STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221 SS=D	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, it was determined that the facility restrained 1 of 12 sample residents without demonstrating that the restraint was necessary in the treatment of a medical symptom. Resident identifier: 5. Findings include: Resident 5 was admitted to the facility on 12/13/06, with diagnoses that included Alzheimer's disease, osteoarthritis, hypertension, insomnia, and edema. A review of resident 5's clinical records was done on 2/27/07. On 1/11/07, a physician's telephone order read, "Order for soft waist restraints d/t (due to) frequent falls et (and) unsteady gait, et combativeness." Observations were made of resident 5 at various times, between 7:00 AM and 4:00 PM, on 2/27/07, 2/28/07, 3/1/07, and between 1:30 PM and 4:00 PM on 3/6/07. At times, while in his wheelchair, resident 5 was observed to have a soft waist restraint applied. At other times, resident 5 was observed in his wheelchair without the soft waist restraint. The following observations of resident 5 were made:	F 221		4/17/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 1	F 221		

a. 2/27/07 at 10:15 AM - Resident 5 was in his wheelchair, in the Special Needs Unit (SNU) dining room. The soft waist restraint secured him to his wheelchair.
b. 2/28/07 at 7:15 AM - Resident 5 was in his wheelchair, in the SNU dining room. The soft waist restraint was not on his wheelchair.
c. 3/1/07 at 8:45 AM - Resident 5 was in his wheelchair, in the SNU dining room. The soft waist restraint secured him to his wheelchair.
d. 3/6/07 at 1:30 PM - Resident 5 was in his wheelchair, in the SNU dining room. The soft waist restraint secured him to his wheelchair.

An interview with certified nursing assistant (CNA) 2 was held on 3/6/07 at 1:35 PM. CNA 2 stated she was assigned to provide cares for resident 5 on this day. The surveyor asked CNA 2 about the use of physical restraints for resident 5. She responded by stating the soft waist restraint was on resident 5 "at all times" when in his wheelchair and that the restraint was "only off during ADLs (activities of daily living)." CNA 2 stated that the restraint was used on resident 5 due to resident 5's falls and wandering. CNA 2 also stated that she had never seen resident 5 fall during her shift.

An interview with Physical Therapist (PT) 1 was held on 3/6/07 at 3:20 PM. PT 1 stated that he had provided therapy services to resident 5 from the resident's admission to the facility until the last week or so. PT 1 stated that resident 5 was discharged from physical therapy because he had plateaued and was not continuing to make progress. PT 1 stated that resident 5 had a limp, to his left side, when he ambulated and that he would not use a walker. PT 1 stated the facility was utilizing a "Lap Buddy" restraint on resident 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 2	F 221		

when he was in his wheelchair. The surveyor asked PT 1 if the facility was using a "Lap Buddy" or a soft waist restraint. PT 1 responded that it was a "Lap Buddy". PT 1 stated that the physical restraint was used "to keep him (resident 5) in his chair so he has less access to things . . . they can't keep an eye on him all the time . . . He goes in to other residents' rooms."

An interview was held with CNA 3 on 3/6/07 at 1:45 PM. CNA 3 stated that whenever resident 5 was in his wheelchair, staff place a soft waist restraint on him. CNA 3 stated the restraint was used to keep resident 5 protected from falls.

An interview was held with CNA 4 on 3/1/07 at 8:45 AM. CNA 4 stated that she placed resident 5 in the soft waist restraint when he was in his wheelchair, on the days when he seemed more unsteady.

An interview was held with Licensed Practical Nurse (LPN) 1 on 3/6/07 at 1:30 PM. LPN 1 was the charge nurse for the SNU on 3/6/07. LPN 1 stated that resident 5 was a, "wanderer" and that he would get up at night and tear stuff apart. She stated that resident 5 was also aggressive at times, and has gotten physical with staff. LPN 1 stated resident 5, "gets into everything." LPN 1 stated that it was up to the nurse on duty to determine if the soft waist restraint should be placed on resident 5. LPN 1 stated that if the resident was not walking well, staff would put the restraint on.

An interview with the Director of Nursing (DON) was held at 10:30 AM on 3/1/07. The DON was asked if resident 5's Power of Attorney (POA) had been consulted prior to implementing the use of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 3	F 221		

physical restraints. The DON stated that she knew that the POA had signed a paper but that she "could not find it."

