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

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 _____	R 05/27/2003

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

(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 157} SS=G	483.10(b)(11) NOTIFICATION OF RIGHTS AND SERVICES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in s483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in s483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and medical record review, it was determined that for 1 of 14 sample residents, the facility did not immediately notify or consult with the resident's medical physician when there was a potential for physician intervention due to self injurious behaviors. In addition, the medical physician was not notified or consulted to obtain orders to treat the residents self inflicted wounds.	{F 157}	MD will be notified of all bruising of unknown origin. MD will be notified of all attempts of self injurous behavior. Nursing staff was in serviced on notification of medical physician and on obtaining orders to provide treatment for self inflicted injuries. DON will insure in monthly quality assurance rounds that all injuries of unknown origin and self injurous behavior were reported to the MD. Infinia at Granite Hills has one resident with self injurious behavior. This resident is currently receiving psychotherapy through Advanced Behavioral Care two to three times a week and attends an SRS program through Valley Mental Health three to 4 times a week. The following plan of action has been implemented to further address Resident 40's injurious behavior: On 5/15/03 Resident 40's room was checked for sharp objects that could be used to cut self. On 5/21/03 Resident 40 was put on an every hour check for safety. On 5/21/03 the shower room magnetic door closure magnet device was removed eliminating the ability for the door to be open. The door now automatically closes, locks and requires a key to open when in use preventing resident access unless supervised. On 5/22/03 the IDT committee which included resident 40's psychologist and a MSW consultant met, reviewed, approved and signed a new Behavioral Care Plan for Resident that identified specific triggers and interventions to prevent resident cutting.	

OVB POC Accepted as submitted dated 6/5/03 VBrumbaugh

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

MSW — Administrator — 6-14-03

deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide cient 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 information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 20 2003 Receipt 403008

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{F 157}	Continued From page 1 Resident identifier: 40 Findings include: Resident 40 was admitted to the facility on 9/4/02 with diagnoses of insulin dependent diabetes mellitus, degenerative joint disease, hypertension, schizophrenia, subdural hematoma, seizure disorder, borderline personality disorder, major depression and chronic obstructive pulmonary disease. On 11/14/02 at 11:40 AM, a facility nurse documented, "...showed CNA (certified nursing assistant) his [left] anterior wrist which has approx (approximately) 4 in (inch) long, superficial but slight bleeding. [Resident 40] stated he did it to himself [with] a plastic knife he obtained from dining rm (room) drawer...wound [checked], cleaned [and] dry gauze applied..." There was no documentation in the medical record of resident 40 to evidence that the resident's medical physician was notified of the self injury on 11/14/02. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury. On 11/30/02 at 3:00 PM a facility nurse documented, "[Resident 40] came to nursing station [with] paper towel over [left] anterior wrist which was saturated [with] blood. {Resident 40] says "I did it with a thumb tac." I uncovered wound [and] found 6 cm (centimeter) long laceration [with] moderate amt (amount) of bleeding. Area cleaned cont (continued) to weep [with] blood. [Facility RN] advised steri strips. These were applied, 3 good closure, dry gauze [and] wrap...I told [resident 40] he made a wound that may require sutures [and] the ER (emergency) room..."	{F 157}	On 5/22/03 Nursing staff signed on a copy of the new Behavioral Plan that they have read and understand making them aware of behaviors (triggers) and interventions for Resident 40. In monthly quality assurance rounds the safety of residents will be discuused including ability of residents to self injure. A tetanus shot is on order and will be given when received. Nursing staff in serviced in reagrds to reporting all attempts at self injury. Safety of residents is discussed at a monthly quality assurance meeting. Daily checks for 90 days by the administrator are performed on insuring that the shower room door is closed and that the residents room is free of objects that resident 40 could us to injure himself. Weekly checks of the facility are being performed to insure the facility and resident rooms are free of sharp or dangerous objects.	6/3/03

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{F 157}	Continued From page 2 There was no documentation in the medical record of resident 40 to evidence that the resident's medical physician was notified of the self injury on 11/30/02. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury that may have required sutures and a visit to the emergency room. On 12/4/02 at 2:55 PM, a facility nurse documented, "[Resident 40] came to nursing station [and] had blood soaked paper towel over [left] wrist (anterior). 5 cm laceration [with] mod (moderate) amt (amount) bleeding. Area cleaned [and] dry gauze placed...[Resident 40's psychologist] was called by me [and] returned call [at] 1450 (2:50 PM)..." On an "Accident/Incident Report" dated 12/4/02 at 2:30 PM, a facility nurse documented that resident 40's psychologist was notified of resident 40's self inflicted injury. The incident report does not document that the resident's medical physician was notified of the self inflicted injury. There was no documentation in the medical record of resident 40, to provide evidence that the resident's medical physician was notified of the self injury on 12/4/02. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury. On 12/30/02 at 2:25 PM, a facility nurse documented, "[Resident 40] came to nursing station [and] [left] anter (anterior) wrist bleeding, sm (small) 2 cm vertical incision (usually he does horizontal) just SQ (subcutaneous) with sm (small) to mod (moderate) amt (amount) of bleeding. Cleaned [and] wrapped [with] dry 4X4's [and] kerlex [sic]. Removed knife he claims to have obtained from the Christmas dinner..."	{F 157}		

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{F 157}	Continued From page 3 There was no documentation in the medical record of resident 40, to evidence that the resident's medical physician was notified of the self injury on 12/30/02. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury. On 1/7/03 at 2:30 PM, a facility nurse documented, "[Resident 40] had 4 cm long, horizontal self inflicted slit on [left] wrist...Clean [with] dry protective dsg (dressing). [Resident 40] used a tac to inflict injury..." There was no documentation in the medical record of resident 40, to evidence that the resident's medical physician was notified of the self injury on 1/7/03. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury. On 1/24/03 at 2:30 PM, a facility nurse documented, "[At] 10:30 [resident 40] came to me [and] showed me his [left] anterior wrist, covered [with] paper towel...[left] anterior wrist [with] 2 cm horizontal slit. Cleaned [and] dry dsg (dressing) applied. [Resident 40] said he did it with a tac..." There was no documentation in the medical record of resident 40, to evidence that the resident's medical physician was notified of the self injury on 1/24/03. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury. On 1/29/03 at 9:30 AM, a facility nurse documented, "Pt (patient) appeared [at] nsg (nursing) station [with] 1 1/2 cm cut on [left] wrist- minimal bleeding. Cleaned [and] dressed..." There was no documentation in the medical record of	{F 157}		

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{F 157}	Continued From page 4 resident 40, to evidence that the resident's medical physician was notified of the self injury on 1/29/03. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury. On 1/31/03 at 4:45 PM, a facility nurse documented, "[Resident 40] came to nursing station [with] paper towel over [left] wrist [and] paper towel was saturated [with] bld (blood). [Check] revealed about 5 cm horizontal self inflicted slit. [Resident 40] refuses to reveal the tool used. Cleaned [and] applied dry protective dsg (dressing)..." There was no documentation in the medical record of resident 40, to evidence that the resident's medical physician was notified of the self injury on 1/31/03. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury. On 2/8/03 at 10:20 AM, a facility nurse documented, "...was gone maybe 5 min (minutes) [and] returned [with] 4 cm horizontal slit to [left] wrist, bleeding moderate [and] slightly lying open. Cleaned [and] applied dry protective dsg (dressing)..." On an "Accident/Incident report" dated 2/8/03 at 8:30 AM, a facility nurse documented that the resident's medical physician was not notified of the self inflicted injury. There was no documentation in the medical record of resident 40, to evidence that the resident's medical physician was notified of the self injury on 2/8/03. There was no evidence that physician orders were obtained to provide treatment for this self inflicted injury.	{F 157}		

