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on 6/21/04 to report that a facility LPN (Licensed Practical Nurse) threatened to and applied soap around a resident's mouth, and that the facility nurse had been counseled, put on probation, and remains working with the residents. Guideline \$483.13 (b) and (c) "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." (42 CFR 488.301) Resident 2 was interviewed on 6/22/04 at 1:10 PM The state surveyor sked the resident if a ABORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVES SIGNATURE was in-serviced on 6/25/04. All staff will received a copy of the updated abuse policy on 7/8/04 in-service and a signature that this was recieved will be placed in the employees files. This was an individual nurse that acted of her own accord. She has been updated to include suspension during investigation. The prior policy stated that we may suspend. The staff had a special abuse in-service on 6/25/04. We acted quickly to remind the staff of what abuse is.		The nursing facility t	elephanod the State A		higher education. Our abuse police	cv has been	
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around a resident's mouth, and that the facility nurse had been counseled, put on probation, and remains working with the residents. Guideline \$483.13 (b) and (c) "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." (42 CFR 488.301) Resident 2 was interviewed on 6/22/04 at 1:10 PM The state surveyor asked the resident if a ASORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE Service and a signature that this was recieved will be placed in the employees files. This was an individual nurse that acted of her own accord. She has been updated to include suspension during investigation. The prior policy stated that we may suspend. The staff had a special abuse in-service on 8/25/04. We acted quickly to remind the staff of what abuse is.		Practical Nurse) thre	eatened to and applied soap		la copy of the updated abuse police	v on 7/9/04 in-	
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resulting physical harm, pain or mental anguish." (42 CFR 488.301) Resident 2 was interviewed on 6/22/04 at 1:10 PM The state surveyor esked the resident if a ABORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	j 1	confinement, iglimida	ation, or punishment with		I ne abuse policy has been update	ed to include	
Resident 2 was interviewed on 6/22/04 at 1:10 PM The state surveyor asked the resident if a ABORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		resultirig physical ha	rm, pain or mental anguish."		stated that we may suspend. The	staff had a	
Resident 2 was interviewed on 6/22/04 at 1:10 PM The state surveyor asked the resident if a ABORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (XC) DATE 7 8/0	•	(42 CPR #88.301)			special abuse in-service on 6/25/0	4. We acted	
PM/ The state surveyor asked the resident if a BORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 7 8/0		Resident 2 was inter-	Viewed on 6/22/04 of 4:40		quickly to remind the staff of what	abuse is.	
BORATORY DIRECTOR'S OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	Ţi	PM/ The state surve	yor asked the resident if a			ļ	
Doministanto 7/8/01	BORATORY			TURE	TITLE		WAL DATE
		1	*		A 1	-10	AU) DATE
	ny deficiency	statement ending with an	vasterisk (*) denotes a deficience until	the least		<u> </u>	WY_

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 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

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Event ID: O2NX11

Facility IO: UT0058

If continuation sheet Page 1 of 17

DEPARTMENT OF HEALTH AND HUN. IN SERVICES

PRINTEU: 0/20/2004 FORM APPROVED

		& MEDICAID SERVICES			OMB NO	. 0938-0391
STATEMEN AND PLAN	nt of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII B. WING		(X3) DATE S COMPLE	URVEY
NAME OF I	PROVIDER OR SUPPLIER	465065			6/23	2/2004
INFINIA	AT OGDEN			REET AODRESS, CITY, STATE, ZIP (524 East 800 Nor th Ogden, UT 84404	ODE ;	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE	(X5) COMPLETION DATE
	nurse had put soap stated, "Yes, she did She (the nurse) was impatient. I wanted surveyor asked the was. The resident state asked the resident stated, "She used he asked the resident stated, very much." The facility nurse, (Lare for resident 2 o incident occurred, was worresident 2 was sweared as swearing. I told swearing because your sesidents. If you don wash your mouth out by the arm over to the soap in the palm of nher mouth. Resident didn't get in her mouth, and dragged to the sink, resident 2, or 5/22/04 at 1:00 PM.	in her mouth. The resident if It was a misunderstanding. It was a misunderstanding a cigarette." The state resident what kind of soap it stated, "It was liquid soap." asked the resident how the er mouth and the resident er hand." The state surveyor what she did after that, and "I went and rinsed. It was not PN 1) who was providing in 6/19/04, the day the as interviewed on 6/23/04 at me. LPN 1 stated the king the unit that day, and ring and using the "F" word. Does this when she can't have burned at mealtime and the upset because resident 2 resident 2 you've got to stop ou're upsetting the other "t stop swearing!" I have to with soap. I took resident 2 e sink and put some foam my hand and wiped it across 2 rinsed it off. The soap h." LPN 1 further stated, "It t 2 was quiet after that. The ame to talk to me, I didn't lie. It resident 2 is mouth, I put it d the resident wasn't esident 2 didn't resist." CNA 2) who had provided in 6/19/04 was interviewed on She stated that she and eard" LPN 1 state that she			I by memo from the for reporting at incident reports. They will also be inistrator or the utilding) to report is not able to estigation. They will be to estigation. The ing and reviewed nistrator, DON, ent Nurse) for till be made to noise. The id Sundays will be in a report is the Nurse that if be disciplined. The staff tiln regarding ator will monitor rearror meeting cess will be neeting.	