A telephone interview with resident 5's son / POA was held on 3/5/07 at 8:00 AM. He stated that one day he had gone to the facility, to visit resident 5, when he noticed that the resident was in the soft waist restraint. He stated that prior to that time, he had not discussed the use of a physical restraint with facility staff. He stated that when he asked about why the resident was in the physical restraint, he was informed that the restraint was being used for falls and wandering. He stated the staff member told him, that if resident 5 were to be in another resident's room and were to fall, that would be dangerous. Resident 5's son stated that he had not signed any form authorizing the use of the physical restraint.

A review of Minimum Data Set (MDS) assessments, completed for resident 5, was done on 2/27/07. On 12/17/06, facility staff completed an admission MDS for resident 5. On 2/13/07, facility staff completed a Medicare 60 day MDS for resident 5. On each of these MDS assessments, facility staff assessed that resident 5 did not require the use of physical restraints and that he required only supervision in walking, both in his room and in the corridor. On the admission MDS, facility staff assessed that resident 5 had the behaviors of being physically abusive, verbally abusive, socially inappropriate/disruptive, resistive to cares, and wandering. The wandering behavior was assessed as occurring daily and was not easily altered. On 12/17/06, facility staff assessed that resident 5 had experienced a fall within the past 31 to 180 days. On 2/13/07,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 4	F 221		

facility staff assessed that resident 5 had experienced a fall in the past 30 days.

A review of resident 5's comprehensive plan of care was completed on 3/6/07. No documentation regarding physical restraints could be found on resident 5's care plan.

A review of facility incident reports was done on 3/6/07. Facility staff documented 10 incident reports in which resident 5 was involved. Of these 10 incident reports, 1 included documentation that resident 5 had fallen; 2/3/07. Three of the 10 incident reports included documentation that resident 5 was found on the floor; 12/14/06, 1/10/07, and 3/1/07. NOTE: These incident reports did not include documentation that resident 5 had fallen. Five of the 10 incident reports included documentation that resident 5 was found in another residents' room; 12/15/06, 12/16/06, 12/23/06, 1/6/07, and 1/24/07. One of the 10 incident reports included documentation that resident 5 was found to have injuries of an unknown origin; 2/24/07.

The incident report, dated 2/3/07, included documentation that resident 5 had "tipped w/c (wheelchair) onto its side [with] soft waist restraint (SWR) in place." The incident report also included documentation that prior to the fall resident 5 was "extremely agitated" and that the resident had no apparent injuries as a result of the fall.

The incident report, dated 3/1/07, included documentation that resident 5 had been checked on by a CNA "20 minutes after being put in w/c [with] SWR. Resident (5) found on floor in room asleep on floor. No apparent injuries. Unknown if resident fell or just layed (sic) down on floor." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 5	F 221		

incident report also stated that prior to the incident resident 5 was "anxious."

Further review of resident 5's clinical record revealed documentation on a IDT (Interdisciplinary Team) MEETING form, that the facility's IDT met on 1/17/07 to review resident 5's cares. This was six days after the physician telephone order was written for the use of the soft waist restraint. The IDT MEETING form included a section entitled "Physical restraints". This section was not checked as having been discussed at the IDT meeting with the family.

Resident 5's clinical record did not include documentation that an assessment had been completed in which the use of a physical restraint was determined to be necessary to treat a medical symptom. On 3/1/07, following discussions about resident 5's physical restraint, with the facility's DON, the DON completed a document entitled "Physical Restraint Evaluation".

A review of the facility's policy regarding physical restraints stated, "A physical restraint will be used only after the Interdisciplinary Team has performed an assessment, attempted alternatives, determined the need for restraint and identified the least restrictive restraint for the resident, except when emergency situations deem otherwise. . . . The emergency use of restraints is a measure of last resort to protect the safety of the resident or others and must not extend beyond the immediate episode."