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{F 157}	Continued From page 5 A review of the resident 40's medical record, revealed an immunization record. The immunization record did not provide evidence that resident 40 had ever received a tetanus shot. It should be noted that resident 40 was causing self injuries to himself with items which included thumb tacks, knives as well as other items he would not disclose to the facility. On 5/16/03 at 10:15 AM, a facility nurse stated that in the past she has contacted the resident's psychologist with concerns of self injury. She further stated that the psychologist told her that they were not suicidal attempts just self mutilation. On 5/19/03 at 8:50 AM, the facility social service worker stated that resident's injuries have been superficial and at times they have contacted the resident's psychologist.	{F 157}		
{F 224} SS=H	483.13(c)(1)(i) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F224 for deficiencies concerning mistreatment, neglect or misappropriation of resident property.) This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility incident reports, resident medical records, facility policies and procedures, and facility's sign-out logs, it was determined that the facility did not adequately assess, care plan and monitor residents with AWOL (absence without leave) behaviors which led to neglect for 4 of 14 sample residents and an additional	{F 224}	OK LB The following plan of correction has been implemented:On 5/21/03 Elopement Policy and Procedure was reviewed and revised. On 5/14/04 the Leave of Absence Books at each nursing station was combined into one book and placed at the North nursing station eliminating confusion on where to sign in and out as required when leaving the facility, as well as easy access for the licensed nurse monitoring residents return. On 5/14/03 a notice was posted at the front door reminding residents/families to sign the LOA Book when leaving facility property. On 5/21/03 An hourly resident check was implemented to account for the whereabouts of all residents.	

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{F 224}	Continued From page 6 4 supplemental residents. Of the 8 residents, 6 (1 closed record) were found to have experienced actual harm as a result of their AWOL behavior. Harm included an auto-pedestrian accident, internal bleeding after alcohol consumption, exposure to inclement weather without adequate clothing, facial lacerations, bruising and scratches. Additionally, one resident exhibited self-injurious behaviors, such as cutting his wrists with razor blades, a knife and a thumbtack, which were not monitored by staff. Resident identifiers: 32, 4, 42, 13, 41, 33, 35, 40 and CR1. The facility's failure to adequately assess, monitor, care plan and intervene led to a finding of Immediate Jeopardy in the area of neglect. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Findings include: 1. Resident 32 was a 50 year old male who was admitted to the facility on 6/8/02 with diagnoses which included major depression with psychotic features, paranoid delusional disorder, organic brain syndrome, history of traumatic brain injury, borderline intellectual functioning and left eye blindness. The most current nurses monthly summary, dated 5/12/03, documented that resident 32 was alert and oriented and confused at times. The summary also documented that resident 32's decision skills were moderately impaired (poor decisions or needs supervision), and he had periods of altered perception and periods of lethargy. On page 11 of the pre-admission screening for resident 32, the reasons to warrant the admission of resident 32 to a nursing facility included "close supervision per impaired cognition..."	{F 224}	If a resident is not accounted for, staff will check the LOA Book and Activity List, then notify charge nurse if still not accounted for the charge nurse will then implement the Missing Person procedures.On 5/14/03, 5/20/03 and 5/21/03 An in-service was held for all staff to inform them of the Elopement Policy and 1 hour resident check. On 5/16 /03 Residents were informed at a special Resident Council meeting that they are required to sign the LOA Book located at the North Nursing Station to inform nursing staff of whereabouts when leaving facility and Elopement policy. On 5/16/03 Activities added supervised walking outing 2'xs a day to their activity calendar. On 5/14/03 all residents Elopement Risk Assessments and Care Plans were reviewed by the IDT committee for accuracy. On 5/22/03 residents identified as Elopement Risk and Care Plans were reviewed by MSW Consultant.	

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{F 224}	Continued From page 7 The care plan for resident 32 included a problem identified by social services to be "Decisions are poor, cues/supervision required r/t (related to) organic affective disorder". On 5/12/03, at 1:45 PM, resident 32 was observed by four state surveyors to be standing in the median area of 3300 South, a busy four-lane street. While resident 32 was standing in the median, a vehicle was observed to slowly pull up to resident 32 and stop immediately adjacent to the resident. The vehicle moved into the path of resident 32 blocking him from walking forward. The driver of the vehicle honked the horn. Resident 32 was observed to continue to stand in the median. During this time, a CNA (certified nurse aide) was observed providing assistance to another resident. She and the other resident were on the sidewalk between the facility and 3300 South. The CNA waved and spoke briefly to resident 32 and proceeded to assist the other resident into the facility. No staff came to assist resident 32 to cross the street. Without regard to traffic, resident 32 proceeded to cross 3300 South. There was no crosswalk located where resident 32 crossed the street. On 5/13/03, the CNA who had waved to resident 32 while he was in the street was interviewed. She stated that she had been walking a blind resident when she observed resident 32 in the street and "had two choices". She stated her first choice was to leave the blind resident and help resident 32 or proceed into the facility and tell staff that resident 32 was in the street. She stated that she had chosen to go into the facility and tell staff. Later on 5/13/03, at 2:15 PM, a meeting was held with	{F 224}	On 5/13/03 new Elopement care plans were written individualizing resident 5/13/03 residents requiring supervision for safety are supervised by facility staff if not leaving facility with family or friends.On 5/22/03 Allowing residents their right to refuse treatment, residents assessed requiring supervision for safety in the community based on past incidents, but refuse supervision were counseled by Social Service of Safety Risk and were given a choice to wear a wander guard (per order by physician), move to a facility that would be located in an area that does not run along such a busy street lower their risk of harm, or if not adjudicated an incapacitated person to exercise their rights to sign an informed consent Refusal of Treatment. On 5/22/03 the Wander/Elopement Log was updated and placed in the Medication and Aide Flow Sheet Books at each nursing station. A new fence in the back yard designed higher to prevent residents from climbing over and harming self was completed along with other fences that will helpinsure the safety of the residents. The social worker will counsel one on one with any resident found to leave facility without signing out or behaving dangerously in the community.	

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{F 224}	Continued From page 8 the facility's administrative staff. The DON (director of nurses) stated that she may have been told that resident 32 was in the street. When asked what she did when the aide told her that resident 32 was in the street, she responded "What? Am I supposed to go in the street?" Facility administrative staff neglected to intervene when they were informed by the facility aide that resident 32 was standing in the middle of the street. 2. Resident 4 was a 47 year old male who was admitted to the facility on 9/1/94 with diagnoses which included dementia secondary to anoxic brain injury, anoxic brain injury and schizophrenia. An assessment completed by the LCSW (licensed clinical social worker) on 10/29/02, documented that resident 4 had "poor short- and long-term memory in addition to poor judgement and decision making skills. He is confused at times." A form titled "Refusal of Treatment", dated 6/3/02, documented that the "physician feels that safety is in jeopardy by going into the community without assistance." The most recent MDS (minimum data set), a mandatory comprehensive assessment of the resident completed by facility staff, dated 3/1/03, documented the following regarding resident 4: - he had short and long term memory problems - his cognitive decision making skills were moderately impaired (decisions poor; cues/supervision required) - he had episodes of disorganized speech - his mental function varied over the course of the day The care plan for resident 4 included the following	{F 224}	Elopement attempts and issues related to elopement will be addressed in a monthly quality assurance meeting.MD will be notified of all bruising of unknown origin. MD will be notified of all attempts of self injurous behavior. Nursing staff was in serviced on notification of medical physician and on obtaining orders to provide treatment for self inflicted injuries. DON will insure in monthly quality assurance rounds that all injuries of unknown origin and self injurous behavior were reported to the MD. Infinia at Granite Hills has one resident with self injurious behavior. This resident is currently receiving psychotherapy through Advanced Behavioral Care two to three times a week and attends an SRS program through Valley Mental Health three to 4 times a week. The following plan of action has been implemented to further address Resident 40's injurious behavior: On 5/15/03 Resident 40's room was checked for sharp objects that could be used to cut self.	

