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 _____	C 6/22/2004

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT OGDEN	COMPLAINT NUMBER: UT00003241	524 EAST 800 NORTH OGDEN, UT 84404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 223 S=G	483.13(b) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, it was determined that the facility did not ensure that a resident was free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. Specifically, a facility licensed nurse threatened to wash a resident's mouth out with soap, the nurse then carried out the threat by applying soap to the outside of, and across the resident's mouth. Resident identifier: 2. Findings include: Resident 2 was a 61 year old female admitted to the facility on 10/7/02 with diagnoses of, schizoaffective disorder, vascular dementia, hypothyroidism, and anxiety. The nursing facility telephoned the State Agency 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 asked the resident if a	F 223	F000 Preparation and/or execution of this Plan of Correction does not constitute an admission of guilt or agreement by the provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F223 The Nurse that was involved in the incident has been terminated and reported to DOPL. She admitted that she was wrong and that she would not do that again. She acted of her own accord and not per the Care Plan for the resident noted. All Nurse staff has been licensed by the State of Utah. They have had professional training and higher education. Our abuse policy has been updated as of 7/2/04. We had abuse training that was in-serviced on 6/25/04. All staff will received a copy of the updated abuse policy on 7/9/04 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 terminated and reported. The abuse policy 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/8/04

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

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

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F 223	Continued From page 1 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 6/19/04, 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." A facility nurse aide, (CNA 2) who had provided care for resident 2, on 6/19/04 was interviewed on 6/22/04 at 1:00 PM. She stated that she and another nurse aide "heard" LPN 1 state that she	F 223	The Nurse staff will be informed by memo from the Administrator on the procedure for reporting incidents and the policy to fill out incident reports during the shift that they happen. They will also be reminded to telephone the Administrator or the DON(when they are not in the building) to report the finding so that the employee is not able to continue working during the investigation. The incident reports will be placed in the Administrator's office each morning and reviewed by the Management Team(Administrator, DON, ADON, Social Work and Treatment Nurse) for possible abuse. Assignments will be made to investigate and monitor discrepancies. The reports for Fridays, Saturdays and Sundays will be in the office on Monday mornings. If a report is not properly filled out or reported the Nurse that was in charge during that shift will be disciplined. The monitoring will be done daily by means of the incident reports and the report system. The staff has already been in-serviced again regarding abuse on 6/25/04. The Administrator will monitor the Plan of Correction. We will be holding a Quality Assurance meeting during July 2004. The abuse process will be tested and reviewed during that meeting. The date of completion will be no later then July 30, 2004.	

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F 223	Continued From page 2	F 223		

washed the resident's mouth out with soap for swearing. The nurse aide stated that she finished her shift, went to a local eating establishment, and called the SW by phone to notify her of the incident.

The facility SW (Social Worker) was interviewed on 6/22/04 at 1:40 PM. The state surveyor asked the SW if she was aware of the incident of resident 2 having her mouth washed with soap. The facility SW stated that she was aware of the incident and she provided the surveyor a copy of the investigation that had been completed. The surveyor asked the SW what the outcome of the investigation was, and what action was taken. The SW stated that the DON (Director of Nursing), facility MDS coordinator, the administrator and herself decided to place LPN 1 on probation. The SW stated, " a lot of the nurses are "over timing" (working a lot of over time) right now. The decision would have been easier to let LPN 1 go (terminate) if we had more nurse staff." She stated," they debated whether to fire LPN 1, and overwork the other RN's (registered nurse) or allow LPN 1 to continue to work." The SW stated, "(LPN 1) made a poor judgment, we felt like there was no intention to harm the resident, by LPN 1. The intention was to have the resident stop swearing. It was stupid and wrong, that's why it was reported." The surveyor asked the SW who was notified first, and what happened after that. She stated that the administrator was notified Saturday night 6/19/04, by another facility nurse, (LPN 2). She (SW) stated that she was notified by the administrator of the incident Sunday by the administrator, and again by two other nurse aides on Sunday 6/20/04. The facility DON was notified about the incident on Sunday 6/20/04. The SW stated that LPN 1 was not taken off of the