The procedure section of the facility's policy regarding physical restraints stated that "the Restraint Evaluation will be completed by the IDT whenever a resident is being assessed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	Continued From page 6 potential restraint usage." NOTE: No documentation could be found that indicated that a Restraint Evaluation had been done for resident 5 prior to the physical restraint being implemented. The procedure section of the facility's policy regarding physical restraints also stated that "the family or legal representative will be notifed of the need for restraint" and that "prior to applying the restraint, a written acknowledgement will be obtained from the resident or legal representative." NOTE: No documentation could be found in resident 5's clinical record that indicated that resident 5's legal guardian had been notified. The procedure section of the facility's policy regarding physical restraints also stated that the doctor's order for physical restraints must state "the type of restraint, the medical symptom for which it will be used, and when the restraint is to be used." No documentation from the doctor was found that indicated when the restraint was to be used. The procedure section of the facility's policy regarding physical restraints also stated that "the resident plan of care will include the type of restraint, the situations requiring use of the restraint and the frequency of restraint usage." No documentation regarding physical restraints could be found on resident 5's care plan.	F 221		
F 242 SS=D	483.15(b) SELF-DETERMINATION AND PARTICIPATION The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;	F 242		4/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 7 interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, individual and group resident and staff interviews, and record review, it was determined that for 2 of 12 sample residents, the facility did not allow the residents the right to make choices about aspects of their life in the facility that was significant to them. Specifically, residents were denied the right to use their electric wheelchairs in the facility, regardless of the residents need, medical condition and/or ability to ambulate. Resident identifiers; 8 and 9. Findings included: 1. Resident 9 was admitted to the facility on 10/13/06 with diagnoses that included, diabetes mellitus, hypertension, chronic obstructive pulmonary diease, cirrhosis of the liver, Berger's disease, pancreatitis, below the knee amputation of left leg, and neuropathy of hands and foot. On 2/28/07 at 3:00 PM an interview with resident 9 was held in the resident's room. Next to resident 9's bed was an electric wheelchair. The resident was asked if she was able to use her electric wheelchair in the facility. Resident 9 stated that on her first day in the facility, she used the electric wheelchair to go down to the nurses station, but that she was quickly told that she couldn't use it because it was against the facility	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 8	F 242		

rules. Resident 9 stated that she was not told by the facility before being admitted on 10/13/06 that the facility had a policy prohibiting the use of electric wheelchairs. Resident 9 also stated that if she had known that the facility had a policy prohibiting the use of electric wheelchairs before she was admitted, she would not have agreed to be at this facility. The facility transferred resident 9 into a manual wheelchair, in which she has to push herself. Resident 9 stated that she had her left leg amputated a few years ago and that she has neuropathy in her hands. She stated that having to push herself was very hard and it caused her a lot of pain in her hands and arms. She stated that she would participate in more activities if she could get around the facility better without it causing her so much pain.

Resident 9's medical record was review on 3/1/07.

The following assessment documentation was found in resident 9's medical record:

An Admission Assessment dated 10/13/06 in the mobility section next to "assistive devices" the box for "cannot self propel w/c (wheelchair)" has been checked, as well as the box for "other" in which is written "BKA (below knee amputee) L (left leg)"

Resident 9's admission MDS (minimum data set) dated 10/28/06, under section G for locomotion (e and f) was assessed as total dependence with 1 person assist.

Nurses notes revealed the following documentation:

On 12/22/06, a weekly nursing note documented,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 9	F 242		

"resident had equal weak hand grasp."

On 1/1/07 at 9:00 PM, "(increased) edema and redness in hands and right leg."

On 2/9/07, weekly nursing notes, "resident able to propel self in w/c, yet complains about her arms hurting."

An interview was held with RN 4 on 2/28/07 at 10:45 AM. RN 4 stated that resident 9 complains about pain in hands and arms on a daily basis.

2. Resident 8 was admitted to the facility on 1/29/07, with diagnoses that included late effects of polio, weakness, hypertension, hypothyroidism, and rhinitis.

On 3/01/07 at 7:45 AM an interview was conducted with resident 8. She stated that when she arrived at the facility on admission she was using her electric wheelchair, however, was told they cause "traffic jams" in the halls. Upon entering the facility she states she was told by the DON (Director of Nursing) that using electric wheelchairs was against facility policy. She states that she was transferred to a manual wheelchair, and her electric wheelchair was placed in storage, and has remained there since. She stated that she had not seen the policy, nor had she signed any documentation about the restriction of her right to use her electric wheelchair.