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{F 224}	Continued From page 9 problems identified by social services: - "Decisions are poor, cues/supervision required r/t (related to) organic brain syndrome" - "Cognitive status/skill/ability has deteriorated in the past 90 days" An elopement risk assessment was completed by facility staff on 4/8/02. The assessment documented the following information regarding resident 4: - his cognitive functioning was "impaired" - he was oblivious to his own safety needs - he was at risk for injury outside the confines of the facility - his decision-making abilities were poor - family and friends felt he was at risk for elopement - he had severe short term memory problems - he "jaywalks" A facility nurse's note and incident report, dated 1/7/03, documented that resident 4 was involved in a motor vehicle - pedestrian accident while crossing the street. Resident 4 was taken to the hospital via ambulance and treated in the emergency department for lacerations he received to his forehead. On 5/13/03 at 2:15 PM, an interview was held with administrative staff. The social service person stated that resident 4 was alert and oriented times one, had short-term memory problems, was "unsafe in the community" and made "poor choices". The ADON (assistant director of nurses) stated that resident 4 "doesn't make correct choices" and "sometimes doesn't let us know where he goes". The DON stated that resident 4 "doesn't make accurate choices", "jaywalks" and had been "hit by a UPS truck". During this same interview, the staff were asked if anyone monitored the LOA (leave of absence) book to ensure that residents were signing out and to check on	{F 224}	On 5/21/03 Resident 40 was put on an every hour check for safety that includes assuring his room has no sharp objects to cut self. On 5/21/03 the shower room magnetic door closure magnet device was removed eliminating the ability for the door to be open. The door now automatically closes, locks and requires a key to open when in use preventing resident access unless supervised. On 5/22/03 the IDT committee met, reviewed, approved and signed a new Behavioral Care Plan for Resident that identified specific triggers and interventions to prevent resident cutting. On 5/22/03 Nursing staff signed on a copy of the new Behavioral Plan that they have read and understand making them aware of behaviors (triggers) and interventions for Resident 40. In monthly quality assurance rounds the safety of residents will be discussed including ability of residents to self injure. A tetanus shot is on order and will be given when received. The hourly checks, the new fence, the new elopement care plans, the compiled LOA book, the supervised walks, the one on one	

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	465142	A. BUILDING _____ B. WING _____	R 05/27/2003

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INFINIA AT GRANITE HILLS, INC	950 EAST 3300 SOUTH SALT LAKE CITY, UT 84106

(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 224}	Continued From page 10 the location of the residents. The ADON replied, "no". Observation of resident 4 on 5/27/03 at 10:30 AM, revealed he was cooperative during the staff supervised walk to the local store. The facility failed to prevent neglect by not providing adequate supervision to this cognitively impaired individual who was a known elopement risk. 3. Resident 42 was a 62 year old male who was admitted to the facility on 12/9/02 with diagnoses which included cerebral vascular accident with delusional agitation, dementia with depressive features and a history of alcohol abuse. A physician's readmission history and physical, dated 12/19/01, documented that resident 42's "Cognition: Markedly impaired, particularly for judgement, high reasoning and new learning." A discharge plan for resident 42, dated 3/27/03, listed the "Reason for Admission: Requires 24 (hour) assist supervision." The most recent MDS for resident 42, dated 3/1/03, documented the following regarding resident 42: - he had both short and long-term memory problems - his cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) - he had episodes of disorganized speech - his mental function varied over the course of the day An elopement risk assessment, dated 10/4/02 and revised 2/28/03, documented the following regarding resident 42:	{F 224}	counseling with the Social Serivices worker were all done and continue to be done for those residents identified in the defeciency (32,4,42,13,41,33,35,40 and CR1) and all other residents and monitored by the administrator to insure the safety of the residents. The administrator will monitor weekly for the nex 90 days that the LOA book is in order and that counseling is being done on those who fail to sign in and out and have safety issues in the community.	6/8/03

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{F 224}	Continued From page 11 - he was oblivious to his own safety needs - he was at risk for injury outside the confines of the facility An elopement/safety risk care plan was completed by facility staff on 2/27/03. This elopement/safety risk care plan documented that "resident requires supervision in the Community r/t Cognitive Loss m/b (manifested by) oblivious to safety needs and safety, et (and then) increased confusion recent fall in community poor nutrition". The goal was that resident 42 "will have zero episodes of leaving the facility, unless supervised by staff." This care plan noted that the physician had ordered a wanderguard for resident 42. On 4/1/03, a physician's order documented that resident 42 "requires a State Guardian (secondary) to Dementia nutritional deficit oblivious to safety." During April 2003, resident 42 eloped from the facility 3 times. On 4/1/03, an incident report noted "Apparently (resident 42) went LOA (leave of absence) last PM (evening) and returned at 0145 (1:45 AM) with bleeding bilateral cheeks. Assessment today shows lg (large) swelling on both maxillary sinus areas with abrasions on each. Abrasions noted on forehead. All abrasions dry." The incident report documents that x-rays were obtained and that the final disposition of resident 42 was "confused". Resident 42 again eloped from the facility on 4/9/03 and 4/10/03, but was returned without injury. The facility failed to prevent neglect by not providing adequate supervision for this cognitively impaired	{F 224}		

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{F 224}	Continued From page 12 individual. 4. Resident 13 was a 55 year old male who was admitted to the facility on 7/19/00 with diagnoses which included a closed head injury, dementia secondary to the closed head injury, and a history of alcohol and polysubstance abuse. The MDS, dated 1/29/03, documented the following regarding resident 13: - he had both short and long-term memory problems - his cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) - he had periods of altered perception or awareness of surroundings (moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) - he had periods of restlessness - his mental function varied over the course of the day A psychosocial assessment completed by an LCSW (licensed clinical social worker) on 7/20/02, documented that resident 13 needed "24-hour supervision". The LCSW also identified resident 13 as an AWOL risk. The care plan for resident 13 included the following two problem areas identified by social services: - "Decisions are poor, cues/supervision required r/t personality disorder" - "Wanders with no rational purpose, seemingly oblivious to needs or safety (less than daily or daily/frequently)". The care plan noted that resident 13 "requires assistance when out in the community". A form titled "Elopement Risk Care Plan", dated	{F 224}		

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{F 224}	Continued From page 13 5/24/02, documented that resident 13 "requires supervision in the community r/t cognitive loss m/b oblivious to safety needs and shoplifts, panhandles, safety, found climbing over fences, danger to self." The goal to this care plan was that resident 13 would "have zero episodes of leaving the facility, unless supervised by staff." The admission history and physical, completed by the physician in "7/2000" identified that resident 13 had "right eye blindness, difficulty with memory, judgement and temper inhibition." The physician also noted that resident 13's legal guardian was his father. A nurse's note, dated 4/3/03 at 11:00 PM, documented that resident 13 "came up to desk and stated he was going out with his father"...and "had signed LOA (leave of absence book) while talking to me." There was no documentation in the medical record of resident 13 to evidence that after he told the nurse he was "going out" at 11:00 at night, that she provided additional supervision and monitoring to ensure his safety. A nurse's note and facility incident report, dated 4/3/03 at 11:30 PM, documented that resident 13 "climbed the back fence" and "cut his hand". A additional nurses note for 4/4/03 at 1:15 AM documented that resident 13 was found in bathroom with his left foot bleeding. "When approached pt. (patient) states he went over fence without shoes on. L (left) foot cleaned off, first L toe with large amounts of bleeding. Deep laceration observed to side of the toe, pressure applied to site. Bleeding amount deceased, but toe still continued to bleed, pressure dressing applied." At 2:00 AM, resident 13 was transported to the hospital via ambulance and received 5 sutures.	{F 224}		