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F 223	Continued From page 3 schedule and was allowed to work Sunday 6/20/04 morning, a 12 hour shift, and again Monday night, a 12 hour shift.	F 223		
F 225 SS=D	483.13(c)(1)(ii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working	F 225	**F225** This was an individual nurse that acted of her own accord. She has been terminated and reported. The abuse policy 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 staff had a special abuse in-service on 6/25/04. We acted quickly to remind the staff of what abuse is. The abuse policy has been updated to include suspension during investigation. The prior policy stated that we may suspend. The Nurse staff will be informed by memo from the Administrator on the procedure for reporting incidents and the policy to fill out incident reports during the shift that they happen. They will also be reminded to telephone the Administrator or the DON(when they are not in the building) to report the finding so that the employee is not able to continue working during the investigation.	

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F 225	Continued From page 4 days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, it was determined that the facility did not ensure that a resident was free from verbal, sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. Specifically, a facility licensed nurse threatened to wash a resident's mouth out with soap, the nurse then carried out the threat, by applying soap to the outside of, and across the resident's mouth. After the incident occurred, facility staff did not protect other residents from possible abuse, by allowing the nurse to continue working at the facility. Facility staff did not report the incident to DOPL (Division of Professional Licensing). Resident identifier: 2. Findings include: Resident 2 was a 61 year old female admitted to the facility on 10/7/02 with diagnoses of, schizoaffective disorder, vascular dementia, hypothyroidism, and anxiety. The nursing facility telephoned the State Agency on 6/21/04 to report that a facility LPN (Licensed Practical Nurse) threatened to and applied soap around a resident's mouth. The facility nurse had been counseled, put on probation, and was allowed to continue 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)	F 225	The incident reports will be placed in the Administrator's office each morning and reviewed by the Management Team(Administrator, DON, ADON, Social Work and Treatment Nurse) for possible abuse. Assignments will be made to investigate and monitor discrepancies. The reports for Fridays, Saturdays and Sundays will be in the office on Monday mornings. If a report is not properly filled out or reported the Nurse that was in charge during that shift will be disciplined. The monitoring will be done daily by means of the incident reports and the report system. The staff has already been in-serviced again regarding abuse on 6/25/04. The Administrator will monitor the Plan of Correction. We will be holding a Quality Assurance meeting during July 2004. The abuse process will be tested and reviewed during that meeting. The date of completion will be no later then July 30, 2004.	

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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 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 6/19/04, 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." A facility nurse aide, (CNA 2) who had provided	F 225		

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F 225	Continued From page 6	F 225		

care for resident 2, on 6/19/04 was interviewed on 6/22/04 at 1:00 PM. She stated that she and another nurse aide "heard" LPN 1 state that she washed the resident's mouth out with soap for swearing. The nurse aide stated that she finished her shift, went to a local eating establishment, and called the SW by phone to notify her of the incident.

The facility SW (Social Worker) was interviewed on 6/22/04 at 1:40 PM. The state surveyor asked the SW if she was aware of the incident of resident 2 having her mouth washed with soap. The facility SW stated that she was aware of the incident and she provided the surveyor a copy of the investigation that had been completed. The surveyor asked the SW what the outcome of the investigation was, and what action was taken. The SW stated that the DON (Director of Nursing), facility MDS coordinator, the administrator and herself decided to place LPN 1 on probation. The SW stated, "A lot of the nurses are "over timing" (working a lot of over time) right now. The decision would have been easier to let LPN 1 go (terminate) if we had more nurse staff." She stated, "We debated whether to fire LPN 1, and overwork the other RN's (registered nurse) or allow LPN 1 to continue to work, LPN 1 made a poor judgment. We felt like there was no intention to harm the resident, by LPN 1. The intention was to have the resident stop swearing. It was stupid and wrong, that's why it was reported." The surveyor asked the SW who was notified first, and what happened after that. She stated that the administrator was notified Saturday night 6/19/04, by another facility nurse, (LPN 2). She (SW) stated that she was notified by the administrator of the incident Sunday by the administrator, and again by two other nurse aides on Sunday 6/20/04. The facility DON was notified

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about the incident on Sunday 6/20/04. The SW stated that LPN 1 was not taken off of the schedule and was allowed to work Sunday 6/20/04 morning, a 12 hour shift, and again Monday night, a 12 hour shift.

