STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER DENTIFICATION NUM	VCLIA MBER:	(X2) A. B B. W
NAME OF P	ROVIDER OR SUPPLIER	405142	STREET ADDR	ESS, C
INFINIA	AT GRANITE HILLS,	INC	950 EAST 3 SALT LAK	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	माम .	II PRE TA
F 324 SS=G	483.25(h)(2) QUALI	TY OF CARE		F 324
		are that each resident reach and assistance devices	to O	poc cey an
	This REQUIREMEN	T is not met as eviden	ced by:	all
	Based on interviews v resident medical recor facility did not ensure		sived me V	NOE NOE
	needing supervision or resident left the facilit	en assessed by the facility in the community. They on 9/9/02, without the lity, fell, and required the second seco	The //	GW BW
	land without the know was not located until a facility did not notify	facility on 9/9/02 with wledge of the facility. almost 24 hours later. the authorities, that the ours after the facility di	Resident 2 The resident	

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

9/17/02

RESS, CITY, STATE, ZIP CODE

300 SOUTH E CITY, UT 84106

PREFIX

TAG

COMPLAINT NUMBER.

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETE DATE

Quality of Care

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.

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

The Administrator will monitor

LABORATORY DIRECTOR STOR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

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

A review of resident 1 and 2's medical records was

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

Findings include:

done on 9/11/02.

Resident 1

disorder.

TITLE

(X6) DATE

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.

CMS-2567L

ATG112000

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Facility ID: UT0059

If continuation sheet 1 o

	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBE	ъ. I'	X2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
16514		465142	a. wn		a. Wing		C 9/17/02	
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS	CITY, STA	TE, ZIP CODE		7()	1/02
-	AT GRANITE HILLS	INC	50 EAST 3300	SOUTH		COMPLAINT		
			ALT LAKE C	ITY, UT	84106	NUMBER. 6	768	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FU SC IDENTIFYING INFORMATIO		ID REFIX TAG	(EACH CO	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPROP DEPICIENCY)	D BE	(X3) COMPLE DATE
F 324 SS≠G	, 10110101010101010101010101010101010101		F 3	24	Quality of	Care	:	
	The facility must ens adequate supervision prevent accidents.	ure that each resident reco and assistance devices to	\cup		Resident 1 was reassessed and discharged to another facility.			
	prevent accidents.		1-1		Resident 2	was reassessed and a	1	
	,	T is not met as evidence	· •			rd was placed on hin		
	Based on interviews resident medical reco	with facility staff and revi ords, it was determined the	ew of 10	III	The IDT to	am will assess each to on admission. The I	new	
	facility did not ensur	e that two residents receiv	ed the	אטןיו	team will a	ssess each current	Di	
	necessary supervision evidenced by:	n to prevent accidents as		· i	resident as	they come up for rev	riew	
	evidenced by.					ays and make		1
		en assessed by the facility		-	a wandergi	dations as to the need lard and care plans.	for	1
needing supervision out in the community. The resident left the facility on 9/9/02, without the knowledge of the facility, fell, and required em		out in the community. Th	e			_		l
			1	The staff h	as been inserviced on	the	1	
	knowledge of the rac room treatment.	mry, rem, and required en	ergency		procedure	ppement policy and on September 25, 200	าว	
			ļ	!	The resider	it elopement procedu	re	
	2. Resident 2, left th	e facility on 9/9/02 with n	esident	i	will be add	ed to the new employ	ree	
i	land without the kno	wledge of the facility. Re	sident 2	-	orientation	agenda. A resident		!
	was not located until	almost 24 hours later. Th	ie		elopement :	manual which contain	05 2	
	facility did not notify	the authorities, that the re	esident		copy of the	policy and procedure	e	
:	was missing until 6 h the resident was miss	ours after the facility disc	overed	!	and copies the north n	of forms is now kept irses station. A list o	at r	
		****B*			residents w	ho require a	T	İ
	Findings include:				wanderguar	d, require supervision	-	ļ
:	gg				outside the	facility and who do n	int	
	A review of resident	I and 2's medical records	was	7	require supe	rvision will be kent i	in	ļ
,	done on 9/11/02.			į	each MAR :	and in each C.N.A		
	Resident I		. .	:	charting boo updated as t	ok. These lists will b needed.	e	[
!	Resident 1 was admir	ted to the facility on 6/5/0	12	į	The Admin	istrator will monitor		
	diagnosis of structure	at brain disease due to trai	z with		this policy a	t the end of each mor	ath	1
į	brain injury, hypoxic	encephalopathy, and seiz	unatic		in his QA re	unds to ensure that it		Ì
	disorder.	pimiopauty, and seiz	41.5	į	will be susta	ined. The QA	-	
					committee v	vill meet and		
!	On 6/18/02, facility s	taff completed un admissi	on	1	implement t	his policy before		
	Minimum Data Set (N	MDS) assessment for resid	lent I,		October 11,	2002.		
RATORY	DIRECTOR POR PROVIDE	R/SUPPLIER REPRISENTATIVE	S SIGNATURE	 	A. Tt	TLE		(X6) DATE
deficiency	- An Cy	<u></u>			Adminis	harten	9	30.0