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{F 224}	Continued From page 14 Twenty days after the above incident, on 4/24/03, facility staff completed a new "elopement/safety risk care plan" for resident 13. The new care plan did not address the subject of resident 13 climbing over fences or any interventions to address this behavior. The facility failed to prevent neglect by not providing adequate supervision to this cognitively impaired individual who was a known elopement risk. 5. Resident 33 was a 53 year old male who was admitted to the facility on 10/18/02 with diagnoses which included traumatic brain injury with psychosis. An MDS, dated 1/23/03, documented the following regarding 33: - he had short and long-term memory problems - he was not able to recall the current season, location of his room, staff names or faces, or that he was in a nursing home - his cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) - he was easily distracted - he had periods of altered perception or awareness of surroundings (moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) - he had periods of restlessness - his mental function varied over the course of the day - he had episodes of disorganized speech A psychosocial assessment completed by the LCSW on 10/18/02 documented that resident 13 was "very confused and disoriented" and an "AWOL risk". A form titled "Elopement Risk Care Plan", dated	{F 224}		

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{F 224}	Continued From page 15 10/4/02, documented that resident 33 "requires supervision in the community r/t cognitive loss m/b oblivious to safety needs and requires constant supervision." The goal to this care plan was that resident 33 would "have zero episodes of leaving the facility, unless supervised by staff." A behavior care plan, dated 12/10/02, documented that resident 33 was "disoriented" and an "AWOL risk". The interventions for this care plan were to "orient resident constantly, ask questions about past and present, redirect into reality, use name frequently, orient to person, place and time". The other interventions were to apply a "wanderguard" and "assist in community". This care plan did not address the need identified in the above elopement care plan of resident 33 requiring "constant supervision". A care plan for resident 33, dated "2003" with the target dated of 7/10/2003, included the following problem as identified by social services: "Wanders with no rational purpose, seemingly oblivious to needs or safety (less than daily or daily/frequently)". One of the interventions was to provide "one on one care for the time being". A facility incident report, dated 3/10/03, documented that "pt. (patient) was discovered missing @ 1800 (at 6:00 PM) apparently jumped the back fence..." The nurse's assessment after resident 33 was found and returned to the facility revealed two scratches on the resident's left leg. Observations performed by all four surveyors during the days of survey, 5/12/03 - 5/20/03, revealed many instances when resident 33 was walking in the facility by himself , not under "constant supervision" and not receiving "one on one care". These were needed interventions identified in care plans by facility staff.	{F 224}		

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{F 224}	Continued From page 16 The facility failed to prevent neglect by not providing adequate supervision to this cognitively impaired individual who was a known elopement risk. 6. Resident CR1 was a 42 year old male who was admitted to the facility on 11/27/02 with diagnoses which included chronic hepatitis C, alcoholic cirrhosis, esophageal varices, liver failure, alcohol abuse, a psychotic disorder, and depression. On 11/27/02, facility staff completed a "Safety Skills Assessment" for resident CR1 which documented the following: - he "drinks alcohol" - he was "oblivious to safety" - he was not familiar with the community around facility - he could not find his was back to facility - he required supervision in the community On 11/27/02, facility staff completed an "Elopement Risk Care Plan" for resident CR1 which documented that he needed "supervision in the community r/t cognitive loss m/b oblivious to safety need and safety/seeks etoh (alcohol)". The goal for this care plan was "resident will have zero episodes of leaving facility, unless supervised by staff." A care plan for resident CR1, with a target date of 3/6/2003, included the following problem as identified by social services, "Cognitive status/skill/ability has deteriorated in the past 90 days". A psychosocial assessment was completed on 11/27/02 by the LCSW and documented that resident CR1 needed "assistance with all activities of daily living..." and "has some problems with depression and is delusional."	{F 224}		

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{F 224}	Continued From page 17 On 5/4/03, a facility nurse completed an incident report regarding resident CR1 and documented the following: "Resident returned to facility @ 0100 this AM vomited 500 cc (cubic centimeters) of coffee ground emesis. Stated he had 6 shots of whiskey and 4 beer...Pt. (patient) was also drinking a full bottle of Old Milwaukee in bed." The nurse's note in the medical record of resident CR1, dated 5/5/03 at 3:00 AM, also noted that the resident stated, "I'm peeing blood." The nurse notified the physician and received orders to send resident CR1 to the hospital emergency room. Two of the diagnoses for resident CR1 were esophageal varices and cirrhosis. Brunner and Suddarth's Textbook of Medical-Surgical Nursing, Ninth Edition, Volume 2, Lippincott, 2000, pg. 951, reads "Bleeding or hemorrhage from esophageal varices occurs in approximately one third of patients with cirrhosis and varices. The mortality rate resulting from the first bleeding episode is 45% to 50%; it is one of the major causes of death in patients with cirrhosis. The mortality rate increases with each subsequent bleeding episode...The patient with bleeding esophageal varices may present with hematemesis (blood in vomit), melena (blood in the stool), or general deterioration in mental or physical status, and often has a history of alcohol abuse." The facility failed to prevent neglect by not providing adequate supervision to this cognitively impaired individual who was a known elopement risk with a history of alcohol abuse. 7. Resident 41 was a 78 year old male who was	{F 224}		

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{F 224}	Continued From page 18 admitted to the facility on 12/19/01 with diagnoses which included paranoid schizophrenia and neurosyphillis. The most recent MDS, dated 3/1/03, documented the following regarding resident 41: - he had both short and long-term memory problems - his cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) - he had periods of altered perception or awareness of surroundings (moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) - he had periods of restlessness - his mental function varied over the course of the day - he had episodes of disorganized speech A psychosocial assessment was completed by the LCSW on 2/26/03 and documented the following regarding resident 41: - he "needs total assistance with all activities of daily living..." - he "is unable to communicate most of his needs and concerns" - "he has some episodes of confusion to place and time" - "this individual has a court appointed legal guardian" An "Elopement Risk Assessment" was completed by facility staff on 4/1/02 and documented the following regarding resident 41: - his cognitive functioning was "impaired" - he required "24 (hour) assistance, supervision" - that his decision-making abilities were "poor" and that he was "unable to make decisions" - that he "wanders aimlessly" - he had a history of elopement	{F 224}		

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{F 224}	Continued From page 19 - that he was a potential elopement risk - that he was oblivious to his safety needs and was unable to find his way home An "Elopement/Safety Risk Care Plan" was completed by facility staff on 2/27/03 and documented that resident 41 "requires supervision in the community r/t cognitive loss m/b oblivious to safety needs and severe short term memory, unable to communicate..." The goal for this care plan was "resident will have zero episodes of leaving facility, unless supervised by staff." A care plan with a target date of 2/27/03, included the following problem areas as identified by social services: - "Wanders with no rational purpose, seemingly oblivious to needs or safety (less than daily or daily/frequently)" - "Decisions are poor, cues/supervision required r/t: schizophrenia" - "Cognitive status/skill/ability has deteriorated in the past 90 days" On 3/25/03, a nurse's note in the medical record documented the following regarding resident 41: "I entered resident's room and he was not in bed. I notified the CNA'a (certified nurse aides) and we searched the facility and grounds and could not locate resident. I conducted another search and saw bus. (business) office door was open and outside door was propped. I went outside and saw resident approaching the building. Resident had old bruises but no new injuries were noted. Resident's skin was cold and a sweater was placed on resident. Resident's wandergard [sic] was intact. Resident denied any injury and stated that he 'just went to the store'...Resident was found at 0545 (5:45 AM)."	{F 224}		

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{F 224}	Continued From page 20 On 4/13/03, at 8:30 AM, a nurse's note in the medical record documented the following regarding resident 41: "Resident was found by SLC (Salt Lake City) Police Dept. (Department) sitting in the parking lot of 7-Eleven- CNA's retrieved pt. (patient) he was returned to facility Zero injuries noted..." Resident 41 would have had to cross 3300 South (busy four-lane street) to reach the 7-Eleven The facility failed to prevent neglect by not providing adequate supervision to this cognitively impaired individual who was a known elopement risk. 8. Resident 35 was a 38 year old male who was admitted to the facility on 4/1/03 with diagnoses which included paraplegia, transient organic mental disorder and post head trauma syndrome. The admission MDS assessment, dated 4/14/03, documented the following regarding resident 35: - he had short-term memory problems - his cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required) - he had episodes of disorganized speech - he had periods of restlessness A psychosocial assessment was completed by an LCSW on 4/6/03, and documented the following regarding resident 35: - he "needs assistance with all activities of daily living" - he "is mobile with the use of a wheelchair" - he "has some episodes of confusion at times" - he "is a danger to himself" - he "has some problems with depression" - he has "a court appointed legal guardian"	{F 224}		