Resident 8 stated that she has had to call for a CNA (certified nursing assistant) to assist her with transport since she is unable to self-propel herself in a manual wheelchair. She stated that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 10	F 242		

would like to independently explore and access the facility.

a. On 3/1/07 a medical record review was completed for resident 8. The following assessment documentation was found in resident 8's medical record:

On the "Admission Assessment" dated 1/29/07 in the mobility section next to "assistive devices" the box for "cannot self propel W/C" has been checked.

b. On the "Therapeutic Recreation Assessment" dated 1/29/07 under the functional factors of mobility she was assessed as "assisted" with "w/c" (wheelchair).

c. In the MDS (Minimum Data Set) dated 2/11/07 under section G for locomotion (e and f) resident 8 was assessed as total dependence with 1 person assist.

On 3/01/07, at approximately 10:00 AM, resident 8 was observed to be assisted by staff with her manual wheelchair to the beauty salon to have her hair done.

On 3/06/07 at 1:40 PM, an interview was conducted with LPN 1. LPN 1 stated she was unaware of a policy regarding electric wheelchairs. She stated that she was unaware of any accident that have occurred due to the use of wheelchairs in the facility. She stated that Resident 8 did not participate in activities, and had not seen resident 8 propel herself in a manual wheelchair.

On 3/06/07 at 2:10 PM, resident 8 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 11	F 242		

interviewed. Resident 8 stated that she missed the independence, socialization, and visiting that her electric wheelchair provided. She stated that when she left the room with the manual wheelchair, staff would have to be with her at all times to help her access the facility, but would only need a transfer to use her electric wheelchair. She stated that she would like to participate in bingo and singing.

On 3/06/07 at 2:48 PM, RN 2 was interviewed. RN 2 stated that she had not seen resident 8 leave her room in either a manual or electric wheelchair.

3. On 2/28/07 at 3:30 PM, a group interview as held with eight residents. The residents were asked about their rights in the facility. Several residents mentioned that the facility did not allow residents to use their electric wheelchairs in the facility. It was stated that the facility had a policy that prohibited the use of electric wheelchairs. One resident stated, "If you come here, they'll take your wheelchair away."

4. On 3/1/07 at 10:45 AM, an interview was held with the Administrator. The Administrator was asked about the facility's policy on motorized wheelchairs. The Administrator stated that the facility implemented a policy that prohibited the use of motorized wheelchairs within the facility. He stated the policy was implemented when he started at the facility as the Administrator, because he felt they were unsafe and dangerous.

5. A review of the facility's policy on Motorized Chairs was done. The policy read, "It is the policy of [name of facility] not to allow the daily use of motorized chairs. The use of such chairs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 242	Continued From page 12 compromise the safety of other current residents due to the high number of corners, blind spots and narrow hallways. It is allowed to use motorized chair when leaving [name of facility] on an outside visit to facilitate transportation independently."	F 242		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not provide maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings included: From 2/27/07 to 3/1/07 it was observed that the dining room heaters located in the special needs unit on the north wall had been broken and were not operating. It was observed that the knobs were missing and loose wires were visible inside the front panel of both heaters. On 3/1/07 an interview with the Administrator, and maintenance supervisor revealed that one of the residents on the special needs unit had been taking them apart, and did need to be repaired. On 2/27/07 it was observed in the 400 hall that the center air-conditioning vent located in the ceiling was separated from the ceiling 3/4 of an inch exposing a gap into the ceiling on the outside of the vent.	F 253		4/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=B	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for 5 of 12 sample residents, the facility did not identify the additional assessments performed through the Resident Assessment	F 272		4/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 14	F 272		

Protocols (RAP). For each of the sample residents, Section V of the Minimum Data Set (MDS) did not include the accurate location and the date of the RAP assessment documentation, or were inaccurate. Resident identifier 3, 4, 5, 8 and 10.

Findings include:

Resident 10 was admitted to the facility on 8/4/05 with diagnoses that included chronic obstructive pulmonary disease, gastric reflux disease, seizure disorder, bi polar, glaucoma and ulcerative colitis.

Resident 10's clinical record was reviewed on 2/28/07. Based on an annual MDS assessment, with an assessment reference date of 8/18/06, resident 10 triggered the following areas of Section V, the Resident Assessment Protocol Summary (RAPS): ADL (activities of daily living) functional/rehabilitation, urinary incontinence and indwelling catheter, behavior symptoms, falls, nutritional status, dehydration/fluid maintenance, pressure ulcer, and psychotropic drug use.