The facility SW was interviewed again on 6/22/04 at 2:30 PM. The SW stated that she called her consultant, for guidance because it was a "gray" area. She stated that her consultant stated "yeah that's a tough-ee, do all you can do, and report it." The SW stated that they had a hard time determining if this incident was abuse or not. She (SW) stated the "intent" of LPN 1 was the hard part. The surveyor asked the SW if she contacted anyone from the corporate office, for additional help and she stated, "I don't think so." The surveyor asked the SW if DOPL (Division of Professional Licensing) had been notified of the incident, and she stated that she was not aware that the incident had been reported to DOPL.

The facility DON was interviewed on 6/22/04 at 2:40 PM. She stated that she was notified about the incident on Monday 6/21/04. She stated that she talked to LPN 1 and that LPN 1 admitted that she had washed resident 2's mouth with soap. The DON stated that she counseled LPN 1 about it, and LPN 1 was put on probation until the facility "figured out what to do". The DON stated, "Honestly, we haven't discussed if abuse occurred. I was appalled, and I won't be surprised if we let her go. We're digging into it more, we have completed the investigation, and haven't made a decision yet".

On 6/22/04 at 1:35 PM, the facility administrator was interviewed by telephone. The surveyor asked the administrator what the outcome of the investigation was. He stated that it was a "gray"

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area, because of the nature of the resident and what LPN 1 had said. He said, looking at it, it was reportable, and needed to be addressed. "We put the nurse on probation because of her statement that the soap was not in her mouth. We wrote her up sternly. We questioned if this was abuse or if LPN 1 was trying to change the behavior of the resident."

On 6/24/04 at 08:50 AM, the facility administrator was again interviewed by telephone. The surveyor asked if he or any of his facility staff had referred the abusive incident to DOPL. The administrator stated, "yes", that the SW had notified DOPL when she notified the Ombudsman, APS (Adult Protective Services), and SA (State Agency). The surveyor asked the administrator when he was notified of the incident. He stated Saturday night at 11:00 PM on 6/19/04. The surveyor asked what had been done to protect the residents from abuse during the investigation. He stated that he notified the facility SW, and she went in to the facility on Sunday 6/20/04, to complete an investigation and determine if LPN 1 had made a mistake or if LPN 1 was an actual threat to residents.

On 6/24/04 at 08:50 AM, the facility SW was interviewed by telephone again for clarification of events of this incident. The SW stated that she did not contact DOPL to report the incident. She also stated that she arrived at the facility on Sunday 6/20/04, around 1:00 or 2:00 PM, to start the investigation. She confirmed that LPN 1 was on a break when she arrived at the facility, and that LPN 1 had been working that morning before she started her investigation of the incident.

The facility's policy and procedure for prohibiting abuse was reviewed. Under the section titled

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F 225	Continued From page 9 Investigation and reporting procedures, number 7 states, following an allegation, the facility will implement increased supervision and monitoring of residents taking all necessary measures to intervene and protect the resident and ensure that all residents are safe from any further abuse. Number 8 says, if the complaint alleges abuse by staff, the facility will take steps to protect residents from any further abuse. This may include suspension of the staff member until the investigation has been completed. Interviews with the facility SW, administrator, and DON have confirmed that LPN 1 who was involved in the incident that occurred on 6/19/04, when a resident's mouth was washed with soap, was placed on probation and was allowed to continue working at the facility. Additionally, facility staff did not report this incident of resident abuse to DOPL.	F 225		
F 309 S=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by s483.25(a)-(m). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined that the facility did not provide the	F 309	**F309** The incident was reported to the Nurse who determined that the resident did not sustain injury. This same Nurse is not longer with us and is the same Nurse that was involved in the F223 and F225 tags. The staff had a special abuse in-service on 6/25/04. We acted quickly to remind the staff of what abuse is. In addition we will in-service the Nurse staff on what type of incidents need to be reported and how to fill out the form that is used to report incidents.	