FORM CMS-2587(02-99) Orevious Versions Obsolete

Event ID: O2NX11

Facility ID: UT0058

If continuation sheet Page 2 of 17

DEPARTMENT OF HEALTH AND HUM, "1 SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		465065	B. WING			2/2004
	ROVIDER OR SUPPLIER		524	ET ADDRESS, CITY, STATE, ZIP 4 EAST 800 NORTH 5DEN, UT 84404		2004
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE : HE APPROPRIATE	(X5) COMPLETION DATE
	swearing. The nursher shift, went to a land called the SW lincident. The facility SW (So on 6/22/04 at 1:40 fithe SW if she was a resident 2 having he resident 2 having he facility SW statincident and she prothe investigation that surveyor asked the investigation was, a The SW stated that Nursing), facility MD administrator and he on probation. The So nurses are "over timitime) right now. The easier to let LPN 1 conurse staff." She stated fire LPN 1, and or (registered nurse) owork." The SW stated harm the resident, but have the resident and wrong, that's who surveyor asked the	art's mouth out with soap for se aide stated that she finished local eating establishment, by phone to notify her of the cial Worker) was interviewed PM. The state surveyor asked aware of the incident of er mouth washed with soap, ed that she was aware of the ovided the surveyor a copy of at had been completed. The SW what the outcome of the nd what action was taken, the DON (Director of DS coordinator, the erself decided to place LPN 1 SW stated, "a lot of the aing" (working a lot of over the decision would have been go (terminate) if we had more ated," they debated whether verwork the other RN's rallow LPN 1 to continue to ed, "(LPN 1) made a poor the there was no intention to by LPN 1. The intention was stop swearing. It was stupid by it was reported." The SW who was notified first.	F 223			
	the administrator wa 6/19/04, by another (SW) stated that she administrator of the administrator, and a on Sunday 6/20/04. about the incident or	after that. She stated that is notified Saturday night facility nurse, (LPN 2). She was notified by the incident Sunday by the gain by two other nurse aides. The facility DON was notified in Sunday 6/20/04. The SW as not taken off of the		·		

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Event ID: O2NX11

Facility ID: UT0058

If continuation sheet Page 3 of 17

DEPARTMENT OF HEALTH AND HUM, IN SERVICES

PRINTED: 6/25/2004 FORM APPROVED DMB NO. 0938-0391

<u>CENTE</u>	RS FOR MEDICARE	& MEDICAID SERVICES	***		OMB NO	. <u>0938</u> -0391
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	SURVEY ETED
		465065	B. WING_		,	C 2/2004
NAME OF F	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP C		2/2004
INFINIA	AT OGDEN			524 EAST 800 NORTH	NOE.	
	<u> </u>			OGDEN, UT 84404	:	
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE : IE APPROPRIATE	(X5) COMPLETION DATE
F 223	Continued From pa	-	F 223			
	6/20/04 morning, a Monday night, a 12					
F 225 SS=D	483.13(c)(1)(ii) STA RESIDENTS	AFF TREATMENT OF	F 225	F225		l .
	been found guilty of mistreating resident had a finding entere registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must ensinvolving mistreatme including injuries of misappropriation of immediately to the atto other officials in a through established State survey and cell the facility must have investigation is in protection of the results of all investigation is in protection of the administrator representative and to accordance with States.	sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the entification agency). In the entire of the facility and accordance with State law procedures (including to the entification agency). In the entire of the facility and accordance with State law procedures (including to the entification agency). In the entire of the facility and accordance with State law procedures (including to the entification agency).		This was an individual nurse accord. She has been term The abuse policy has been is suspension during investigated that we may suspend special abuse in-service on quickly to remind the staff of The staff had a special abuse 6/25/04. We acted quickly to what abuse is. The abuse policy has been to suspension during investigated that we may suspend The Nurse staff will be informed that we have been appeared incidents and the policy to fill during the shift that they hap be reminded to telephone the DON (when they are not in the finding so that the employentinue working during the	sinated and reporte updated to include ation. The prior point of the staff had a 6/25/04. We acted the factor of the staff what abuse is. The staff had a 6/25/04. We acted the staff what abuse is. The prior point of the staff will be staff the staff of the prior point of the staff of the staff of the prior point of the staff the staff of the prior point of the prior point of the staff	ed. e policy ed f of e policy on the ports so or the port

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

Event ID: Q2NX11

Facility ID: UT0058

FAX NO.: 8017823594

If continuation sheet Page 4 of 17

DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICAL SERVICES

FORM APPROVED
OMB NO. 0938-0391

	of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ILTIPLE CONSTRUCTI DING	ON	(X3) DATE SURVEY COMPLETED	
		465065	B. WIN	3	:	6/22/2004	
	PROVIDER OR SUPPLIER		!	STREET ADDRESS, CI 524 EAST 800 NOI OGDEN, UT 844	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTIVE ACTION SHO ERENCED TO THE APPL DEFICIENCY)	OULD BE COMPLÉ	
F 225	verified appropriate taken. This REQUIREMENT by: Based on resident a determined that the resident was free frand mental abuse, involuntary seclusic licensed nurse three mouth out with soar the threat, by apply across the resident occurred, facility stresidents from possourse to continue with staff did not report of Professional Licensed nurse to continue with facility on 10/7/c schizoaffective discontinued in the facility on 10/7/c schizoaffective discontinued in the professional Licensed nurse to continue in the facility on 10/7/c schizoaffective discontinued in the professional Licensed nurse to continue in the facility on 10/7/c schizoaffective discontinued in the professional licensed in the facility on 10/7/c schizoaffective discontinued in the professional licensed in the facility on 10/7/c schizoaffective discontinued in the professional licensed in the facility on 10/7/c schizoaffective discontinued in the professional licensed in the facility on 10/7/c schizoaffective discontinued in the professional licensed in the facility on 10/7/c schizoaffective discontinued in the facility on 10	and if the alleged violation is corrective action must be of the process of and staff interviews, it was facility did not ensure that a comporal punishment and in. Specifically, a facility attend to wash a resident's post the nurse then carried out ing soap to the outside of, and is mouth. After the incident aff did not protect other sible abuse, by allowing the rorking at the facility. Facility the incident to DOPL (Division ensing). Resident identifier: 2.	F 23	The incident re Administrator's by the Manage ADON, Social possible abuse investigate an reports for Frie in the office or not properly fil was in charge The monitoring incident report has already be abuse on 6/25 the Plan of Co	eports will be placed a office each mornin ement Team(Admini Work and Treatmer Assignments will discrepant days, Saturdays and Monday mornings and out or reported to during that shift will g will be done daily to and the report system in-serviced against a completion will be not sometiment of the report system of the repor	g and reviewed strator, DON, nt Nurse) for be made to cles. The if Sundays will be if a report is the Nurse that be disciplined. by means of the stem. The staff in regarding stor will monitor trance meeting cess will be neeting.	