For ADL function/rehabilitation facility, urinary incontinence and indwelling catheter, nutritional status, and pressure ulcers the facility documented the location and date of the RAP assessment as "ADL flow sheet 8/11/06 - 8/17/06". For behavioral symptoms the facility documented the location and date of the RAP assessment as "Nurses notes 8/10/06 - 8/17/06". For falls, dehydration/fluid maintenance and psychotropic drug use the facility documented the location and date of the RAP assessment as "Med (medication) sheets 8/11/06 - 8/17/06".

After reviewing resident 10's clinical record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 15 referred to in the RAP for the dates cited, the corresponding concerns were not assessed for resident 10. Resident 4 was admitted to the facility on 12/13/06, with diagnoses that included Schizoaffective disorder, dementia of alzheimer late onset with behavior disturbances, diabetes. A review of resident 4's clinical records was done on 2/27/07. Based on the initial MDS assessment, with an assessment reference date of 11/29/06, resident 4 triggered in the following areas of section V, the RAPS: cognitive loss, ADL functional/rehabilitation potential, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms, falls, nutritional status, dental care, psychotropic drug use, and pressure ulcers. For ADL functional/rehabilitation potential, and urinary incontinence the facility documented the location and date of the RAP assessment as "ADL flow 11/22/06 to 11/28/06." For behavior symptoms, and psychotropic drug use, the facility documented the location and date of the RAP assessment as "Med sheets 11/22/06 to 11/28/06." After reviewing resident 4's clinical records referred to in the RAP assessment for the dates cited, the corresponding concerns were not assessed for resident 4.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 16	F 272		

Resident 8 was admitted to the facility on 1/29/07, with diagnoses that included late effects of polio, weakness, hypertension, hypothyroidism, and rhinitis.

A review of resident 8's clinical records was done on 2/27/07. Based on the initial MDS assessment, with an assessment reference date of 2/11/07, resident 8 triggered in the following areas of section V, the RAPS: cognitive loss, visual functioning, ADL functional/rehabilitation potential, urinary incontinence, mood, behavior, falls, nutritional status, and pressure ulcers.

For ADL functional/rehabilitation potential, nutritional status, and pressure ulcers the facility documented the location and date of the RAP assessment as "ADL flow 1/29/07 to 2/10/07." For falls the facility documented the location and date of the RAP assessment as "Med sheets 1/29/07 to 2/10/07." For Mood state the facility documented the location and date of the RAP assessment as "Mood Tracking 1/29/07 to 2/10/07."

After reviewing resident 8's clinical records referred to in the RAP assessment for the dates cited, the corresponding concerns were not assessed for resident 8.

Resident 5 was admitted to the facility on 12/13/06, with diagnoses that included Alzheimer's disease, osteoarthritis, hypertension, insomnia, and edema.

A review of resident 5's clinical records was done

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 17	F 272		

on 2/27/07. Based on the initial MDS assessment, with an assessment reference date of 12/13/06, resident 5 triggered in the following areas of section V, the RAPS: delirium, cognitive loss, communication, ADL functional/rehabilitation potential, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms, falls, nutritional status, dehydration/fluid maintenance, dental care, psychotropic drug use, and pressure ulcers.

For delirium, the facility documented the location and date of the RAP assessment as "MD [doctor] notes (Crestwood) 11/24/06." For ADL functional/rehabilitation potential, pressure ulcers, and urinary incontinence, the facility documented the location and date of the RAP assessment as "ADL flow sheets 12/13 -- 12/17/06." For nutritional status the facility documented the location and date of the RAP assessment as "Diet order 12/13/06." For dehydration/fluid maintenance, the facility documented the location and date of the RAP assessment as "Medication sheets 12/13 --12/17/06." For psychotropic drug use, the facility documented the location and date of the RAP assessment as "Med (medication) sheets 12/13 --12/17/06."

After reviewing resident 5's clinical records referred to in the RAP assessment for the dates cited, the corresponding concerns were not assessed for resident 5.