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

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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 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 5/31/04 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 [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 out at the time of her assessment on 5/31/04, but 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	F 309	In-servicing on the proper use of the incident report forms and the procedure for documenting and reporting them will take place on 7/09/04. When a new Nurse is hired the DON will ensure that the training is passed on to the Nurse to ensure that they know the procedure. In-servicing on the proper use of the incident report forms and the procedure for documenting and reporting them will take place on 7/09/04. When a new Nurse is hired the DON will ensure that the training is passed on to the Nurse to ensure that they know the procedure. The incident reports will be placed in the Administrator's office each morning and reviewed by the Management Team(Administrator, DON, ADON, Social Work and Treatment Nurse) for possible abuse. Assignments will be made to investigate and monitor discrepancies. The reports for Fridays, Saturdays and Sundays will be in the office on Monday mornings. If a report is not properly filled out or reported the Nurse that was in charge during that shift will be disciplined. The monitoring will be done daily by means of the incident reports and the report system. The staff has already been in-serviced again regarding abuse on 6/25/04. The Administrator will monitor the Plan of Correction. The DON will monitor the training of the Nurse staff. We will be holding a Quality Assurance meeting 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 30, 2004.	

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F 309	Continued From page 11 incident. The facility ADON (Assistant Director of Nursing) documented on resident 1's care plan on 5/31/04, "risk for skin breakdown/injury r/t (related to) Braden Assessment score" "mult. (multiple) ecchymosis - periarea, et. extremities". The facility ADON did not document the ecchymosis in the resident's medical record. On 6/1/04, the facility DON was notified of the bruising that was reported on 5/31/04. The DON documented in her investigation that resident 1 had bruising to her right knee, right shin, right inner forearm, left inner thigh and bruising between resident 1's legs. The DON documented the bruising on the incident report dated 5/31/04. The DON documented in resident 1's medical record on 6/1/04, "1st (first) bruise on right knee about 4 inches in diameter, color yellow. 2nd (second) bruise on right shin about 4 inches long and 1 inch wide, color very light yellow almost back to normal. 3rd (third) bruise on right inner forearm about ½ inch in diameter and perfectly round, color yellow. 4th (fourth) bruise on left inner thigh about ½ inch in diameter and perfectly round, color purple. 5th (fifth) bruise between the legs. Bruise is about 5 inches long, 2 inches wide above the labia and decreasing to 3/4 inch wide on the right labia. Color is purple in the center and yellow on the edges". The physician was notified and recommended "permanent bedrest". On 6/4/04, LPN 3 documented in the nurses notes for resident 1, " ...cont. (continues) to cry out @ (at) times". On 6/4/04 at 7:00 PM, LPN 2 documented in the nurses notes for resident 1, "reported to this	F 309		

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F 309	Continued From page 12	F 309		

nurse by C.N.A. (certified nurse assistant) that resident is crying out in px (pain) that resident has been having problems a week ago. Nothing noted in notes but C.N.A. reports that it had been passed along to 'the nurses'". LPN 2 further documented "on assessment resident's right hip is distended, right leg shorter than left by approx. (approximately) 2", right leg turned inwards, bruise to hip et knee, et resident extremely tearful et crying out when extremity is moved or as she is moved". The physician was notified and orders were obtained for a pelvis, right hip et knee x-ray "stat".

This x-ray was obtained five days after resident 1's bruising was reported to a facility charge nurse.

On 6/5/04 at 9:00 AM, LPN 1 documented in the nurses' notes for resident 1, "x-ray result received via telephone". The x-ray report documented a right intertrochanteric fracture with varus (an abnormal position in which a part of a limb is turned inward toward the midline) deformity.

LPN 1 further documented that hospice contacted the family and that they wanted resident 1 treated with comfort measures only.

On 6/5/04, the facility ADON again documented in resident 1's care plan, "multiple bruising, calling out in pain".