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{F 224}	Continued From page 21 An "Elopement/Safety Risk Care Plan" was completed by facility staff on 4/1/03 and documented that resident 35 "requires supervision in the community r/t cognitive loss m/b oblivious to safety needs and resident safety." The goal for this care plan was "resident will have zero episodes of leaving facility, unless supervised by staff." A care plan with a target date of 7/10/03, included the following problem as identified by social services: "Decisions are poor, cues/supervision required r/t: Transient organic mental disorder nos (not otherwise specified)." A facility incident report, dated 4/4/03 at 5:45 PM, documented "Got out of building he can't recall who let him out was located @ Albertson's (grocery store) in the parking lot." To get to the Albertson's parking lot, resident 35 would have had to cross 900 East (busy 2-lane street). The nurse documented that there were no apparent injuries. The facility failed to prevent neglect by not providing adequate supervision to this cognitively impaired individual who was a known elopement risk. 9. The facility's policy and procedure regarding "Elopement Assessment and Prevention" was reviewed on 5/13/03 and 5/14/03. The policy stated: "Residents who are wander/elopement risks should be identified prior to or at the time of admission. Identified wander/elopement risk residents shall be observed and supervised to minimize their wondering [sic] away from the facility." The facility had established three categories for its residents; those who required a wanderguard, those	{F 224}		

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{F 224}	Continued From page 22 who required supervision outside of the facility and those who did not require supervision outside of the facility. The facility put each resident into one of the categories and posted this information at both nurse's stations. It should be noted that three of the residents (32, 4, CR1) who were classified in the "Do not require supervision outside Facility" were cited within this immediate jeopardy deficiency. Resident 32 was the individual who was observed standing in the middle of a busy four-lane street, resident 4 was the individual hit by the UPS truck and resident CR1 was the individual who returned to the facility vomiting coffee ground emesis and complaining of blood in his urine after drinking a large amount of alcohol. Number 12 on the facility's Elopement and Prevention Policy stated "Residents are requested to sign in and out on the Release of Responsibility for Leave of Absence (LOA) form." During an interview with the administrative staff on 5/13/03 at 2:15 PM, the facility staff were asked if anyone monitored the "LOA book" to ensure that it was being filled out correctly, to see if residents were signing in and out and to follow-up with resident whereabouts. The ADON stated, "No". Number 6 of the facility's Elopement and Prevention Policy stated, "Plan of Care interventions should address resident's specific behavioral patterns." Review of facility care plans revealed that staff used the same pre-typed care plan for each resident called the "Elopement/Safety Risk Care Plan". The care plan listed the same problem, same goal and same approaches for each resident.	{F 224}		

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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

(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 224}	Continued From page 23 Number 7 of the facility's Elopement and Prevention Policy stated, "Residents without a history of wandering and/or elopement should be accounted for at least every two hours day and night by C.N.A.'s (certified nurse assistants)." Two state surveyors made observations within the facility on 5/12/03 from 6:00 PM to 9:15 PM. No staff were observed at or near the north nurse's station to monitor the main entrance (closest to the business office) to ensure that residents were adequately supervised. On 5/13/03, the facility was asked if they had any documentation to evidence that they had been monitoring the AWOL/elopement situation in the building. Surveyors were presented with a document labeled "Standards of Care Intervention Team Meeting" which was dated 3/19/03. Problem #12 on the meeting minutes addressed "Safety for res (residents) who are allowed to leave the building". The listed "cause" was "Res not crossing street at cross walk". The team recommendations were "Speak to staff and res Watch res when they leave building disabled people ahead street signs". The follow up was to "monitor" and the person assigned to the task was "staff". Facility staff were not able to provide documentation to evidence that monitoring had taken place, what kind of monitoring was performed or who had performed the monitoring. The facility failed to adequately assess, care plan, supervise and intervene for these cognitively impaired residents with known elopement risks. 10. Resident 40 was admitted to the facility on 9/4/02, with diagnoses of insulin dependent diabetes mellitus, degenerative joint disease, hypertension, schizophrenia, subdural hematoma, seizure disorder, borderline personality disorder, major depression and	{F 224}		

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{F 224}	Continued From page 24 chronic obstructive pulmonary disease. Resident 40's medical record was reviewed 5/14/03 through 5/19/03. On 8/30/02, a pre-admission screening for resident 40 was completed by a licensed clinical social worker. On page 4 the diagnostic impressions included, "...has a hx (history) of self-harm that is impulsive in nature...His self-harm behaviors are related to access to sharps..." On page 11 the reasons to warrant the admission of resident 40 to a nursing facility included, "...Poor short-term memory. Poor insight and judgement. Needs close monitoring for any sharp objects or suicidal intent..." On 9/4/02, resident 40 was admitted to the facility with a history of self injurious behaviors and suicide attempts/ideation. A "Psychosocial Assessment" completed by the facility consultant social worker on 9/6/02, did not identify that resident 40 had a history of self injurious behaviors or suicidal attempts/ideation. On 9/11/02, resident 40's physician documented, "...Cuts on himself when upset..." On 11/14/02 at 11:40 AM, a facility nurse documented, "...showed CNA (certified nursing assistant) his [left] anterior wrist which has approx (approximately) 4 in (inch) long, superficial but slight bleeding. [Resident 40] stated he did it to himself [with] a plastic knife he obtained from dining rm (room) drawer..." On 11/30/02 at 3:00 PM a facility nurse documented, "[Resident 40] came to nursing station [with] paper towel over [left] anterior wrist which was saturated	{F 224}		

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{F 224}	Continued From page 25 [with] blood. [Resident 40] says "I did it with a thumb tac." I uncovered wound [and] found 6 cm (centimeter) long laceration [with] moderate amt (amount) of bleeding...I told [resident 40] he made a wound that may require sutures [and] the ER (emergency) room..." On 12/4/02 at 2:55 PM, a facility nurse documented, "[Resident 40] came to nursing station [and] had blood soaked paper towel over [left] wrist (anterior). 5 cm laceration [with] mod (moderate) amt (amount) bleeding..." On 12/30/02 at 2:25 PM, a facility nurse documented, "[Resident 40] came to nursing station [and] [left] anter (anterior) wrist bleeding, sm (small) 2 cm vertical incision (usually he does horizontal) just SQ (subcutaneous) with sm (small) to mod (moderate) amt (amount) of bleeding. Removed knife he claims to have obtained from the Christmas dinner..." On 1/7/03 at 2:30 PM, a facility nurse documented, "[Resident 40] had 4 cm long, horizontal self inflicted slit on [left] wrist...[Resident 40] used a tac to inflict injury..." On 1/24/03 at 2:30 PM, a facility nurse documented, "[At] 10:30 [resident 40] came to me [and] showed me his [left] anterior wrist, covered [with] paper towel...[left] anterior wrist [with] 2 cm horizontal slit...[Resident 40] said he did it with a tac..." On 1/29/03 at 9:30 AM, a facility nurse documented, "Pt (patient) appeared [at] nsg (nursing) station [with] 1 1/2 cm cut on [left] wrist- minimal bleeding..." On 1/31/03 at 4:45 PM, a facility nurse documented, "[Resident 40] came to nursing station [with] paper towel over [left] wrist [and] paper towel was saturated	{F 224}		