Resident 3 was admitted to the facility on 6/22/06, with diagnoses that included irritable bowel syndrome, agoraphobia, depression, anxiety, reflux, hypertension, dysthymic disorder, incontinence, sleep apnea, obesity, hypothyroid and disaccharide malabsorption.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 18 A review of resident 3's clinical records was done on 2/27/07. Based on the initial MDS assessment, with an assessment reference date of 6/22/06, resident 3 triggered in the following areas of section V, the RAPS: delirium, cognitive loss, ADL functional/rehabilitation potential, urinary incontinence, mood state, behavioral symptoms, falls, dental care, and psychotropic drug use. For ADL functional/rehabilitation potential the facility documented the location and date of the RAP assessment as "ADL flow 6/22 -- 6/28/06." For psychotropic drug use, the facility documented the location and date of the RAP assessment as "Med sheets 6/22 --6/28/06." After reviewing resident 3's clinical records referred to in the RAP assessment for the dates cited, the corresponding concerns were not assessed for resident 3.	F 272		
F 311 SS=G	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, individual and group resident and staff interviews, and record review, it was determined that for 2 of 12 sampled residents, the facility did not ensure that each resident maintained or improved his/her abilities in ambulation. "Ambulation" means how a resident moves between locations in his/her room and adjacent corridor on same floor.	F 311		4/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 19	F 311		

The facility had developed and implemented a policy prohibiting the use of electric wheelchairs and/or electric scooters. Resident identifiers; 8,and 9.

Finding included:

1. Resident 9 was admitted to the facility on 10/13/06 with diagnoses that included, diabetes mellitus, hypertension, chronic obstructive pulmonary diease, cirrhosis of the liver, Berger's disease, pancreatitis, below the knee amputation of left leg, and neuropathy of hands and foot.

On 2/28/07 at 3:00 PM, an interview with resident 9 was held in the resident's room. Next to resident 9's bed was an electric wheelchair. The resident was asked if she was able to use her electric wheelchair in the facility. Resident 9 stated that on her first day in the facility, she used the electric wheelchair to go down to the nurses station, but that she was quickly told that she couldn't use it because it was against the facility rules. Resident 9 stated that she was not told by the facility before being admitted on 10/13/06 that the facility had a policy prohibiting the use of electric wheelchairs. Resident 9 also stated that if she had known that the facility had a policy prohibiting the use of electric wheelchairs before she was admitted, she would not have agreed to be at this facility. The facility transferred resident 9 into a manual wheelchair, in which she has to push herself. Resident 9 stated that she had her left leg amputated a few years ago and that she has neuropathy in her hands. She stated that having to push herself is very hard and it causes her a lot of pain in her hands and arms. She stated that she would participate in more activities if she could get around the facility better without it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 20 causing her so much pain. Resident 9's medical record was review on 3/1/07. The following assessment documentation was found in resident 9's medical record: An Admission Assessment dated 10/13/06 in the mobility section next to "assistive devices" the box for "cannot self propel w/c (wheelchair)" has been checked, as well as the box for "other" in which is written "BKA (below knee amputee) L (left leg)" Resident 9's admission MDS (minimum data set) dated 10/28/06, under section G for locomotion (e and f) was assessed as total dependence with 1 person assist. Nurses notes revealed the following documentation: On 12/22/06, a weekly nursing note documented, "resident had equal weak hand grasp." On 1/1/07 at 9:00 PM, "(increased) edema and redness in hands and right leg." On 2/9/07, weekly nursing notes, "resident able to propel self in w/c, yet complains about her arms hurting." An interview was held with RN 4 on 2/28/07 at 10:45 AM. RN 4 stated that resident 9 complains about pain in hands and arms on a daily basis.	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 21	F 311		

2. Resident 8 was admitted to the facility on 1/29/07, with diagnoses that included late effects of polio, weakness, hypertension, hypothyroidism, and rhinitis.

On 3/01/07 at 7:45 AM an interview was conducted with resident 8. She stated that when she arrived at the facility on admission she was using her electric wheelchair, however, was told they cause "traffic jams" in the halls. Upon entering the facility she states she was told by the DON (Director of Nursing) that using electric wheelchairs was against facility policy. She states that she was transferred to a manual wheelchair, and her electric wheelchair was placed in storage, and has remained there since. She stated that she had not seen the policy, or had signed any documentation about the restriction of her right to use her electric wheelchair.

