </ul>	ted if she was awa e stated that she wa d belongings had b 11/20/07 a residen nducted. Residents y were treated by s residents present of mbers treat them of ident stated that so guage in from of th at was meant by "b idents reported, "s 11/20/07, during th sident 2 stated that ower. The surveyo vate, to discuss the sident 2 stated that ower. The surveyo vate, to discuss the sident 2 stated that d been here, the Cl over when you didu- ted that the other of e was supposed to t she told the CNA sident 2 reported th d over and over ag- ower, even though tated, I told her "no e a shower anyway 3.15(h)(1) ENVIRO e facility must prov- mfortable and homo- resident to use his he extent possible	At 12 was interviewed and re of a room search, and as not aware that her room een searched. At group interview was is in general were asked how staff members. The majority omplained that staff disrespectfully. One ome of the aides use bad nem. The surveyor asked oad language" and the wear words". At she was "forced" to take a rs met with Resident 2, in e events of the incident. t ever since the new DON NA's made you take a n't want to. Resident 2 lay she didn't feel well, and take a shower that day, and she didn't want to. nat she was "pestered" and ain, that she had to take a she didn't want to. Resident y, and I just didn't feel good. NMENT ide a safe, clean, elike environment, allowing s or her personal belongings		241			1/11/08

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 MAPPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		465100	B. WIN	√G_		12/0	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 LSC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D 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	and interview it was acility did not provide a safe, ad homelike environment. blinds for privacy and airing a dripping faucet in a a 5. b year old female admitted to 7 with diagnoses that nputation of both arms and bn, 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 off of the window when djust them. She stated that he concerns to various the Maintenance Supervisor owever, the faucet was still	F	25			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 A APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		IPLE CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
		465100	B. WIN	√G _		12/0	3/2007
NAME OF PR	ROVIDER OR SUPPLIER			1	IREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
INFINIA A	T ALTA			1	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	٦IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 252 F 272 SS=B	that he had faxed a correplacement 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 nursin identified. The facility was asked bill for replacement pa- room 5, that was sub- office. The facility was of the bill. On 12/03/07 at 1:15 F maintenance log loca station revealed that in needed for room 5's w 483.20, 483.20(b) CC ASSESSMENTS The facility must conc a comprehensive, acc 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 n 5, the Maintenance it he was unaware that they aintenance Supervisor stated y 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		252	2		1/11/08

Facility ID: UT0002

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	-	ND HUMAN SERVICES				F	NTED: 01/29/2008 ORM APPROVED 3 NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION		E SURVEY PLETED	
		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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(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				FORM	D: 01/29/2008 M APPROVED D. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		465100	B. WI	NG		12/0	3/2007
NAME OF PR	OVIDER OR SUPPLIER			1	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI 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 documants) ADL's (activities of data the source and the source of the source of the source and the source of the source of the source summary, RAP documants)	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			

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 01/29/2008 FORM APPROVED IB NO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		465100	B. WIN	NG .		- 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 LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 272 F 273 SS=D	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) RESID WHEN REQUIRED A facility must conduct	PM, an interview with the seach of these items was not PM, an interview with the se was initiated. She was RAPS, and missing location assessment stated that the nurse that sments no longer worked at DENT ASSESSMENT-		<sup>:</sup> 27			1/11/08	
	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 at determined that the fa comprehensive asses timely manner. Resident 20 Findings included: Resident 20 was adm							

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 M APPROVED O. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SI COMPLE	JRVEY	
		465100	B. WIN	NG_		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 TAG	FIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD 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 and record review it was acility did not provide the services to attain or maintain e physical, mental, and ng, in accordance with the sement and plan of carefor mple resident. Resident						

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/29/2008 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		465100	B. WIN	NG .		1:	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 TAC	FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 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 / initiated with resident she had received a p medication with aceta hours for pain. She s told her that she coul 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) assess 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 stated that the facility had d not exceed 4 grams of 24-hour period, and needed n medications. Resident 20 able to take enough our period to keep her pain tated that on a scale from 1 ras at 9 or 10. Al chart was reviewed on 20's evaluation indicated that nitive with good short term ry, and was oriented, and t 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			