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{F 224}	Continued From page 26 [with] bld (blood). [Check] revealed about 5 cm horizontal self inflicted slit. [Resident 40] refuses to reveal the tool used..." On 2/8/03 at 10:20 AM, a facility nurse documented, "...was gone maybe 5 min (minutes) [and] returned [with] 4 cm horizontal slit to [left] wrist, bleeding moderate [and] slightly lying open..." A monthly summary dated 3/18/03, a facility nurse documented that resident 40 was withdrawn, easily gets upset and was cooperative. In addition, the facility nurse documented, "...Continues to cut wrist [with] any thing he can find..." On 4/26/03 at 11:45 AM, a facility nurse documented, "...[resident 40] came to nursing station [and] said "I have to be honest" [and] showed me his [left] anterior wrist, which had an approx (approximate) 3 cm slit [with] minimal bleeding. Horizontal slice..." An Accident/Incident Report" dated 4/26/03 at 11:30 AM, documented, "...[Resident 40] said he obtained the razor blade from a razor found in the shower rm (room)..." On 4/29/03 the 7:00 AM to 3:00 PM shift, a facility nurse documented, "...requesting wandergaurd be moved to ankle...eventually cut it off himself [with] razor blade..." The "Behavior Care Plan" for resident 40 was completed on 12/10/02, by facility staff which identified the following problems: "Self mutilation Makes small superficial cuts on arms, then shows staff Uses plastic knifes, push pins, sharp objects" The facility staff identified the following possible triggers/precipitators:	{F 224}		

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{F 224}	Continued From page 27 "Environment Situation Hates self Attention-seeking Boredom" The facility's plan of action included: "Assess situation Refer to Valley Mental Health Refer to Advanced Behavioral Care and notify psychologist Remind resident that behavior is dangerous Review in psychotropic med review" The facility's documented the following desired outcome for resident 40: "Resident will have [zero] episodes of cutting self Ask for help or to speak with psychologist before cuts" On 5/14/03 at 9:00 AM, an interview was held with resident 40. Resident 40 stated about 3-4 weeks ago he had obtained a bic razor from a shower room and used it to cut his left wrist. In a follow-up interview with resident 40 on 5/16/03 at 9:30 AM, resident 40 stated that he had injured himself with a razor blade more than once. Resident 40 stated that his intent was to hurt himself. He further stated that when he was in the mood to hurt himself he would try to find something like a razor blade or thumb tac or knife. When asked where he would look to find these items resident 40 stated he would look in the facility halls and rooms. On 5/16/03 at 10:15 AM, a facility nurse stated that resident 40 was admitted with suicidal attempts but resident 40's psychologist had told her they were not suicidal attempts just self mutilation. She further stated that he has obtained items like thumb tac's, plastic utensils and a razor blade from a shower room to injure himself with.	{F 224}		

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{F 224}	Continued From page 28 On 5/16/03 at 10:50 AM, a facility CNA stated that resident 40 had injured himself with a thumb tac a long time ago and for awhile after that they had done 15 minute checks on him. When asked how long ago she stated she did not know the exact time but it was quite awhile ago. On 5/16/03 at 10:55 AM, a facility CNA stated that he usually works nights and they don't monitor resident 40 at night because he usually injures himself during the day. On 5/19/03 at 8:50 AM, an interview was held with the facility's social service worker. The social service worker stated that the facility was aware of resident 40's behaviors prior to him being admitted to the facility. She further stated that resident 40's injuries had been superficial and at times they had contacted the resident's psychologist. She stated that resident 40 had injured himself with push pins, plastic knives and razor blades. She also stated that they do a lot of monitoring of resident 40. When asked what kind of monitoring, the social service worker replied "we just monitor". The social service worker further stated that the facility assesses the resident and depends on the professionals to intervene. The social service worker stated that she receives all resident behavioral reports. When asked for behavioral reports for resident 40 she was only able to provide one behavioral report concerning resident 40's self injurious behaviors. On 5/19/03 at 3:45 PM, an interview was held with resident's 40 psychologist. The psychologist stated he works for resident 40 not the facility and that he does not participate in any facility interdisciplinary team meetings. He further stated that he usually just speaks with resident 40, but on two occasions he was concerned enough to speak with the facility staff. The	{F 224}		

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{F 224}	Continued From page 29 psychologist stated that he was aware of at least 10 incidents of resident 40 causing self injurious behaviors in the past 6 months but the facility had only contacted him concerning 2 of the incidents. He further stated that he should have been contacted with each incident. When the psychologist was asked what resident 40 would injure himself with, he stated razor blades usually, but could get his hands on any number of things. The psychologist stated cutting is not a danger to resident 40, "it's just cutting". When asked if cutting is a risk for harm the psychologist stated "right". The psychologist stated that he had visited with resident 40 today (5/19/03) and that resident 40 felt like cutting if he could get access to something. When asked if he had informed the facility staff the psychologist replied that he had not. The psychologist was also asked if he had provided in-services to facility staff regarding the types of things which would trigger resident 40 to hurt himself and what interventions the staff could implement to possibly reduce resident 40's self-injurious behaviors. The psychologist stated that he had not. The facility failed to prevent neglect by not providing adequate monitoring, supervision and assessment to this individual who had known self injurious behaviors.	{F 224}		
{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	{F 225}	Investigations will be done on all bruising of unknown origin. The facility social worker was inserviced on 6/11/03 about reporting all injuries of unknown origin. Resident 40 has a bruise like birthmark on his back that could have been mistaken for a bruise. All injuries of unknown origin will be addressed in a monthly quality assurance meeting.	6/11/03

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{F 225}	Continued From page 30 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 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 interview and record review, it was determined that the facility did not report or investigate a bruising of unknown origin. Resident identifier: 40 As part of the off site preparation for a recertification survey, state agency records are reviewed to determine if the facility has reported any injuries of unknown origin to the State Agency and or Adult Protective Services.	{F 225}		

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{F 225}	Continued From page 31 Findings include: Resident 40 was admitted to the facility on 9/4/02 with diagnoses of insulin dependent diabetes mellitus, degenerative joint disease, hypertension, schizophrenia, subdural hematoma, seizure disorder, borderline personality disorder, major depression and chronic obstructive pulmonary disease. During a record review of resident 40's medical record on 5/19/03, a nurse's note dated 2/6/03 11:00 PM-7:00 AM shift, revealed the following, "...Bruise approx. (approximately) 3 cm (centimeters) X (by) 2 cm present on pt's (patients) [left] upper back area. Pt (patient) states he does not know how he received bruise..." The facility social worker on 5/19/03 at 8:50 AM stated, bruises are not always reported and if they are they will be on an incident report. She further stated that she did not have any incident reports in February 2003 concerning bruising of unknown origin for resident 40. A review of the facility's incident reports was completed on 5/19/03. There was no incident report completed to document how resident 40 may have sustained a bruising of unknown origin on 2/6/03. The facility could not provide documentation to evidence that the injury of unknown origin regarding resident 40 had been thoroughly investigated or reported to the required agencies.	{F 225}		
{F 226} SS=D	483.13(C)(1)(i) STAFF TREATMENT OF RESIDENTS	{F 226}		

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{F 226}	Continued From page 32 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. (Use F226 for deficiencies concerning the facility's development and implementation of policies and procedures.) This REQUIREMENT is not met as evidenced by: Based on review of the facility's abuse policies and procedures and interview it was determined that the facility failed to develop written policies and procedures which addressed identification of possible instances of abuse. Findings include: The facility's abuse policies were reviewed on 5/14/03 and 5/15/03. The abuse policies and procedures did not address identification (to include events such as suspicious bruising of residents, occurrences, patterns and trends which may constitute abuse). See the correlating deficiency cited at F225. On 5/15/03 at approximately 5:30 PM, the facility administrator stated that the abuse policy and procedure that he provided to the survey team was what the facility was currently working off of.	{F 226}	The abuse poilicies and procedures were updated to address identification of suspicious or unknown origin of bruising of residents, occurrences, patterns and trends that may constitute abuse. All injuries of unknown origin will be addressed in a monthly quality assurance meeting.	6/2/03
{F 241} SS=E	483.15(a) QUALITY OF LIFE The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full	{F 241}		

