STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465142	A. BUILDING _____ B. WING _____	C 9/17/02

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106 COMPLAINT NUMBER. 6768

(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) COMPLETE DATE
F 324 SS=G	483.25(h)(2) QUALITY OF CARE	F 324	**Quality of Care**	

The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on interviews with facility staff and review of resident medical records, it was determined that the facility did not ensure that two residents received the necessary supervision to prevent accidents as evidenced by:

1. Resident 1 had been assessed by the facility as needing supervision out in the community. The resident left the facility on 9/9/02, without the knowledge of the facility, fell, and required emergency room treatment.

2. Resident 2, left the facility on 9/9/02 with resident 1and without the knowledge of the facility. Resident 2 was not located until almost 24 hours later. The facility did not notify the authorities, that the resident was missing until 6 hours after the facility discovered the resident was missing.

Findings include:

A review of resident 1 and 2's medical records was done on 9/11/02.

Resident 1

Resident 1 was admitted to the facility on 6/5/02 with diagnosis of structural brain disease due to traumatic brain injury, hypoxic encephalopathy, and seizure disorder.

On 6/18/02, facility staff completed an admission Minimum Data Set (MDS) assessment for resident 1,

POC acceptable C amended copy attached 10/1/02 CBrenbank RN

The staff has been inserviced on the resident elopement policy and procedure on September 25, 2002. The resident elopement procedure will be added to the new employee orientation agenda. A resident elopement manual which contains a copy of the policy and procedure and copies of forms is now kept at the north nurses station. A list of residents who require a wanderguard, require supervision outside the facility and who do not require supervision will be kept in each MAR and in each C.N.A. charting book. These lists will be updated as needed.

The Administrator will monitor this policy at the end of each month to ensure that it will be sustained. This will be completed October 11, 2002.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	9.30.02

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 9/19/
FORM APPROVE
2567

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INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106	COMPLAINT NUMBER: 6768

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F 324 SS=G	483.25(h)(2) QUALITY OF CARE The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff and review of resident medical records, it was determined that the facility did not ensure that two residents received the necessary supervision to prevent accidents as evidenced by: 1. Resident 1 had been assessed by the facility as needing supervision out in the community. The resident left the facility on 9/9/02, without the knowledge of the facility, fell, and required emergency room treatment. 2. Resident 2, left the facility on 9/9/02 with resident 1and without the knowledge of the facility. Resident 2 was not located until almost 24 hours later. The facility did not notify the authorities, that the resident was missing until 6 hours after the facility discovered the resident was missing. Findings include: A review of resident 1 and 2's medical records was done on 9/11/02. Resident 1 Resident 1 was admitted to the facility on 6/5/02 with diagnosis of structural brain disease due to traumatic brain injury, hypoxic encephalopathy, and seizure disorder. On 6/18/02, facility staff completed an admission Minimum Data Set (MDS) assessment for resident 1,	F 324 OK LD 10/11/02	**Quality of Care** Resident 1 was reassessed and discharged to another facility. Resident 2 was reassessed and a wanderguard was placed on him. The IDT team will assess each new resident upon admission. The IDT team will assess each current resident as they come up for review every 90 days and make recommendations as to the need for a wanderguard and care plans. The staff has been inserviced on the resident elopement policy and procedure on September 25, 2002. The resident elopement procedure will be added to the new employee orientation agenda. A resident elopement manual which contains a copy of the policy and procedure and copies of forms is now kept at the north nurses station. A list of residents who require a wanderguard, require supervision outside the facility and who do not require supervision will be kept in each MAR and in each C.N.A. charting book. These lists will be updated as needed. The Administrator will monitor this policy at the end of each month in his QA rounds to ensure that it will be sustained. The QA committee will meet and implement this policy before October 11, 2002.	

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

[signature] | Administrator | 9.30.02

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days aft such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 324	Continued From page 1	F 324		

that documented resident 1's cognitive skills for daily decision making were moderately impaired. The facility staff also documented that resident 1 wandered (moved with no rational purpose, seeming oblivious to needs or safety) on a daily basis and the wandering behavior was not easily altered.

A care plan for resident 1 documented under the problem AWOL (absent without leave) risk, that resident 1 would not have any attempts of leaving on a daily basis and that resident 1's whereabouts would be monitored frequently.

An "Elopement Risk Assessment" for resident 1, completed by facility staff on 6/5/02, documented that resident 1 was a potential risk for elopement based on the following:

1. Resident 1's cognitive functioning was impaired.
2. Resident 1 was was oblivious to safety needs.
3. Resident 1 was at risk for injury outside the facility.
4. Resident 1's decision making abilities were impaired.
5. Resident 1 had a history of wandering.
6. Resident 1 had a history of elopement.

An "Elopement Risk Care Plan" for resident 1 dated 6/5/02 and updated 6/20/02, documented, "Resident requires supervision in the community r/t [related to] cognitive Loss m/b [manifested by] oblivious to safety needs and impaired cognitive status short term memory." The Goal documented, "Resident will have zero episodes of leaving the facility, unless supervised by staff. Physician order for electronic monitoring device 'wanderguard' YES."

Resident 2

Resident 2 was admitted to the facility on 5/1/02 with

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F 324	Continued From page 2	F 324		

diagnosis of pneumonia, urinary tract infection, cerebral vascular accident and right and left toes amputation. Resident 2 had bilateral amputations of the hands and toes.

On 8/12/02, facility staff completed a quarterly MDS assessment for resident 2, that documented that resident 2's cognitive skills for daily decision making were moderately impaired. The facility staff also documented that resident 2 required extensive assistance of one person with ADL's (activities of daily living), limited assistance of one person for transfers and extensive assistance of one person for ambulation. Resident 2 was able to propel himself in a wheelchair.