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

Event ID: 02NX11

Facility ID: UT0058

FAX NO, : 8017823594

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/25/2004 FORM APPROVED OMB NO. 0938-0391

A45065 NAME OF PROVIDER OR SUPPLIER INFINIA AT OGDEN STREET ADDRESS, CITY, STATE, ZIP CODE 524 EAST 800 NORTH OGDEN, UT 84404 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NULTIPLE CO	INSTRUCTION		(X3) DATE S COMPLI	ETED
INFINIA AT OGDEN STREET ADDRESS, CITY, STATE JPP CODE STREET ADDRESS, CITY, STATE JPP CODE STREET ADDRESS, CITY, STATE JPP CODE STAMARY STATEMENT OF DEPICIENCIES TAG SUBMARY STATEMENT OF DEPICIENCIES TAG SUBMARY STATEMENT OF DEPICIENCIES TAG SUBMARY STATEMENT OF DEPICIENCIES TAG PROVIDERS PLAN OF CORRECTION RESULATORY OR LSO (DENTIFYING INFORMATION) F 225 Continued From page 5 Resident 2 was interviewed on 6/22/04 at 1:10 PM. The state surveyor asked the resident if a nurse had put soap in her mouth. The resident stated, "Yes, she idd. It was a misunderstanding. She (the nurse) was teasing me for being impatient. I wanted a digaratti." The state surveyor asked the resident what he did after that, and the resident stated, "It was liquid soap." The facility nurse, (LPN 1) who was providing care for resident 2 on 6/19/04, the day the incident occurred was interviewed on 6/22/04 at 10:500 AM by telephone. LPN 1 stated the following, "I was working the unit that day, and resident 2 was swearing and using the "F" word. (Resident 2) usually does this when she can't have a cigarette. This occurred off meeltime and the other residents were upset because resident 2 was swearing. I told resident 2 you've got to stop swearing because you're upsetting the other residents. If you don't stop swearing ill have to wash your mouth out with soap, I took resident 2 by the arm over to the sink and put some foam soap in the pain or my hand and wiped it across her mouth. Resident 2 was quiet after that. The SW (social worker) came to talk to me, I didn't lie. I didn't put the soap in resident 2 smouth, I put it across her mouth, and the resident wasn't dragged to the sink, resident 2 with hand provided	_	• .	465065	B. WII	NG		_	6/2	C 2/2nna
RESULATORY OR US DEMINFORMATION) F 225 Continued From page 5 Resident 2 was interviewed on 6/22/04 at 1:10 PM. The states surveyor asked the resident if a nurse had put soap in her mouth. The resident stated, "Yes, she did. It was a misunderstanding. She (the nurse) was teasing me for being impatient. I wanted a cligaretia. The state surveyor asked the resident what kind of soap it was. The resident stated, "It was liquid soap." The state surveyor asked the resident what kind of soap it was. The resident stated, "It was liquid soap." The state surveyor asked the resident what he did after that, and the resident what she did after that, and the resident stated, "I went and rinsed. It was not very much." The facility nurse, (LPN 1) who was providing care for resident? on 9/19/04, the day the incident occurred was interviewed on 9/23/04 at 10:50 AM by telephone. LPN 1 stated the following, "I was working the unit that day, and resident? 2 was swearing and using the "F" word. (Resident 2) usually does this when she can't have a cigarette. This occurred at meatitime and the other residents. If you don't stop swearing lil have to wash your mouth out with soap. I took resident 2 by the arm over to the sink and put some foam soap in the paim of my hand and wiped it across her mouth. Resident 2 is mouth, I put it across her mouth. But it is first that the sage in the paim of my hand and wiped it across her mouth. Resident 2 as mouth, I put it across her mouth, and the resident wasn't dragged to the sink, resident 2 didn't resist." A facility nurse side, (CNA 2) who had provided	INFINIA	AT OGDEN			524 EAS	T 800 NORTH	PCODE		2/2004
Resident 2 was interviewed on 6/22/04 at 1:10 PM. The state surveyor asked the resident if a nurse had put soap in her mouth. The resident stated, "Yes, she did. It was a misunderstrading. She (the nurse) was teasing me for being impatient. I wanted a cigarette." The state surveyor asked the resident what kind of soap it was. The resident stated, "It was liquid soap." The state surveyor asked the resident whom the nurse put soap in her mouth and the resident on the nurse put soap in her mouth and the resident stated, "She used her hand." The state surveyor asked the resident what she did after that, and the resident stated, "I went and rinsed. It was not very much." The facility nurse, (LPN 1) who was providing care for resident 2 on 6/19/04, the day the incident occurred was interviewed on 6/23/04 at 10:50 AM by telephone. LPN 1 stated the following." was working the unit that day, and resident 2 was wearing and using the "F" word. (Resident 2) usually does this when she can't have a cigarette. This occurred at mealtime and the other residents were upset because resident 2 was swearing. I told resident 2 you've got to stop swearing because you're upsetting the other residents. If you don't stop swearing! I'll have to wash your mouth out with soap. I took resident 2 by the arm over to the sink and put some foam soap in the palm of my hand and wipped it across her mouth. Resident 2 rinsed it off. The soap didn't get in her mouth. "LPN 1 further stated, "It wasn't wise. Resident 2 was opin resident 2% mouth. I put it across her mouth, and the resident wasn't dragged to the sink, resident 2 didn't resist." A facility nurse side, (CNA 2) who had provided	PREFIX	(EACH DÉFICIENC	Y MUST BE PRECEEDED BY FULL	PREF		(EACH CORRECTIVE AC ROSS-REFERENCED TO	TION SHOU THE APPRO	JLD BE	(XS) COMPLETION DATE
PM. The state surveyor asked the resident if a nurse had put soap in her mouth. The resident stated, "Yes, she did. It was a misunderstanding. She (the nurse) was teasing me for being impatient. I wanted a cigarette." The state surveyor asked the resident what kind of soap it was. The resident stated, "It was liquid soap." The state surveyor asked the resident how the nurse put soap in her mouth and the resident stated, "She used her hand." The state surveyor asked the resident what she did after that, and the resident stated, "I went and rinsed. It was not very much." The facility nurse, (LPN 1) who was providing care for resident 2 on 6/18/04, the day the incident occurred was interviewed on 6/23/04 at 10:50 AM by stelephone. LPN 1 stated the following, "I was working the unit that day, and resident 2 was swearing and using the "F" word. (Resident 2) usually does this when she can't have a cigarette. This occurred at meatitime and the other residents were upset because resident 2 was swearing. I told resident 2 you've got to stop swearing because you're upsetting the other residents. If you don't stop swearing fill have to wash your mouth out with soap. I took resident 2 by the arm over to the sink and put some foam soap in the paim of my hand and wiped it across her mouth. Resident 2 rinsed it off. The soap didn't get in her mouth. LPN 1 further stated, "It wasn't wise. Resident 2 was quiet after that. The SW (social worker) came to talk to me, I clidn't lie, I didn't put the soap in resident 2 smouth, 1 put it across her mouth, and the resident wasn't dragged to the sink, resident 2 didn't resist." A facility nurse aide, (CNA 2) who had provided	F 225	Continued From p	age 5	F2	225				
care for resident 2 on 6/19/04, the day the incident occurred was interviewed on 6/23/04 at 10:50 AM by telephone. LPN 1 stated the following, "I was working the unit that day, and resident 2 was swearing and using the "F" word. (Resident 2) usually does this when she can't have a cigarette. This occurred at mealtime and the other residents were upset because resident 2 was swearing. I told resident 2 you've got to stop swearing because you're upsetting the other residents. If you don't stop swearing I'll have to wash your mouth out with soap. I took resident 2 by the arm over to the sink and put some foam soap in the paim of my hand and wiped it across her mouth. Resident 2 rinsed it off. The soap didn't get in her mouth." LPN 1 further stated, "It wasn't wise. Resident 2 was quiet after that. The SW (social worker) came to talk to me, I didn't lie. I didn't put the soap in resident 2's mouth, I put it across her mouth, and the resident wasn't dragged to the sink, resident 2 didn't resist." A facility nurse aide, (CNA 2) who had provided		PM. The state sur nurse had put soa stated, "Yes, she of the nurse) with impatient. I wante surveyor asked the was. The resident The state surveyor nurse put soap in stated, "She used asked the resident stated the resident stated."	rveyor asked the resident if a p in her mouth. The resident did. It was a misunderstanding, as teasing me for being at a cigarette." The state e resident what kind of soap it a stated, "It was liquid soap." It asked the resident how the her mouth and the resident her hand." The state surveyor is what she did after that, and						
		care for resident 2 on 6/19/04, the day the incident occurred was interviewed on 6/23/04 at 10:50 AM by telephone. LPN 1 stated the following, "I was working the unit that day, and resident 2 was swearing and using the "F" word. (Resident 2) usually does this when she can't have a cigarette. This occurred at mealtime and the other residents were upset because resident 2 was swearing. I told resident 2 you've got to stop swearing because you're upsetting the other residents. If you don't stop swearing I'll have to wash your mouth out with soap. I took resident 2 by the arm over to the sink and put some foam soap in the palm of my hand and wiped it across her mouth. Resident 2 rinsed it off. The soap didn't get in her mouth." LPN 1 further stated, "It wasn't wise. Resident 2 was quiet after that. The SW (social worker) came to talk to me, I didn't lie. I didn't put the soap in resident 2's mouth, I put it across her mouth, and the resident wasn't dragged to the sink, resident 2 didn't resist."							
				·		:			