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{F 241}	Continued From page 33 recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based upon observations and interviews, it was determined that for 1of 14 residents and 8 additional residents, the facility did not promote care for its residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. Resident identifiers: 52, 17, 1, 6 and 48. Findings include: 1. On 5/13/03 at 6:37 AM, resident 52 was observed sitting on the toilet in her room providing person cares to herself. The doors to both her bathroom and her bedroom were both open and resident 52 could easily be seen from from the main hallway. A facility nurse aide was observed to stop in and visit with resident 52 while she sat on the toilet and was heard to say, "Remember it's your shower day today." The aide left and did not shut either door to allow resident 52 dignity while attending to personal cares. On 5/13/03 at 12:20 PM, resident 52 was observed using the bathroom in her room. The doors to her bathroom and room were both opened. Resident 52 was visible from the hallway. Resident 48 was observed in his wheelchair in the hallway outside of resident 52's room while she was using the restroom. 2. On 5/17/03, at approximately 8:15 AM, resident 17 was observed to leave the dining room in a grey sweat outfit which had multiple large clumps of food debris on it from breakfast. At 9:30, while the surveyor was visiting resident 17 in his room, he was observed to still have the same food debris all over the front of his sweat shirt and on his sweat pants.	{F 241}	OK 6 Resident 52 was encouraged to close door while using the restroom and reminded that a rope was provided to assisst her in closing the bathroom door. All staff will encourage all residents to keep door closed while using the toilet. In service to educate staff on preserving dignity and shutting doors done on 6/3/03 and will be redone on 6/25/03. Inservice is scheduled on 6/25/03 about cleaning up residents after meals. Resident room was spoken to about how his meals were displyed and he does not want to change. Resident 1's personal aide was spoken to and asked if he would provide a platter to display the food. Inservice was done on knocking and waiting prior to entering the resident rooms. Issue will be readdressed at an in service on 6/25/03. Signs are posted throughout the facility and at every resident room reminding staff to knock and wait for a response before entering. Dignity related issues will be addressed at a monthly quality assurance meeting. The administrator will monitor weekly for the first 90 days dinigty issues related to the shutting of resident bathroom doors, knocking and waiting before entering resident rooms, serving residents at the same table at the same time and the cleaning of residents after meals. Resident 52,17,1,6 and 48 will specifically be monitored weekly for the identified dignity issue in the defeciency.	6/25/03

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{F 241}	Continued From page 34 3. On 5/13/03 and 5/19/03, resident 1 was observed to be fed his breakfast off a large cafeteria tray, not a plate. Staff were observed to take his food and place it all over the tray and then assist resident 1 to eat. The set up of his food did not promote dignity for resident 1. 4. During the confidential group interview on 5/14/03, four residents stated that either staff did not knock prior to entering their rooms, or staff knocked as they walked into their rooms not giving them the opportunity to respond. 5. During meal observations on 5/13/03 and 5/14/03, it was noted that not all residents sitting at the same table were served at the same time. Residents who had not been served were observed to sit and watch their tablemates eat, sometimes for 20 or more minutes. For example, on 5/14/03, breakfast in the dining room was observed. Residents 6, 48 and 52 were observed to share a dining room table. At 7:50 AM, resident 48, was observed to receive his breakfast. At 8:00 AM (10 minutes after resident 48 was served his meal), resident 52 was observed to receive her breakfast. At 8:12 AM, after resident 6 got up and complained about not having been served his breakfast, resident 6 was observed to receive his breakfast. This was 22 minutes after resident 48 received his meal and 12 minutes after resident 52 received her meal. 6. On 5/15/03 at 7:50 AM, a staff member was observed to enter rooms 214, 215 and 217 without knocking to distribute linens. 7. On 5/19/03 at 8:37 AM a staff member was observed to walk into room 216 with a breakfast tray without knocking or identifying herself.	{F 241}		

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{F 242}	Continued From page 35	{F 242}		
{F 242} SS=D	483.15(b) QUALITY OF LIFE The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, individual interviews and record review, it was determined that for 1 of 14 residents and 1 additional resident the facility did not allow the residents the right to make choices about aspects of their life in the facility that were significant to them. Specifically, one resident was put on a weight loss program in which he was not involved in the decision and did not want to lose weight and another resident had his smoking privileges taken away from him. Resident identifiers: 13 and 40. Findings include: 1. On 5/12/03 at 7:30 PM, resident 13 was observed to ask one of the facility nurses for a cigarette. The nurse stated to the resident that his smoking privileges had been taken away due to his smoking in his room. The nurse then told the resident he could talk to the administrator about it. The resident stated to the facility nurse that he had smoked in his room over a week ago and was then observed to walk away without speaking to the administrator. On 5/12/03 at 7:35 PM, the facility administrator stated that resident 13 had his cigarettes taken away due to smoking in the bathroom. The administrator	{F 242}	Resident 13 is on hourly staff supervised cigarrette breaks. Staff will also monitor posssession of lighters and other cigarette materials. All residents will be informed of their diet. Resident 40 is no longer on a weight reduction diet. Nursing and dietary staff will get approval regarding any diet changes. All physician approved diet changes will be noted by dietary supervisor and list given to administrator with resident consent if applicable and resident notification of change on a monthly basis for review. Resident rights related issues will be addressed in a monthly quality assurance meeting.	6/2/03

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	465142	A. BUILDING _____ B. WING _____	R 05/27/2003

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{F 242}	Continued From page 36 further stated, that resident 13 had been assessed by the DON and ADON and was not to get any cigarettes from the facility. The administrator stated that resident 13 will get cigarettes from other residents. On 5/12/03 at 8:30 PM, the facility administrator told the surveyor that resident 13's physician had written an order to have the resident's smoking privileges taken away. A physician order dated 5/1/03,documented the following, "[Due to] smoking in facility being a danger to self [and] others residents [resident 13] has lost his smoking privlidges[sic] [at] Granite hills." On 5/1/03 7:00 AM to 3:00 PM shift, a facility nurse documented, "Resident has been found numerous times smoking in bathroom. Res (resident) has had supervised smoking on back patio. Res will butt smoke (smoke others people's cigarette stubbs) and then found later smoking in room..." There was no documentation in the medical record to evidence that the facility had attempted consistent one on one, staff to resident, supervised smoking privileges for resident 13. 2. On 5/14/03 at 9:00 AM, resident 40 told the surveyor that the facility won't let him have any extra food and that the facility had put him on a diet. Resident 40 further stated that he did not know who had placed him on a diet but that he did not want to be on one. On 5/16/03 at 9:30 AM, resident 40 told the surveyor that on the previous night he wanted more food and that the facility staff would not give him any so he took food off of another resident's tray. Resident 40 further stated that the facility staff told him he was not to do	{F 242}		

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{F 242}	Continued From page 37 that and he did not understand why because he had seen other resident's take food off of other resident trays. On 12/15/02, the dietary manager documented the following, "...weight 231 [down] 9 lb (pounds) [times] 3 months weight loss is planned will cont (continue) same. Some non compliance noted..." On 3/13/03, the dietary manager documented the following, "...Resident has weight gain...NCS (no concentrated sweets) diet restrictioned [sic]. Resident is consuming other residents food at meals. Reminders required of need for weight loss..." There was no documentation in the medical record to evidence that resident 40 had consented to a planned weight loss program. There was no care plan in the medical record that addressed a planned weight loss for resident 40. On 5/19/03 at 8:35 AM, the dietary manager stated that resident 40 was on a weight loss program up until last week when she talked with him and he told her he did not want to be on a weight loss program. She further stated that resident 40 would take food from other resident trays. The dietary manager stated that resident 40 would get regular portions when she wanted him to lose weight he would just not get any seconds.	{F 242}		
{F 253} SS=E	483.15(h)(2) ENVIRONMENT The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by:	{F 253}		