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/29/2008 A APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION		(X3) DATE SUI COMPLET	RVEY
		465100	B. WI	NG_			12/0	3/2007
NAME OF PF	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODI 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 LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOU	LD BE	(X5) COMPLETION DATE
F 309	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 physic revealed that, on 11/- clarifying the pain me order documented the 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			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY
		465100	B. WI	NG_		12/0	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 TAC	=IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309 F 315 SS=G	same pain relieving s exceed the 4 grams of 24-hour period. A review of the physic revealed a physician Lortab 10/500 to be of for Lortab 10/325 mill every 4 hours as nee The facility staff did n residents pain and set to manage Resident 1 two weeks, during wh continued to be in pa 483.25(d) URINARY Based on the residen assessment, the facil resident who enters t indwelling catheter is resident's clinical con catheterization was n who is incontinent of treatment and service infections and to rest function as possible. This REQUIREMENT by: Based on observation review, it was determ ensure that a residen continent without a cl	w order. The MDS at the new order had the trength, but would not of acetaminophen in a cian telephone orders order dated, 12/03/07, for liscontinued and a new order igrams, one or two tablets ded for pain. ot properly assess the ee apppropriate interventions 20's pain successfully for nich time the resident in. INCONTINENCE t's comprehensive ity must ensure that a he facility without an not catheterized unless the dition demonstrates that ecessary; and a resident bladder receives appropriate es to prevent urinary tract ore as much normal bladder		· 31			1/11/08

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-		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 01/29/2008 FORM APPROVED //B NO. 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	· · · ·	ATE SURVEY MPLETED
		465100	B. WIN	NG _			12/03/2007
NAME OF PROVIDER OR SU	PPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
INFINIA AT ALTA					4035 SOUTH 500 EAST SALT LAKE CITY, UT 84107		
PREFIX (EACH	I DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
on a toiletin sample res Findings ind Resident 20 facility on 1 limb amput Resident 20 and long te oriented, ar consistent, mode of loc person ass on staff for documente awareness or bladder a medical rec (minimum of assessmen complete a medical rec plan docum Toileting ca extensive a for toileting On 12/03/0 Resident 20 she was in 20 stated th	and main ang program ident. Ref cluded: 0 was a 56 1/15/07 w ations. 0's medica Resident 2 was cogr rm memoind mentall reasonab comotion w istance. R transfers d that Res of safety i assessment cord. They data set/co t) assessr sessment cord on 11 mented cord ref plan in ssist by tw indicated 7 at 9:00 / 0 was initial the facility nat when s ent of bow after being	e 64 tain normal bladder function a for one supplemental sident identifier: 20. S year old admitted to the ith diagnoses including four al chart was reviewed on 20's evaluation indicated that itive with good short term ry. Resident 20 was y independent with le decisions. Resident 20's vas in a wheelchair with one esident 20 was dependent and toileting. The notes sident 20 showed good issues. There was no bowel int found in Resident 20's re was no admission MDS omprehensive resident ment in the record. The t was due to be in the /28/07. The resident care intinent of bowel and bladder. dicated resident needed vo persons. The schedule per resident request. AM, an interview with ated. Resident 20 stated r for rehabilitation. Resident 20 g at the facility for a week, et assistance with toileting	F	<sup>;</sup> 31			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 / APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		465100	B. WIN	√G_		12/0	3/2007
NAME OF PR	OVIDER 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 SC 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 315 F 334 SS=E	and was soiling her br times a day. Residen assistants offered incorresident to wear to pra and bedding. Reside "holding it" (urine and without assistance fror restroom, she would j of holding it. Residen 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 the however, they have re on the east hall and o west to east halls. Ch 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 devet 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, im facility staff to get to the ust release due to the pain int 20 had a fear of having to not receiving timely 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 ind she felt humiliated. PM, an interview with CNA om 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 NA 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		<sup>3</sup> 31			1/11/08