74 M905:S1 4005 80 .IJL

FAX NO. : 8017823594

Facility ID: UT0058

FROM : Infinia Healthcare Ogden

If continuation sheet Page 6 of 17

DEPARTMENT OF HEALTH AND HUM... SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V BOIFDING	LE CONSTRUCTION	COMPL	COMPLETED C	
		465065	B. WING	<u> </u>		2/2004	
	ROVIDER OR SUPPLIER		524	ET ADDRESS, CITY, STATE, ZIP C I EAST 800 NORTH BDEN, UT 84404	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE ; E APPROPRIATE	(X5) COMPLETION DATE	
F 225	6/22/04 at 1:00 PM another nurse aide washed the resident swearing. The nurse her shift, went to a land called the SW incident. The facility SW (So on 6/22/04 at 1:40 lithe SW if she was a resident 2 having her facility SW statements and she protected that the investigation was, a The SW stated that Nursing), facility MI administrator and hon probation. The same "over timing" (whow. The decision LPN 1 go (terminate She stated, "We detand overwork the orallow LPN 1 to continuent to harm the intention was to have it was stupid and who reported." The surnotified first, and will stated that the admission of the Saturday night 6/19 (LPN 2). She (SW	on 6/19/04 was interviewed on She stated that she and "heard" LPN 1 state that she it's mouth out with soap for se aide stated that she finished local eating establishment, by phone to notify her of the cial Worker) was interviewed PM. The state surveyor asked aware of the incident of lear mouth washed with soap, led that she was aware of the lovided the surveyor a copy of leat had been completed. The SW what the outcome of the learnd what action was taken. If the DON (Director of DS coordinator, the lease of decided to place LPN 1 SW stated, "A lot of the nurses looking a lot of over time) right would have been easier to let lease if we had more nurse staff." Dated whether to fire LPN 1, ther RN's (registered nurse) or inue to work, LPN 1 made a lefelt like there was no le resident, by LPN 1. The lease the resident stop swearing, rong, that's why it was veyor asked the SW who was not happened after that. She hinistrator was notified 1/04, by another facility nurse, stated that she was notified	F 225				
	administrator, and a	r of the incident Sunday by the again by two other nurse aides The facility DON was notified		: - -	:		