Facility ID: UT0059

If continuation sheet 1 o

ATG112000 Event I 002:M11

CMS-2567L

DEPARTMENT OF HEALTH AND HU N SERVICES HEALTH CARE FINANCING ADMINISTRATION

PRINTED: 9/19/ FORM APPROVE

STATEMEN	T OF DEFICIENCIES	(XI) PROJUDEN STATES					2567
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
			ABEK:	A. BUILDIN			LETED
				B. WING			C
NAME OF E	PROVIDER OR SUPPLIER	465142				-	
· · · · · · · · · · · · · · · · · · ·	NO VIDER OR SUPPLIER		STREET ADI	ORESS, CITY, ST	ATE, ZIP CODE		9/17/02
INFINIA	AT GRANITE HILLS	. INC	950 EAST	3300 SOUTH	ł		
		,	SALT LAI	KE CITY, UT	84106		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES					
PREFIX	(EACH DEFICIENCY	MUST RE PRECEEDED DV	ET IX X	ID PREFIX	PROVIDER'S PLAN OF CORRECT	TION	(X5)
TAG REGULATORY OR LSC		SC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OPPLATE	COMPLETE
				<u>. </u>	DEFICIENCY)	OFMATE	DATE
F 324				F 324			<u> </u>
	that documented resi	dent 1's cognitive skills	: for daily	F 324			
	decision making were	moderately impaired	The				•
	facility staff also docu	Imented that resident 1	Wandered	ĺ			
	(moved with no ration	ial purpose, seeming of	divious to				
	needs or safety) on a (daily basis and the wan	dering	-			
;	behavior was not easi	ly altered.	dering				
A care plan for resident 1 docur problem AWOL (absent withou	•	i	j			1	
	A care plan for reside	nt 1 documented under	the				
į	problem AWOL (abse	ent without leave) risk	that :				
problem AWOL (absent without leave) risk, that resident 1 would not have any attempts of leaving daily basis and that resident 1's whereabouts work monitored frequently.		Ving on a	ĺ				
!	daily basis and that re-	sident 1's whereahouts	would be	İ			1
monitored frequently.			would be				
:			ì				
i	An "Elopement Risk Assessment" for resident 1,						
	completed by facility s	staff on 6/5/02, docume	ented that	i			
	resident 1 was a poten	tial risk for elopement	nased on				!
i	the following:	oropomoni	based on				
i	_						i 1
:	1. Resident 1's cogniti	ve functioning was imp	naired	:			:
	Resident I was was	oblivious to safety nee	de				
1	3. Kesident I was at ri	sk for injury outside th	e facility	i			i
į	4. Resident 1's decisio	n making abilities were	· lacinty.	İ			
4	ımpaired.		, ; 	}			!
i,	5. Resident I had a his	story of wandering	!				
1	6. Resident I had a his	story of elopement					ĺ
			į	[1
i,	An "Elopement Risk C	are Plan" for resident 1	dated	i			
(6/5/02 and updated 6/2	0/02, documented, "Re	sident	!			
; 1	equires supervision in	the community r/t frets	ted tol				
٠ (cognitive Loss m/b ∫ma	mifested by oblivious	to safety	į			i 1
; 1	reeds and impaired cog	initive status short term		:			1
r	nemory." The Goal do	ocumented, "Resident w	rill have	i			1
. 2	ero episodes of leaving	g the facility, unless su	nervised	İ			j J
t	y staff. Physician orde	er for electronic monito	ring				i 1
Ċ	levice 'wanderguard' Y	ES."	rung :				1
	<i>y</i> - 1.	==:	ļ				
· F	Resident 2						;
				İ			
· R	Resident 2 was admitted	to the facility on 5/1/	: المثنية (20	!			