Facility ID: UT0002

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 M APPROVED O. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		465100	B. WIN	٩G _		12/0	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 LSC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 334	<ul> <li>(ii) Each resident is or immunization Octobe annually, unless the i contraindicated 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 residen</li> <li>(A) That the residen</li> <li>representative was puthe benefits and pote immunization; and</li> <li>(B) That the residen influenza immunization or the facility must deve that ensure that</li> <li>(i) Before offering the immunization, each relegal representative rethe benefits and pote immunization;</li> <li>(ii) Each resident is or immunization;</li> <li>(iii) The resident or the benefits and pote immunization, each relegal representative rethe benefits and pote immunization;</li> <li>(iii) Each resident is or 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 or the representation that imfollowing: <ul> <li>(A) That the resident</li> </ul> </li> </ul></li></ul>	ffered an influenza r 1 through March 31 mmunization is medically e resident has already been s time period; e resident's legal e opportunity to refuse edical record includes ndicates, at a minimum, the t or resident's legal rovided education regarding ntial side effects of influenza t either received the on or did not receive the on due to medical efusal. elop policies and procedures pneumococcal esident, or the resident's eceives education regarding ntial side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; e resident's legal e opportunity to refuse edical record includes ndicated, at a minimum, the	F	. 33			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/29/2008 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SL COMPLE	JRVEY
		465100	B. WIN	NG _		12/	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 AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 334	the benefits and pote pneumococcal immur (B) That the residen pneumococcal immur the pneumococcal immur the pneumococcal immur (v) As an alternative, and practitioner recor pneumococcal immur years following the fir immunization, unless the resident or the resi refuses the second im This REQUIREMENT by: Based on interview a determined that the far resident's medical red that indicated the resident's 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 umunization due to medical fusal. based on an assessment mmendation, a second nization may be given after 5 rst pneumococcal medically contraindicated or sident's legal representative nmunization. T 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 imunization or did not occal immunization due to tion or refusal. for 5 of 11	F	33			

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		IPLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY
		465100	B. WIN	IG _		12/0	3/2007
NAME OF PF	OVIDER 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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD 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 docume or their legal represer regarding the benefits of pneumococcal imm An interview of the D was held. The DON s where the pneumococ The medical records s interviewed on 12/3/0 She was asked for he residents' pneumococ documentation. She documentation regard immunization. 483.35(e) THERAPEL Therapeutic diets mus attending physician. This REQUIREMENT by: Based on observation medical record review facility did not provide prescribed by the atte sample residents and resident. 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 inunization. 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. ep 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 <i>y</i> , 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				FO	ED: 01/29/2008 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE COMPL	SURVEY
		465100	B. WIN	NG.		12	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 SC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD 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 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			

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/29/2008 RM APPROVED NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
		465100	B. WI	NG _		12	/03/2007
NAME OF PR	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP COE	DE	
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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 367	Continued From page shell.	e 70	F	36	67		
	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 conduc Resident 2 was obse hamburger sandwich not wearing her dentu observed to not recei	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					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
		465100	B. WI	NG_		12/0	3/2007
NAME OF PR	OVIDER 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 SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 367	to eat as well.	971 d, and was hard and difficult ovided the breakdown	F	36	57		
	menu's for therapeuti November 14th indica	c diets. The menu for ated that those residents soft diets, should have					
F 371 SS=E	kitchen workerwas int mechanical soft diets acknowledged that fo 11/14/07, the menu for not been followed.	. The kitchen worker	F	37	1		1/11/08
	The facility must store serve food under san	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				FORM	D: 01/29/2008 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
		465100	B. WIN	NG _		12/0	3/2007
NAME OF PR	ROVIDER 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 TAG	=IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	Continued From page		F	37	71		
	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					
	A one pound carton of cheese with expiration	of Cream O' Weber cottage n date of 11/5/07.					
		tover vanilla pudding, dated ontainers 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 conno date.	ontained two pie crusts with					
		crowave had pink/red drops 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
	If specialized rehabili 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: 01/29/2008 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE COMPL	SURVEY
		465100	B. WIN	NG _		12	2/03/2007
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 TAG	٦I	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 406	health rehabilitative s and mental retardatio resident's compreher must provide the requ required services fror accordance with §483	ervices for mental illness	F	40	06		
	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.	m). Specifically, not tracking rvices being implemented For 3 out of 11sample ple receiving SRS in the					
	to the facility on 10/20 included moderate m	67 year old female admitted D/98 with diagnoses that ental retardation, seizure					
	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	ular accident. I's medical record was 07. No SRS data tracking or d to SRS were found in der since September 2007. 57 year old female admitted 06 with diagnoses that dation, infantile cerebral dementia, and depression. 2's medical record was					

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
		465100	B. WIN	NG _		12/0	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 LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 406 F 469 SS=D	completed on 11/28/C progress notes relate resident 2's SRS bind 3. Resident 11 was a admitted to the facility that included mental in hypothyroidism. A review of resident 12 completed on 11/28/C progress notes relate resident 11's SRS bind On 11/27/07 at 4:30 F initiated with the facilit asked about SRS sen stated that residents of the facility had not be summarized since Ju 483.70(h)(4) PHYSIC CONTROL The facility must main control program so th and rodents. This REQUIREMENT by: Based on observation determined the facility effective pest control	<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	)6		1/11/08
	Findings included:						