If continuation sheet Page 7 of 17

FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: UT0058

Event ID: Q2NX11

DEPARTMENT OF HEALTH AND HUN, A SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/25/2004 FORM APPROVED OMB NO. 0938-0391

STATEMEN	7 OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MLII TIDI	LE CONSTRUCTION	(X3) DATE S	. 0930-0391 SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPL	ETED
		AGENCE	B. WING	<u> </u>		C
NAME OF P	ROVIDER OR SUPPLIER	465065	CTDG		6/2	<i>2/</i> 2004
	AT OGDEN		524	ET ADDRESS, CITY, STATE, ZIP CODE BEAST 800 NORTH GDEN, UT 84404	:	
(X4) ₹D PREFIX - TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULLO BE	(XS) COMPLETION DATE
F 225	Continued From page 7		F 225	:		
	about the incident of stated that LPN 1 w schedule and was a	on Sunday 6/20/04. The SW ras not taken off of the allowed to work Sunday 12 hour shift, and again				
	at 2:30 PM. The Syconsultant, for guidarea. She stated that that's a tough-ee, do The SW stated that determining if this in (SW) stated the "int part. The surveyor contacted anyone fradditional help and The surveyor asked Professional Licens incident, and she stated	s interviewed again on 6/22/04 W stated that she called her cance because it was a "gray" at her consultant stated "yeah o all you can do, and report it." they had a hard time ncident was abuse or not. She ent" of LPN 1 was the hard asked the SW if she om the corporate office, for she stated, "I don't think so." I the SW if DOPL (Division of ling) had been notified of the ated that she was not aware if been reported to DOPL.				
	2:40 FM. She state the incident on Monshe talked to LPN 1 she had washed re The DON stated that, and LPN 1 was pufigured out what to "Honestly, we haver occurred. I was appurprised if we let he more, we have comhaven't made a decion of 6/22/04 at 1:35 F	PM, the facility administrator				
	was interviewed by tasked the administra	telephone. The surveyor ator what the outcome of the de stated that it was a "gray"				

FORM CM\$-2567(02-99) Previous Versions Obsolete

Event ID: O2NX11

Facility ID: UT0058

If continuation sheet Page 8 of 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTEU: 0/23/2004 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465065	(X2) M A. BUI B. WII	LDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 6/22/2004	
	ROVIDER OR SUPPLIER		:	5	REET ADDRESS, CITY, STATE, ZIP CODE 324 EAST 800 NORTH DGDEN, UT 84404	:	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 225	what LPN 1 had so was reportable, and "We put the nurse of statement that the statement of the residence of the statement of the sta	e nature of the resident and aid. He said, looking at it, it if needed to be addressed. On probation because of her soap was not in her mouth. emly. We questioned if this N 1 was trying to change the dent." O AM, the facility administrator wed by telephone. The e or any of his facility staff had e incident to DOPL. The di, "yes", that the SW had in she notified the (Adult Protective Services), ncy). The surveyor asked the he was notified of the Saturday night at 11:00 PM erveyor asked what had been residents from abuse during the stated that he notified the example went in to the facility on complete an investigation and had made a mistake or if LPN eat to residents. O AM, the facility SW was obnone again for clarification ident. The SW stated that she PL to report the incident. She arrived at the facility on ound 1:00 or 2:00 PM, to start the confirmed that LPN 1 was ne arrived at the facility, and an working that morning before estigation of the incident.	F	225			
		and procedure for prohibiting d. Under the section titled					

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

Event ID: Q2NX11

Facility ID: UT0058

EUX NO': 8011853294

If continuation sheet Page 9 of 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 5/25/2004 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN B. WING			(X3) DATE SURVEY COMPLETED C		
ΝA	ME OF P	ROVIDER OR SUPPLIER	703003	ST	REET ADDRESS, CITY	STATE ZIR CORE	0122	/2004
IN	IFINIA /	AT OGDEN		5	24 EAST 800 NORTH	H	:	
	(X4) ID REFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	'S PLAN OF CORRECT ECTIVE ACTION SHOL ENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	F 225	Continued From pa	ge 9	F 225				
		states, following an implement increase of residents taking a intervene and prote all residents are saf Number 8 says, if the staff, the facility will residents from any include suspension investigation has be Interviews with the following the incident and in the incident are sident's mas placed on probe continue working at	eporting procedures, number 7 allegation, the facility will ad supervision and monitoring all necessary measures to act the resident and ensure that fe from any further abuse. The complaint alleges abuse by take steps to protect further abuse. This may of the staff member until the een completed. Facility SW, administrator, and ad that LPN 1 who was lent that occurred on 6/19/04, nouth was washed with soap, wation and was allowed to the facility. Additionally, report this incident of resident					
	F 309 S=G	483.25 QUALITY O	F CARE	F 309	2			
		provide the necessa or maintain the high mental, and psycho	ary care and the facility must ary care and services to attain nest practicable physical, isocial well-being, in a comprehensive assessment		determined tha injury. This sar	as reported to the heat the resident did no ne Nurse is not longure that was involved.	ot sustain ger with us	
		Use F309 for quality covered by s483.25	y of care deficiencies not i(a)-(m).		6/25/04. We a what abuse is Nurse staff on	special abuse in-sceed quickly to remined in addition we will what type of incider ow to fill out the formate.	ind the staff in-service t nts need to	he be
		by: Based on staff inter	view and record review, it was facility did not provide the		gio report incide	i II.a.	— ! !	