An "Elopement Risk Assessment" for resident 2, completed by facility staff on 5/1/02, documented that resident 2 was not a potential elopement risk based on he always returns but requires assistance for safety.

On 9/10/02, the facility administrator reported to the state agency that resident 1 and resident 2 had been missing from the facility since 9/9/02 at 2:30 PM.

An interview was held with a facility staff nurse on 9/10/02 at 4:20 PM. The nurse stated that on 9/9/02 at approximately 1:30 PM, a resident of the facility had approached her and asked her if she had seen resident 1 and resident 2. The resident stated that she had not seen resident 1 or resident 2 since lunch. The facility staff nurse stated she immediately informed the facility administrator that resident 1 and resident 2 were not in the facility. The nurse stated that approximately one half hour later, she again approached the administrator and asked if resident 1 and resident 2 had been located. The administrator stated that he had not started looking for resident 1 and resident 2. The facility staff nurse stated she then reported to the Director of Nursing (DON) that resident 1 and resident

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F 324	Continued From page 3	F 324		

2 were not in the facility. The nurse stated that at that time the DON and the administrator initiated a search for resident 1 and resident 2. The nurse also stated that the local authorities were not contacted at that time, that resident 1 and resident 2 were missing.

An interview was held with the facility administrator on 9/10/02 at 3:05 PM. The administrator stated that on 9/9/02, at approximately 2:00 PM, a facility staff nurse reported to him that resident 1 and resident 2 were not in the facility. The administrator stated at that time, facility staff searched the facility and the immediate area surrounding the facility. The administrator stated that when resident 1 and resident 2 were not located during the initial search, he got in his car and searched for resident 1 and resident 2. The administrator stated he returned to the facility at 4:00 PM and started calling local hospitals. He stated that at approximately 5:00 PM, a local hospital indicated that resident 1 was in the hospital emergency room. The hospital informed the administrator that resident 1 had been brought to the emergency room via ambulance. The hospital informed the administrator that resident 1 had been found by the ambulance drivers at 150 South State at 2:53 PM. Resident 1 had fallen and sustained a head laceration, so the ambulance personnel took him to the hospital.

The administrator stated he then called the ambulance service to obtain information on the incident with resident 1. The ambulance personnel told the administrator that they were driving on State street and at approximately 3:00 PM observed resident 1 on the ground at 150 South State. The ambulance personnel stated they contacted the fire department and the police department. Resident 1 was treated by the paramedics and transported to a hospital emergency room. The administrator stated he then contacted the police department and was told that resident 2 had

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F 324	Continued From page 4	F 324		

been with resident 1, and resident 2 had been left at the scene, and did appear to be in any distress.

The administrator stated after contacting the hospital, the ambulance service and the police department, he got in his car and went to search the area where resident 2 had last been seen. The administrator stated he was not able to locate resident 2.

On 9/12/02, the surveyor contacted the sheriffs department and was told that a facility nurse had contacted them on 9/9/02 at 6:59 PM and had reported to them that resident 2 was missing.

The administrator stated a facility nurse contacted the hospital at 9:00 PM on 9/9/02, to inquire about resident 1's condition. The nurse was informed that resident 1 had been treated and released to the police.

A review of the hospital emergency room report, dated 9/9/02, revealed that resident 1 had assaulted an emergency room nurse. Resident 1 was treated and "discharged in the custody of police to place in incarceration."

The administrator stated on the following morning at 8:00 AM, he called the jail and was informed that resident 1 was still in jail. There was still no information as to the whereabouts of resident 2. The administrator stated on 9/10/02 at 11:00 AM, he received a telephone call form the fire department and was informed that the fire department had received a call that there was a man on the ground at 1501 South Main. The fire department had determined that it was resident 2 and had called the facility. The administrator stated he went and picked up resident 2 and took him back to the facility. The administrator stated that the fire department had assessed resident 2 and he did not appear to be injured.

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F 324	Continued From page 5	F 324		

The administrator stated that resident 1 was returned to the facility on 9/10/02 , by resident 1's brother at 2:00 PM.

A nurses note dated 9/10/02 at 2:00 PM in resident 1's facility medical record documented, "Pt [patient] returned to facility by brother....(brother) reported resident was released from jail and broke in brothers...home...."

A review of the facility elopement policy was done on 9/10/02. The policy documented that when a resident is unaccounted for, the charge nurse will coordinate a search, becoming the 'Search Coordinator'. All available staff are to initiate a facility search. If the resident is not located on facility grounds, the Charge Nurse is to notify the administrator and DON. If the resident is not found within 30 minutes, the 'Search Coordinator will notify the local authorities (police /sheriff) to participate in the search.

The facility elopement policy also documented that staff would be informed of the elopement/missing resident policy during new hire orientation and at annual inservice meetings. During the interview with the facility staff nurse on 9/10/02 at 4:20 PM, the facility nurse stated that she had not been informed by the facility, what procedure was to be followed if a resident was missing.

The facility did not initiate a search for resident 1 and resident 2 until 30 minutes after resident 1 and resident 2 were first reported missing to the facility administrator. The local authorities were not contacted at that time.

Resident 1 was located on 9/9/02 at 5:00 PM, 3 1/2 hours after he was reported missing to the facility

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F 324	Continued From page 6 administrator. Resident 1 sustained an injury during that 3 1/2 hours, requiring medical attention at a hospital emergency room. Resident 2 was not located until 9/10/02 at 11:00 AM. The local authorities were not contacted until 6:59 PM on 9/9/02, 5 1/2 hours after the facility was aware that resident 2 was not in the facility.	F 324		