On 6/7/04 at 7:30 PM, the facility DON received a telephone order for "permanent bedrest due to right hip fracture". The DON documented in resident 1's medical record, "After questioning many staff members I was not able to find any one person who witnessed the injury or the alleged slide from the Hoyer. However, gossip

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among the staff indicate that anywhere from 1-4 nurses aides were involved in the incident or assisted to get [resident 1] back into bed".

On 6/8/04, the DON documented in resident 1's medical record, that resident 1's physician saw the resident and "did not order any changes in care".

The DON documented on the facility investigation dated 6/10/04, "I feel confident that this was an accident and had it been reported properly, the action could have been taken sooner to ease [resident 1's] discomfort".

On 6/11/04, the DON documented in resident 1's medical record, "I have been conducting an investigation into the incident. I have interviewed many staff members and no one will come forward with direct information regarding this. I am unable to pinpoint a direct cause or date of this incident. I suspect that an accident occurred and was not reported".

C.N.A. 1 was interviewed via telephone on 6/23/04. C.N.A. 1 stated that resident 1 was slipping backwards out of the Hoyer sling during a transfer from the wheelchair to the bed on or around 5/26/04. C.N.A. 1 stated that another facility C.N.A. lowered the resident to the floor. C.N.A 1 stated that she grabbed the back of resident 1's pants while C.N.A 2 grabbed her legs and "lowered her to the floor". C.N.A 1 stated that she immediately notified the charge nurse after "lowering the resident to the floor". C.N.A 1 stated that the nurse did come and look at resident 1, but did not do any range of motion exercises or check for any injuries as a result of the fall but that the resident "cried".

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F 309	Continued From page 14 C.N.A. 2 was interviewed on 6/22/04. C.N.A. 2 stated that resident 1 "slipped" from the Hoyer sling. She stated that resident 1's feet were almost touching the floor when she and another facility C.N.A. lowered resident 1 to the floor. C.N.A 2 stated that she had the resident underneath her arms and that C.N.A 1 grabbed the resident's feet and then was lowered to the floor.	F 309		
F 498 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. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interview, it was determined that the facility did not ensure that nurse aides were 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. Specifically, the facility did not ensure proper training on usage of the facility Hoyer lift, resulting in a resident sliding out of the Hoyer sling and sustaining a fracture of the right hip. Findings include: Resident 1 was admitted to the facility on 8/30/00 with diagnoses including Alzheimer's disease, depressive psychosis, osteoarthrosis and hypertension.	F 498	F498 The lift training was done on 6/25/04 and a list of those who attend that meeting has been documented. In addition a copy of the lift procedures from the owners manual will be given to the CNA's on 7/09/04 at the monthly in-service meeting. The lift training was done on 6/25/04 and a list of those who attend that meeting has been documented. In addition a copy of the lift procedures from the owners manual will be given to the CNA's on 7/09/04 at the monthly in-service meeting. The CNA's will be trained on the use of the lifts and a copy of the procedures will be given them before they use the lift. This will be documented in the employee file. 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. All new hires will be instructed on the proper use of the Hoyer as part of the orientation.	

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F 498	Continued From page 15 A review of resident 1's medical record and of a facility incident report for resident 1 was completed on 6/22/04. On 5/31/04, a facility nurse documented on the incident report for resident 1, "During a brief change, C.N.A. (certified nurse aide) noted dark bruising on the [right] side of residents' labia and some lighter bruising on the back of her thighs". On 6/1/04, 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 6/22/04 and 6/23/04 five facility C.N.A.'s were	F 498	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 during this month July 2004. 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 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.	

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F 498	Continued From page 16 interviewed. All five C.N.A.'s stated that they had not received any training on the proper use of the facility Hoyer Lift or how to properly place a resident in the Hoyer. The DON was interviewed on 6/22/04. The DON was asked for copies of inservices and attendance logs for proper usage of the facility Hoyer lift training. The DON stated "I don't think there is any since I've been here". On 6/23/04, C.N.A. 1, who was employed by the facility at the time that resident 1 slipped from the Hoyer was interviewed. C.N.A.1 stated that she had not received any training on the Hoyer lift during her employment at the facility. C.N.A.1 stated that it was "self explanatory". She further stated that "you just roll the resident forward and backward and slap the sling on them".	F 498		