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

Event ID: Q2NX11 Facility ID: UT0058

FAX NO, : 8017823594

If continuation sheet Page 10 of 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINIEU: 6/25/2004 FORM APPROVED OMB NO. 0938-0391

INFINIA AT OGDEN ON ORTH CODEN, UT 34404 F 309 Continued From page 10 necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, resident 1 sustained a fail out of the facility Hoyer lift on or around 5/26/04 and was not assessed for injuries until 6/4/04, at which time resident 1 was diagnosed with a right hip fracture. Findings include: Resident 1 was admitted to the facility on 8/30/00 with diagnoses including Atzheimer's disease, depressive psychosis, osteoarthrosis, and hypertension. A review of resident 1's medical record and of a facility incident report for resident 1 was completed on 8/22/04. On 5/3/104 at 11:00 AM, a facility Licensed Practical Nurse (LPN 1) documented on a facility incident report for resident 1, "During a brief change," C.N.A. (certified nurse assistant) noted dark bruising on the [right] side of residents' labia and some lighter bruising on the back of her thighs. This was reported to this nurse and I examined resident et (and) found the same". The employee did not document this incident in resident 1's medical record. A telephone interview was conducted with LPN 1 on 6/23/04. She stated that resident 1 was crying		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 6/22/2004
S22 EAST 800 NORTH OGDEN UT 84404	NAME OF F	TOWNER OR SUNSE	485065	I Ara	CET ADDRECK CITY STATE ZID CODE	012212004
FREETY TAG Continued From page 10 necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, resident 1 sustained a fall out of the facility Hoyer lift on or around 5/26/04 and was not assessed for injuries until 6/4/04, at which time resident 1 was diagnosed with a right hip fracture. Findings include: Resident 1 was admitted to the facility on 8/30/00 with diagnoses including Alzheimer's disease, depressive psychosis, osteoarthrosis, and hypertension. A review of resident 1's medical record and of a facility incident report for resident 1 was completed on 8/22/04. On 6/31/04 at 11:00 AM, a facility Licensed Practical Nurse (LPN 1) documented on a facility incident report for resident 1, "During a brief change, C.N.A. (certified nurse assistant) noted dark bruising on the pick pist de of residents' labia and some lighter bruising on the back of her thighs. This was reported to this nurse and I examined resident et (and) found the same". The employee did not document this incident in resident 1's medical record. A telephone interview was conducted with LPN 1 on 8/23/04. She stated that resident 1 was crying			; ·	52	24 EAST 800 NORTH	
necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, resident 1 sustained a fall out of the facility Hoyer lift on or around 5/26/04 and was not assessed for injuries until 6/4/04, at which time resident 1 was diagnosed with a right hip fracture. Findings include: Resident 1 was admitted to the facility on 8/30/00 with diagnoses including Alzheimer's disease, depressive psychosis, osteoarthrosis, and hypertension. A review of resident 1's medical record and of a facility incident report for resident 1 was completed on 6/22/04. On 5/3-1/04 at 11:00 AM, a facility Licensed Practical Nurse (LPN 1) documented on a facility incident report for resident 1, "During a brief change, C.N.A. (certified nurse assistant) noted dark bruising on the [right] side of residents' labia and some lighter bruising on the back of her thighs. This was reported to this nurse and I examined resident et (and) found the same". The employee did not document this incident in resident 1's medical record. A telephone interview was conducted with LPN 1 on 6/23/04. She stated that resident 1 was crying	PREFIX	(EACH DEFICIENCY	MUST BE PRECEEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLETION
that she did not assess the resident for range of motion deficits to her legs. LPN 1 further stated that resident 1 normally cries out and that she is "very stiff". LPN 1 also stated that she did not think that the bruising was related to the Hoyer during July 2004. The abuse process will be tested and reviewed during that meeting. We will also discuss the progress of the incident report reporting and documentation process. The date of completion will be no later then July	F 309	necessary care and the highest practical psychosocial well-t comprehensive as Specifically, reside facility Hoyer lift on not assessed for intime resident 1 was fracture. Findings include: Resident 1 was ad with diagnoses include: Resident 1 was ad with diagnoses includeressive psychologypertension. A review of resider facility incident report for change, C.N.A. (codark bruising on thand some lighter bringhs. This was rexamined resident this medical temployee did not cresident 1's medical A telephone intervion 6/23/04. She sout at the time of hithat she did not as motion deficits to hithat resident 1 nor "very stiff". LPN 1	d services to attain or maintain able physical, mental, and being, in accordance with the sessment and plan of care. Int 1 sustained a fall out of the or around 5/26/04 and was ajuries until 6/4/04, at which is diagnosed with a right hip mitted to the facility on 8/30/00 luding Alzheimer's disease, sis, osteoarthrosis, and int 1's medical record and of a cort for resident 1 was 1/04. O AM, a facility Licensed PN 1) documented on a facility resident 1, "During a brief criffied nurse assistant) noted be [right] side of residents' labia truising on the back of her reported to this nurse and interest this incident in all record. It was conducted with LPN 1 that the discument this incident in the lated that resident 1 was crying the assessment on 5/31/04, but sess the resident for range of the legs. LPN 1 further stated mally cries out and that she is also stated that she did not	F 309	report forms and the procedure for and reporting them will take place When a new Nurse is hired the DC that the training is passed on to the ensure that they know the procedure for the procedure forms and the procedure forms and the procedure forms and reporting them will take place When a new Nurse is hired the DC that the training is passed on to the ensure that they know the procedure for the incident reports will be placed Administrator's office each morning the Management Team(Admin ADON, Social Work and Treatme possible abuse. Assignments will investigate and monitor discrepar reports for Fridays, Saturdays and be in the office on Monday morning is not properly filled out or reported was in charge during that shift will be the plan of Correction. The DON training of the Nurse staff. We will be holding a Quality Assigning July 2004. The abuse processed and reviewed during that also discuss the progress of the reporting and documentation process.	documenting on 7/09/04. ON will ensure e Nurse to ure. the incident of documenting on 7/09/04. ON will ensure to ure en Nurse to ure. If in the mag and reviewed istrator, DON, on the made to oncies. The documenting of the Nurse that if the disciplined. If a report the disciplined is the nurse that if the disciplined is the nurse that in regarding ator will monitor the nurse meeting. We will incident report to the nurse that the nurse