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 01/29/2008 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	· · · ·	E SURVEY PLETED
		465100	B. WIN	NG _		1	2/03/2007
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 SC IDENTIFYING INFORMATION)	ID PREF TAC	=IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 469	the facility on 11/15/0 included traumatic and 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 she has had ants cranst stated that since she was unable to pick up floor and when the root 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 u 20's bed. The ants we the food particles on a 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 perint The Maintenance Sup documented that the sprayed the building of about room 5, the Maintenance Sup	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 hing because the ants had 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. 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	F	46	39		

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/29/2008 RM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		465100	B. WIN	NG _		12	2/03/2007
NAME OF PR	OVIDER 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 SC IDENTIFYING INFORMATION)	ID PREF TAG	٦IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 469	Continued From page	976	F	46	9		
F 490 SS=J	Maintenance Supervi 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	0		1/11/08
	by: Based on resident int administrative staff in staff interviews, and f determined that the fa- in a manner that ensu abuse, and that allega misappropriation of re- immediately reported and that employee so required by federal re- policies and procedur and respond to the ab- residents, was determ immediate threat to re- Resident identifiers: CNA 20, CNA 21, CN 1, and Nurse 7. Findings included: 1. Interviews were here	esident property were , thoroughly investigated, reening occurred as quirements and facility res. The failure to prevent buse of 1 of 10 sampled hined to present an esidents' health and safety.					

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SU COMPLET	IRVEY
		465100	B. WIN	NG _		12/0	)3/2007
NAME OF PR	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	<ul> <li>(SSW), Maintenance</li> <li>Aide (CNA)13, and C</li> <li>and 11/27/07. Consist</li> <li>was that resident 1 cl</li> <li>not want to shower or</li> <li>staff were utilized to e</li> <li>showered on 10/29/0</li> <li>expressed that she different fought with the</li> <li>as they prepared the</li> <li>resident fought with the</li> <li>resident 1 continued the</li> <li>want to shower as the</li> <li>removed her clothing</li> <li>Administrator and SS</li> <li>as the four staff mem</li> <li>to the shower and we</li> <li>cries for staff to stop,</li> <li>Also consistent from to</li> <li>once undressed, resided</li> <li>four facility staff mem</li> <li>Cross-refer F-223.</li> <li>Interviews were he</li> <li>resident 3, resident</li> <li>DON, current SSW, fo</li> <li>Supervisor, Nurse Aid</li> <li>14, and the Businesss</li> <li>interviewed between</li> <li>Although facility staff</li> <li>abuse to resident 1, a</li> <li>property of residents</li> <li>Administrator did not</li> <li>investigated thorough</li> <li>accordance with fede</li> <li>facility's own policies</li> <li>ensure that screening</li> <li>conducted in accordation</li> </ul>	Supervisor, Certified Nurse NA 14 between 11/14/07 stent from these interviews early 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 W 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 ibers and stopped yelling. eld with resident 1, resident t 19, the Administrator, ormer 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 and procedures, and to g of employees was	F	<sup></sup> 49	90		

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &					FOR	D: 01/29/2008 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 SL COMPLE	JRVEY
	465100	B. WIN	NG_		12/0	03/2007
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE 4035 SOUTH 500 EAST		
INFINIA AT ALTA				SALT LAKE CITY, UT 84107		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
resident in accordance standards and practic accurately documente systematically organic The clinical record mainformation to identify resident's assessment services provided; the preadmission screend and progress notes. This REQUIREMENT by: Based on record revision the facility did not main each resident in accord professional standard residents. (Residents 4, 2, 13, 3) Resident 4 Findings included: 1. Resident 4 was accord 7/13/06 with diagnose cerebral accident, reconsidered infections and lumbage Resident 4's medical 11/27/07. The August (Minimum Data Set) we by the nurse coordinal	<ul> <li>Attain clinical records on each be with accepted professional best that are complete;</li> <li>ed; readily accessible; and zed.</li> <li>aust contain sufficient of the resident; a record of the fact the resident; a record of the fact to the results of any ing conducted by the State;</li> <li>T is not met as evidenced</li> <li>ew it was determined that intain clinical records on ordance with accepted ds for 4 of 11 sample</li> <li>32)</li> <li>dmitted to the facility on es including: spinal stenosis, current urinary tract go.</li> <li>record was reviewed on at 2007 quarterly MDS was not dated as completed ator.</li> <li>dmitted to the facility on</li> </ul>	F	51			1/11/08