Resident 8 stated that she has had to call for a CNA (certified nursing assistant) to assist her with transport since she is unable to self-propel herself in a manual wheelchair. She stated that she would like to independently explore and access the facility.

a. On 3/1/07 a medical record review was completed for resident 8. The following assessment documentation was found in resident 8's medical record:

On the "Admission Assessment" dated 1/29/07 in the mobility section next to "assistive devices" the box for "cannot self propel W/C" has been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 22	F 311		

checked.

b. On the "Therapeutic Recreation Assessment" dated 1/29/07 under the functional factors of mobility she was assessed as "assisted" with "w/c".

c. In the MDS dated 2/11/07 under section G for locomotion (e and f) resident 8 was assessed as total dependence with 1 person assist.

On 3/01/07, at approximately 10:00 AM, resident 8 was observed to be assisted by staff with her manual wheelchair to the beauty salon to have her hair done.

On 3/06/07 at 1:40 PM, an interview was conducted with LPN 1. LPN 1 stated she was unaware of a policy regarding electric wheelchairs. She stated that she is unaware of any accident that have occurred due to the use of wheelchairs in the facility. She stated that Resident 8 does not participate in activities, and has not seen resident 8 self-propel herself in a manual wheelchair.

On 3/06/07 at 2:10 PM, resident 8 was interviewed. Resident 8 stated that she misses the independence, socialization, and visiting that her electric wheelchair provided. She stated that when she leaves the room with the manual wheelchair staff have to be with her at all times to help her access the facility, but would only need a transfer to use her electric wheelchair.

On 3/06/07 at 2:48 PM, RN 2 was interviewed. RN 2 stated that she had not seen resident 8 leave her room either in a manual or electric wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 23 3. On 2/28/07 at 3:30 PM, a group interview as held with eight residents. The residents were asked about their rights in the facility. Several residents mentioned that the facility did not allow residents to use their electric wheelchairs in the facility. It was stated that the facility had a policy that prohibited the use of electric wheelchairs. One resident stated, "If you come here, they'll take your wheelchair away." 4. On 3/1/07 at 10:45 AM, an interview was held with the Administrator. The Administrator was asked about the facility's policy on motorized wheelchairs. The Administrator stated that the facility implemented a policy that prohibited the use of motorized wheelchairs within the facility. He stated the policy was implemented when he started at the facility as the Administrator, because he felt they were unsafe and dangerous. 5. A review of the facility's policy on Motorized Chairs was done. The policy read, "It is the policy of [name of facility] not to allow the daily use of motorized chairs. The use of such chairs compromise the safety of other current residents due to the high number of corners, blind spots and narrow hallways. It is allowed to use motorized chair when leaving [name of facility] on an outside visit to facilitate transportation independently."	F 311		
F 323 SS=B	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 by: Based on observation the facility did not ensure that the resident environment remained as free of accident hazards as is possible. Findings included: On 2/27/07 the oxygen storage room was observed to be unlocked at 9:00 AM, 10:00 AM, and 2:45 PM. Oxygen cylinders were observed to be stored loosely and in milk crates, and were not secured by the chain attached to the wall of the storage room.	F 323		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not store, prepare, distribute and serve food under sanitary conditions. Findings include: 1. On 2/27/07 at approximately 8:30 am, the following observations were made in the refrigerator: a. Four bowls of pears that were uncovered and undated. b. One package of pepperoni on a shelf above raw celery. c. One bowl of a yellow substance that was unlabeled.	F 371		4/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 25 d. One container of mandarin orange slices dated 2/22/07. e. One box of fresh eggs on shelf above 2 packages of bread. 2. On 2/27/07 at approximately 8:40 am, the following observations were made: a. One bag of beans stored in a bin of open rice. b. Plastic scoops located in a bin of sugar and in a bin marked "potato pearls." 3. On 3/1/07 the following observations were made: a. In the refrigerator, a raw pork loin was thawing over raw cubes of margarine as well as milk cartons. b. Plastic scoop located in a bin marked "potato pearls." c. Two boxes of cereal bags on floor of dry storage. Dietary manager reported that the boxes were delivered on 2/27/07. d. Dietary staff member put away water carafes while still wet. e. Cook 1 was observed to touch toast while serving breakfast at 8:00 AM, go to the refrigerator and take something out, and then continue to serve breakfast. At no time during this process was cook 1 observed to wash his hands. f. At 8:10 AM cook 1 was observed. He pulled the garbage can closer to him and then proceeded to discard leftover food from residents into the garbage can. An aide came in to the kitchen to ask cook 1 for something. Cook 1 then wiped his hands on his apron, picked up a plate and put a sausage link on it, and then touched a piece of toast. At no time during this process was cook 1 observed to wash his hands.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 26 4. On 3/1/07 between 11:50 am and 12:30 pm the following observations were made during trayline: a. Cook 1 was observed to touch his eye glasses and then touch the bowls the soup was served in. The soup bowls had been put away wet and had puddles of water around them on the bottom of the tray. b. Cook 1 was observed to touch the rim of a bowl on his apron which he had previously wiped his hands on. c. Cook 1 was observed to wipe sweat off of his forehead with his left forefinger and then continue to serve lunch. He then touched his eyeglasses again and touched 4 lunch plates, putting 4 fingers on each plate. d. Cook 1 was again observed to touch his eyeglasses and then put his fingers inside the soup bowls as well as touch the cornbread as he served it.	F 371		
F 431 SS=B	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		4/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 27 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined that the facility was using medications that were not labeled in accordance with currently accepted professional principles. Specifically, medications and vaccines were found to be passed the manufacturer's expiration date. Findings include: The refrigerator located in the nurse medication room was observed, on 2/28/07 at 2:00 PM, to have the following; 1. Six vials of Lorazepam (drug for anxiety) 2 mg. (milligram)/ ml (milliliter) which expired on 1/5/07, 2. Three vials of Hepatitis B Vaccine 10 mg./0.5 ml which expired on 1/10/07.	F 431		
F 502 SS=B	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory	F 502		4/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 28	F 502		