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

Event ID: O2NX11

30, 2004. Facility ID: U10058

FAX NO.: 8017823594

If continuation sheet Page 11 of 17

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

FORM APPROVED
OMB NO. 0938-0391

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465065	A. BUILUING B. WING	E CONSTRUCTION	l '	
	ROVIDER OR SUPPLIER	1	524	ET ADDRESS, CITY, STATE, ZIP C EAST 800 NORTH DEN, UT 84404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DAYE
F 309	incident. The facility ADON documented on re "risk for skin break Braden Assessme ecchymosis - peris facility ADON did not the resident's med on 6/1/04, the fact bruising that was not documented in he had bruising to he inner forearm, left between resident the bruising on the record on 6/1/04, about 4 inches in (second) bruise or and 1 inch wide, co back to normal. 3 forearm about ½ i round, color yellow inner thigh about 1/2 i round, color purplegs. Bruise is ab above the labia aron the right labia. and yellow on the notified and recont On 6/4/04, LPN 3 notes for resident out @ (at) times".	(Assistant Director of Nursing) sident 1's care plan on 5/31/04, down/injury r/t (related to) and score" "mult. (multiple) area, et. extremities". The not document the ecchymosis in lical record. Hity DON was notified of the reported on 5/31/04. The DON or investigation that resident 1 or right knee, right shin, right inner thigh and bruising 1's legs. The DON documented incident report dated 5/31/04. Intend in resident 1's medical of the first (first) bruise on right knee diameter, color yellow. 2nd or right shin about 4 inches long color very light yellow almost rod (third) bruise on right inner ench in diameter and perfectly of the first of the song the cout 5 inches long, 2 inches wide and decreasing to 3/4 inch wide color is purple in the center edges". The physician was amended "permanent bedrest". documented in the nurses 1, "cont. (continues) to cry	F 309			
		PM, LPN 2 documented in the esident 1, "reported to this		; •		

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

Event ID: O2NX11

Facility ID: UT0058

LUX NO': 80118532204

If continuation sheet Page 12 of 17

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 5/25/2004 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C				
465065			B. WI	B. WING				6/22/2004		
NAME OF PROVIDER: OR SUPPLIER INFINIA AT OGDEN				STREET ADDRESS, CITY, STATE, ZIP COI 524 EAST 800 NORTH OGDEN, UT 84404						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		(EACH COR	R'S PLAN OF CORRI RECTIVE ACTION SI RENCED TO THE AP DEFICIENCY)	SHOULD BE COMPLETION		LÉTION	
F 309	resident is crying or been having proble noted in notes but 0 passed along to the documented "on as is distended, right le (approximately) 2", bruise to hip et kneet crying out when emoved". The physi were obtained for a "stat". This x-ray was obtall's bruising was remurse. On 6/5/04 at 9:00 A nurses notes for revia telephone". The right intertrochanter abnormal position in turned inward toward toward toward inward toward toward toward toward toward in pain". On 6/5/04 at 7:30 F telephone order for right hip fracture", resident 1's medical	ertified nurse assistant) that at in px (pain) that resident has me a week ago. Nothing C.N.A. reports that it had been a nurses. LPN 2 further sessment resident's right hip ag shorter than left by approx. right leg turned inwards, at resident extremely tearful extremity is moved or as she is cian was notified and orders pelvis, right hip at knee x-ray ined five days after resident ported to a facility charge. M. LPN 1 documented in the sident 1, "x-ray result received a x-ray report documented a ric fracture with varus (and which a part of a limb is red the midline) deformity.	F	309						
	one person who wit	nessed the injury or the he Hoyer. However, gossip				:				

FORM CMS-2567(02-99) Pravious Versions Obsolets

Event ID: O2NX11 Facility ID: UT0058

FAX NO, : 8017823594

If continuation sheet Page 13 of 17

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 0/20/2004
FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		465065	B. Wi	NG	:			2/2004
	PROVIDER OR SUPPLIER		-	524 EAS	DDRESS, CITY, STATE, ZIP ST 800 NORTH N, UT 84404	CODE	:	
(X4) ID PREFIX TAG	(EACH DEFIGIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOU HE APPR	AD BE	(X5) COMPLETION DATE
F 309	among the staff ind nurses aides were assisted to get [res On 6/8/04, the DOI medical record, that the resident and "dicare". The DON documer dated 6/10/04, "I fe accident and had it action could have b [resident 1's] discordinated in a could have b [resident 1's] discordinated in the property of the	licate that anywhere from 1-4 involved in the incident or ident 1] back into bed". If documented in resident 1's it resident 1's physician saw id not order any changes in atted on the facility investigation el confident that this was an been reported properly, the een taken sooner to ease infort". If N documented in resident 1's ave been conducting an elincident. I have interviewed is and no one will come information regarding this. I into a direct cause or date of ect that an accident occurred ed". Interviewed via telephone on stated that resident 1 was out of the Hoyer sling during a neelchair to the bed on or N.A. 1 stated that another ed the resident to the floor, she grabbed the back of while C.N.A 2 grabbed her legs the floor". C.N.A 1 stated that tified the charge nurse after int to the floor". C.N.A 1	F :	309	DEFIGIENCY			
ĺ	resident 1, but did n	e did come and look at ot do any range of motion for any injuries as a result of resident "cried".						
ORM CMS-256	87(02-99) ^b revious Versions	Obsolete Event ID: Q2NX11	Fac	ility ID: UT(0058	f continu	ation sheet F	Page 14 of 17