DEPARTMENT OF HEALTH AND HL N SERVICES HEALTH CARE FINANCING ADMINISTRATION

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA MBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	2567 SURVEY LETED
		465142		B. WING		ľ	C
NAME OF P	ROVIDER OR SUPPLIER	403142	STREET AD	DRESS, CITY, STA	Tr. 710 Good		0/17/02
				3300 SOUTH	TE, ZIP CODE		<u> </u>
INFINIA	AT GRANITE HILLS,	INC	SALT LA	KE CITY, UT	84106		
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	न ।	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
	diagnosis of pneumon cerebral vascular acci amputation. Resident the hands and toes. On 8/12/02, facility st assessment for resider resident 2's cognitive were moderately impa documented that resid assistance of one persoliving), limited assistance assistance assistance Resident 2 was able to An "Elopement Risk A completed by facility stresident 2 was not a post he always returns but ron 9/10/02, the facility state agency that resident and asket as and resident 2 massing from the facility approximately 1:30 PM approximate	aff completed a quarter aff completed a quarter at 2, that documented the skills for daily decision ired. The facility staff ent 2 required extensive on with ADL's (activiting of one person for an appropriate property of the facility staff of the facility staff of the facility staff on 5/1/02, document 1 and resident 2 had seen the stated that approximate aff on 1 and resident 2 we stated that approximate approached the administration	rly MDS hat n making also re es of daily ransfers nbulation. neelchair. at 2, ented that based on safety. d to the d been PM. rse on 9/9/02 at lity had resident had not facility ne facility re not in ely one inistrator not The	F 324	DEFICIENCY		
1 !	acility staff nurse stated Director of Nursing (DO	ishe then reported to t	he				

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ſ			ADMINIC RATION				FOR	M APPROV
	STATEMENT OF DEF AND PLAN OF CORR	FICIENCIES ECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	VCLIA MBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE COMPL	
ļ	<u> </u>		465142		B. WING		!	C
l	NAME OF PROVIDER	OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE ZIP CODE	9	/17/02
INFINIA AT GRANITE HILLS, INC		950 EAST 3	300 SOUTH E CITY, UT					
	(X4) ID PREFIX (E TAG RI	ACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	CT II 1	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO TI DEFICIENC'	TON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	2 were time the for resident administration and the control of the	erview was held of the province of the facility staff iate area surrous strator stated the facility and searched for strator stated durant searched for strator stated held started calling oximately 5:00 ident 1 was in the facility in the facility and searched for strator stated held started calling oximately 5:00 ident 1 was in the facility in the facility in the facility of the	lity. The nurse stated to administrator initiated ident 2. The nurse also ies were not contacted in resident 2 were mission of the administrator stately 2:00 PM, a facility and that resident 1 and resident 2 and the administrator stately 2:00 PM, a facility and the facility and the facility and the initial search, I are resident 1 and resident 2:53 PM. Resident administrator that reference in the mount on the hospital difference and laceration, so the pook him to the hospital difference personnel told the were driving on State so PM observed resident 1 and the fident 1 was treated by sident 1 was treated by sident 1 was treated by	hat at that I a search I stated at that sing. mistrator ated that ity staff dent 2 ated at nd the resident he got in nt 2. The at 4:00 ated that dicated room, resident 1 istrator nce ent 1 had mbulance with treet and on the resonnel he	F 324	D.J. POJENC		
			was nealed by	ıne	i			