services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, and interviews it determined the facility did not meet the needs of 2 of 12 sample residents for laboratory services as ordered. Resident identifiers 7 and 5.

Findings include:

Resident 7 was admitted to the facility on 6/4/04 with diagnoses that included essential tremors, generalized anxiety disorder, osteoarthritis, psoriasis, chronic obstructive pulmonary disease, and insulin dependent diabetes mellitus.

Resident 7's clinical record was reviewed on 2/27/07.

Resident 7's recertification orders dated 11/06 documented that resident 7 was to have a Valproic level (blood test) Q6 MO (every 6 months) Depakote (tremor/seizure medication) usage (May/Nov). The most recent Valproic level was drawn on 5/26/06, the next level was due 11/06. There was no documentation in resident 7's clinical record that the Valproic level had been drawn in November 2006.

Resident 7's readmission physician's orders, dated 2/17/07, documented BC+ (blood culture positive) MRSA (methicillin resistant staphylococcus aureus). The was no documentation on the clinical record of a hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 29 laboratory test that was positive for MRSA. In an interview with the DON (Director of Nursing), on 3/1/07 at 9:30 AM she confirmed that the Valproic level was not done in November 2006. The DON stated "it was overlooked". She also said that the blood culture was done at the hospital and a copy had not been requested. Resident 5 was admitted to the facility on 12/13/06, with diagnoses that included Alzheimer's disease, osteoarthritis, hypertension, insomnia, and edema. A review of resident 5's clinical records was done on 2/27/07. A lab order for a Basal Metabolic Panel (BMP) to be done on resident 5 was ordered on 1/29/07. No lab results could be located in resident 5's chart. An interview with RN 1 was held on 2/28/07 regarding the missing results for resident 5. She was also unable to locate the lab results. She did provide documentation that the lab was performed on 1/30/07. On 3/1/07 documentation of lab results was provided and placed in resident 5's clinical record.	F 502		
F 520 SS=B	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		4/17/07

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465065	A. BUILDING _____ B. WING _____	03/06/2007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 30 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based upon interview with the facility administrator it was determined that the facility did not have evidence that a MD (medical doctor) attended or reviewed the QA (quality assurance) minutes. Findings include: In an interview with the Administrator (Adm.), on 2/27/07 at 8:45 AM during entrance for the annual survey, he said the medical director of the facility had not attended any QA meeting since he (the ADM.) had started at the facility last August. The Adm. also confirmed the medical director had not reviewed the minutes of the QA meetings.	F 520		