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 6/25/2004 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) ML	DITIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 6/22/2004		
465065			B. WIN			
NAME OF PROVIDER OR SUPPLIER INFINIA AT OGDEN			,	STREET ADDRESS, CITY, STATE, ZIP CO 524 EAST 800 NORTH OGDEN, UT 84404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE !	(X5) COMPLETION DATE
F 309	C.N.A. 2 was intenstated that resident sting. Sine stated that almost touching the facility C.N.A. lower C.N.A.2 stated that	riewed on 6/22/04. C.N.A. 2 1 "slipped" from the Hoyer nat resident 1's feet were 1 floor when she and another red resident 1 to the floor. she had the resident	F 3(9		
F 498	the resident's feet a floor	ns and that C.N.A 1 grabbed and then was lowered to the		F498		
F 496 S=G	483.75(f) ADMINISTRATION The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.		F 49	The lift training was done on 6/2 those who attend that meeting hidocumented. In addition a copy procedures from the owners mai to the CNA's on 7/09/04 at the meeting.	1	
	by: Based on record re it was determined to that nurse aides we competency in skills care for residents' r resident assessmen of care. Specifically proper training on u resulting in a reside	view and facility staff interview, nat the facility did not ensure re able to demonstrate and techniques necessary to needs, as identified through nts, and described in the planty, the facility did not ensure sage of the facility Hoyer lift, nt sliding out of the Hoyer a fracture of the right hip.		The lift training was done on 6/2: those who attend that meeting hidocumented. In addition a copy procedures from the owners may to the CNA's on 7/09/04 at the meeting. The CNA's will be trained on the and a copy of the procedures will before they use the lift. This will in the employee file.		
	Findings include: Resident 1 was admitted to the facility on 8/30/00 with diagnoses including Alzheimer's disease, depressive psychosis, osteoarthrosis and hypertension.			The ADON will make sure that the is updated in the CNA's files. The enlist the help of the front office discrepancies in the employee's will make sure that the CNA's are on how to use the lifts. This reviquanterly for accuracy. All new instructed on the proper use of the orientation.	ne ADON may to review for files. The ADOI e properly traine ew will be done nires will be	7

FAX NO. : 8017823594

PRINTED: 0/20/2004 DEPARTMENT OF HEALTH AND HUN "SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAIU SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A BUILDING C B. WING 465065 6/22/2004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 524 EAST 800 NORTH INFINIA AT OGDEN **OGDEN, UT 84404** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL (XS) COMPLETION PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 498 | Continued From page 15 F 498 A review of resident 1's medical record and of a The ADON will make sure that the documentation facility incident report for resident 1 was is updated in the CNA's files. The ADON may completed on 6/22/04. enlist the help of the front office to review for discrepancies in the employee's files. The ADON On 5/31/04, a facility nurse documented on the will make sure that the CNA's are properly trained incident report for resident 1, "During a brief on how to use the lifts. This review will be done change, C.N.A. (certified nurse aide) noted dark quarterly for accuracy. The first quarter review will bruising on the [right] side of residents' labia and be done during this month July 2004. some lighter bruising on the back of her thighs".

On 6/s/04, the facility DON (Direct of Nursing) began an investigation into the source of resident 1's bruising. The DON determined that the bruises were in various stages of healing ranging from purple to light yellow.

On 6/5/04, an x-ray of resident 1's right hip, right knee and pelvis was completed after a C.N.A. reported to LPN 2 that resident 1 was "crying out in px (pain)" and that resident 1 "has been having problems for a week".

On 6/4/04 at 7:00 PM, LPN 2 documented that resident 1's "[right] hip is distended, right leg shorter than [left] by approx (approximately) 2", right leg turned inward, bruise to hip et (and) knee, at resident extremely tearful et crying out when extremity is moved or she is moved".

During an on going investigation, by the DON, into the bruising and the new diagnosis of "intertrochanteric fracture with varus deformity" it was determined that resident 1 had a "slip" from the Hoyer lift on or around 5/26/04.

On 6/10/04, the DON documented in resident 1's medical record, "the staff was inserviced on proper lifting and transfer techniques".

On 6/2/2/04 and 6/23/04 five facility C.N.A.'s were

The ADON will make sure that the documentation is updated in the CNA's files. The ADON may enlist the help of the front office to review for discrepancies in the employee's files. The ADON will make sure that the CNA's are properly trained on how to use the lifts. This review will be done quarterly for accuracy. The first quarter review will be done done during this month July 2004.

We will be holding a Quality Assurance meeting during July 2004. The completion of the training will be reviewed during that meeting.

The date of completion will be no later then July 30, 2004.

FORM CM\$-2567(02-99) Previous Versions Obsolete

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DEPARTMENT OF HEALTH AND HUM SERVICES
CENTERS FOR MEDICARE & MEDICAL SERVICES

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTIO	(X3) DATE SURVEY COMPLETED			
		465065	B. WING			6/22/2004		
INFINIA AT OGDEN (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			524	ET ADDRESS, CIT 4 EAST 800 NORT 3DEN, UT 8440	W22,200=			
(X4) ID PRÉFIX TAG	SUMMARY STA (EACH DEFICIENCY RECULATORY OR L	PROVIDERS PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			JLD BE	(05) COMPLETION DATE		
F 498	any training on the Lift or how to prope Hoyer. The DON was interwas asked for copic attendance logs for Hoyer lift training. There is any since I On 6/23/04, C.N.A. facility at the time the Hoyer was interview had not received and during her employm stated that it was "s	ted that they had not received proper use of the facility Hoyer rly place a resident in the viewed on 6/22/04. The DON es of inservices and proper usage of the facility The DON stated "I don't think we been here". 1, who was employed by the nat resident 1 slipped from the wed. C.N.A.1 stated that she by training on the Hoyer lift nent at the facility. C.N.A.1 elf explanatory". She further troil the resident forward and	F 498					

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

Event ID: O2NX11

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