paramedics and transported to a hospital emergency room. The administrator stated he then contacted the police department and was told that resident 2 had

DEPARTMENT OF HEALTH AND HU N SERVICES PRINTED: 9/19/ HEALTH CARE FINANCING ADMINI. FORM APPROVE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 465142 NAME OF PROVIDER OR SUPPLIER 9/17/02 STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST 3300 SOUTH INFINIA AT GRANITE HILLS, INC SALT LAKE CITY, UT 84106 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX PREFIX (X5) COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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

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resident 2 and had called the facility. The

and he did not appear to be injured.

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

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

Event I 00ZM11

Facility ID: UT0059

If continuation sheet 5 o

CT ATEL ATE		ADMINISTRATION					2567
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	VCLIA MBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE COMPL	SURVEY ETED
		465142		B. WING			С
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	9	/17/02
INFINIA	AT GRANITE HILLS,		950 EAST SALT LAI	3300 SOUTH KE CITY, UT 8			
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FILL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD RE	(X5) COMPLETE DATE
F 324	Continued From page 5			F 324			_!
:	the facility on 9/10/02 PM. A nurses note dated 9 facility medical record returned to facility by resident was released brothershome" A review of the facility 9/10/02. The policy dis unaccounted for, the search, becoming the "	ted that resident 1 was 2, by resident 1's broth 10/02 at 2:00 PM in red documented, "Pt [pat brother(brother) repfrom jail and broke in y elopement policy was commented that when a c charge nurse will coo Search Coordinator'.	esident 1's ient] ported s done on a resident rdinate a				
	available staff are to in	nitiate a facility search. on facility grounds, the dministrator and DON of thin 30 minutes, the "S of the local authorities (If the Charge I. If the Search				
:	The facility elopement staff would be informed resident policy during annual inservice meeting the facility staff nursed facility nurse stated that the facility, what proced resident was missing.	d of the elopement/mis new hire orientation an ngs. During the intervion on 9/10/02 at 4:20 PM, at she had not been info	ssing ad at ew with , the ormed by				
:	The facility did not init resident 2 until 30 minutes were first reported madministrator. The location acted at that time.	ates after resident 1 and issing to the facility	nt l and d resident				
1	Resident I was located	l on 9/9/02 at 5:00 PM	4 , 3 1/2	i .		1	

hours after he was reported missing to the facility

DEPARTMENT OF HEALTH AND HU. N SERVICES HEALTH CARE FINANCING ADMINISTRATION

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AND DIAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					2567			
	o. CORRECTION			A. BUILDING	LE CONSTRUCTION	(X3) DATE COMPL	SURVEY ETED			
				B. WING		20.112	С			
NAME OF P	ROVIDER OR SUPPLIER	465142	~	L_		9				
				ADDRESS, CITY, STATE, ZIP CODE						
———	AT GRANITE HILLS	, INC	950 EAST SALT LAK	3300 SOUTH Œ CITY, UT	84106					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY MUST ID			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE	
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		11:00 AM.	F 324	DETICIENCY)					
!	on 9/9/02, 5 1/2 hour resident 2 was not in t	is after the facility was	aware that							
:	•									
				:		ļ				
į				:		 				
:				:		! ; 				
			i : :			!				
: i			i : :							
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:			i :							