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	-	ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 01/29/2008 ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE	ESURVEY PLETED
		465100	B. WI	NG_		1	2/03/2007
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	FIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD 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	C C					
	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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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 01/29/2008 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		465100	B. WIN	NG_		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 / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	=IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Continued From page	80	F	51	14		
	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						
	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 11/12	ot documented as being 2/07 at 5:00 PM and 8:00 at 5:00 PM and 8:00 PM.					
	Lantus Insulin, was no 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 tal 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 PM. 11/14/07 at 11:00 AM. . 11/24/07 at 11:00 AM, and 5:00 PM.					
		dmitted to the facility on s of chronic obstructive oint and pelvis pain,					

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/29/2008 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY
		465100	B. WIN	۱G _		12/0	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 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
TAG F 514	Continued From page hypothyroidism, diabe and irritable bowel sy On 11/14/07 resident reviewed, including h (medication administr medications were not administered. Ex Lax 25, was not do adiministered on 11/ 11/22/07, 11/23/07, 1 11/28/07, and 11/29/07 Premarin, was not do administered on 11/2 11/24/07, 11/25/07, 1 11/29/07. Prilosec, was not doc administered on 11/1 11/28/07. Levothyroxine, was n administered on 11/2 KCL (Potassium), wa administered on 11/2	e 81 etes mellitus, hypertension, ndrome. 32's medical record was er August, 2007, MAR ration record). The following documented as being 13/07, 11/20/07, 11/21/07, 1/24/07, 11/25/07, 11/27/07, 07. cumented as being 1/07, 11/22/07, 11/23/07, 1/27/07, 11/28/07, and		51	DEFICIENCY)		
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
							1

Facility ID: UT0002

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 01/29/2008 M APPROVED O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
		465100	B. WIN	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	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 li issues with respect to and assurance activit develops and implem action to correct iden A State or the Secre disclosure of the reco except insofar as suc compliance of such o requirements of this s Good faith attempts to and correct quality de a basis for sanctions. This REQUIREMENT by: Based on interviews it was determined that that the Quality Asse- identification of abuse resident property; rep allegations of pain mar incontinence cares. Resident identifiers:	<ul> <li>in a quality assessment and a consisting of the director of hysician designated by the other members of the</li> <li>ent and assurance east quarterly to identify o which quality assessment ites are necessary; and tents appropriate plans of tified quality deficiencies.</li> <li>tary may not require ords of such committee to the ommittee with the section.</li> <li>by the committee to identify efficiencies will not be used as</li> <li>T is not met as evidenced and review of facility records, at the facility did not ensure ssment and Assurance of the facility did not ensure ssment and Assurance of the areas of:</li> <li>e and misappropriation of porting and investigating and misappropriation of eening of employees; hagement; and provision of</li> </ul>	F	52			

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/29/2008 ORM APPROVED NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE COMPI	
		465100	B. WI	NG .		1:	2/03/2007
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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(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 abuses resident property to a federal requirements procedures; and that to determine appropriaccordance with facil</li> </ol> </li> <li>The facility failed to in allegations of abuses</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 een they forced her to rill. ity Assessment and e did not ensure facility staff abuse and misappropriation that facility staff reported and misappropriation of ogencies in accordance with and facility policy and employees were screened iateness of employment in ity policies and procedures. hvestigate and report and misappropriation of 3 of 10 sampled residents, residents.		52	DEFICIENCY)		
	employees in accord policies and procedu Employee identifiers:	creen 9 of 14 sampled ance with their written res. CNA 9, CNA 16, CNA 17, IA 23, CNA 24, NA 1, and					

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		ND HUMAN SERVICES MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	ILDIN		(X3) DATE SURVEY COMPLETED		
	465100		B. WING			12/03/2007		
NAME OF PROVIDER OR SUPPLIER				ST	IREET ADDRESS, CITY, STATE, ZIP CODE			
INFINIA AT ALTA				4035 SOUTH 500 EAST				
					SALT LAKE CITY, UT 84107		1	
(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 CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD BE COMPLETION		
F 520	Continued From page 84		F	520	o			
	Cross-refer: F-225 and F-226.							
	Cross-refer: F-225 and F-226. 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. Cross-refer: F-309. 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. Cross-refer: F-315.							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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