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{F 253}	Continued From page 38 Based on observations over six days of survey and interviews with residents and staff, it was determined the facility did not provide housekeeping and maintenance services as needed to maintain a sanitary and comfortable interior in common areas and some resident bedrooms and bathrooms. Findings included: Observations were made of the facility interior areas on 5/12/03, 5/13/03, 5/14/03, 5/15/03, 5/16/03 and 5/19/03. Identified concerns were: Floors in all hallways had the appearance of both surface dirt and ground in dirt across the width and length of the hallways, especially on the east side of the building. The baseboards along the hallways had visible, textured dust along the top edges and dirt and scuff marks up the sides. In an area near the east patio door and the north nurse's station, cottony dust pillows remained for two days, on 5/15/03 and 5/16/03. In a mini-exit with the administrator and department heads, at 5:10 PM on 5/15/03, the corporate administrator stated, "They've been buffing the dirt in." She stated the floors had been scheduled to be cleaned, but were rescheduled due to survey. The carpet in the day room was soiled and stained. The laundry room that is used by residents had small, portable heating type units on the floor in front of the washing machine. There was a bulky pile of a brown substance in the corner between the dryer and the wall. A dried pile of feces was observed crusted over the cords on the heaters on 5/12/03, 5/13/03, 5/14/03, 5/15/03 and 5/16/03. On 5/19/03, after the equipment had been removed, some of the crusted feces remained.	{F 253}	All floors were stripped and waxed and a deep cleaning schedule of resident rooms has been developed. The carpet in the dayroom was spot treated and cleaned entirely. The resident laundry room will be part of the daily housekeeping responsibilities. The downstairs resident bathroom is now part of the daily housekeeping responsibilities. Daily housekeeping responsiblities were placed on each cart and will be monitored by the housekeeping supervisor weekly for 60 days. Housekeeping staff was in serviced about cleaning responsibilites. Housekeeeeping related issues will be addressed in a monthly quality assurance meeting.The hole has been covered in the downstairs resident bathroom. The dresser in room 114 is owned by a resident and he does not want the bottom drawer attached. The bottom drawer was thrown away. Housekeeping staff was in serviced about cleaning responsibilites.In maintenance monthly quality assurance rounds furniture in rooms will be addressed to whether it needs replacement or fixing. Holes in walls wil be identified in monthly quality assurance rounds by the maintenace supervisor and put in the maintenace log if discovered by other staff members. The administrator will monitor in monthly quality assurnace meetings that holes are being patched in a proper amount of time.	6/16/03

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{F 253}	Continued From page 39 The residents' bathroom that was downstairs by the dining room had built up dirt on the floor, around the edges of the room and on the walls. There was a hole approximately 11 inches by 7 inches in the wall to the left of the commode. Across the hall from room 206, an electrical outlet was dirty and the bottom left corner was broken off. On 5/14/03, a white shirt and a pair of men's undershorts were on the floor of the laundry room, at the bottom of a table used by the surveyors. The clothing had solid feces over it. Room 211 had a doorknob size hole behind the door. Around the hole there was an area approximately 8 inches square that appeared to have been plastered but not painted or repaired. There was an area approximately 1/8 inch wide and 24 inches high against the right side of the bathroom door frame where the wall board didn't quite meet the door frame. In room 114, the resident's dresser drawer had the front of the bottom drawer broken off and laying on the floor against the dresser. A blue lounge chair in room 207 near the door was soiled. There was a black build up of dirt along the edges of the room, greatest in the area of the entrance. The bathroom that room 207 shared with room 206 had one roll of toilet paper on 5/12/03. The paper was on the back of the toilet so that it had to be handled by anyone who wanted to use it. On 5/15/03 and 5/16/03, there was no toilet paper in the bathroom. The sink was loose from the wall, paint was chipped from the wall to the left of the soap dispenser. Raised spears of a substance were dried on the light switch cover and	{F 253}		

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{F 253}	Continued From page 40 on the wall under the light switch. Dirt build up was around the door frame on both sides of the room and in the tile / linoleum joint. The wall was dirty behind the sink and around the toilet. There was a dark, raised substance and scrapes on the bottom and sides of the bathtub. In room 113, the closet door had holes and chips in the wood and was duct taped together. The bathroom shared by room 113 had a gouge in the wall about 3 inches long by 1/4 inch wide. Showers had hoses that were long enough for the shower heads to rest completely on the floor were without anti-syphon valves. One in the main shower room had the valve, and one did not. Room 104, bed B, was observed to have a broken side rail attached. The right side rail did not fit snugly against the mattress. It was observed that a bolt was missing where the top of the right side rail should have been attached, and that the side rail leaned at a 30 degree angle away from the bed. The top bar of the side rail rested three to four inches away from the mattress while the bottom bar of the side rail was against the mattress. The top bar of the side rail moved another three inches away from the mattress when it light pressure was applied. The bathroom used by the nurses and nurse aides at the north side nurse's station was observed on 5/13/02 from 8:00 AM until 10:00 AM to have no soap or paper towels. A second observation of no hand soap was made of the north side nursed station on 5/15/03. During all days of survey, the north nurse's station did not appear to have been swept or mopped. Visible dust and surface dirt remained constant. The baseboards of the entryway into the north nurse's	{F 253}		

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{F 253}	Continued From page 41 station were splintered and there was a large build up of dirt. The privacy curtain in room 201 was soiled and had a stain approximately 5 inches long. Paint was scraped along the west wall. Room 206 had a plastered area on the west wall which measured approximately 20 inches square. There were pink splatters on the ceiling and textured debris on the ceiling above bed A. The resident in the room stated that his room needed to be painted. There was mildew on the floor and up the shower wall in the bathroom shared by room 204 and 205. The wall was dirty behind and around the sink and toilet with three dime-size chips in the paint. Rooms 204 and 109 had broken window sills.	{F 253}		
{F 279} SS=E	483.20(k) RESIDENT ASSESSMENT The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under s483.25; and Any services that would otherwise be required under s483.25 but are not provided due to the resident's exercise of rights under s483.10, including the right to refuse treatment under s483.10(b)(4).	{F 279}	Ok On 5/22/03 the IDT committee resident 40's psychologist and a MSW consultant met, reviewed, approved and signed a new Behavioral Care Plan for Resident that identified specific triggers and interventions to prevent resident cutting.On 5/22/03 Nursing staff signed on a copy of the new Behavioral Plan that they have read and understand making them aware of behaviors (triggers) and interventions for Resident 40. There have been no incidents of resident 40 causing injury to himself. If an incident of self injury occurrs the behavioral care plan will be addressed in IDT meeting and incident discussed.	

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{F 279}	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for 5 of 14 sample residents and an additional 4 supplemental residents, the facility did not develop comprehensive care plans for each resident based on their individual needs identified by the facility staff. Resident identifiers: 4, 13, 32, 33, 35, 40, 41, 42 and CR1 Findings include: 1. Resident 40 was admitted to the facility on 9/4/02, with diagnoses of insulin dependent diabetes mellitus, degenerative joint disease, hypertension, schizophrenia, subdural hematoma, seizure disorder, borderline personality disorder, major depression and chronic obstructive pulmonary disease. Resident 40's medical record was reviewed 5/14/03 through 5/19/03. On 9/11/02, resident 40's physician documented, "...Cuts on himself when upset..." A "Psychosocial Assessment" completed by the facility consultant social worker on 9/6/02, did not identify that resident 40 had a history of cutting himself when upset. The care plan completed by the consultant social worker on 9/6/02 did not incorporate a plan of care which addressed self injurious behaviors. The "Behavior Care Plan" for resident 40 was completed on 12/10/02, by the facility staff which identified the following problems: "Self mutilation	{F 279}	A revised elopement risk assessment was completed on every resident addressing individual goals and approaches for each resident. If elopement occurrs the elopement risk assessment will be reviewed and elopement incident addressed in a monthly quality assurance meeting. During quarterly IDT meeting elopement assessments and care plans will be re-assessed and updated. Individualized elopement risk care plans were developed for every resident including those identified in the defeciency (resident 4,13,32,33,35,40,41,42,CR1 discharged prior to survey.)	6/2/03

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{F 279}	Continued From page 43 Makes small superficial cuts on arms, then shows staff Uses plastic knifes, push pins, sharp objects" The facility staff identified the following possible triggers/precipitators: "Environment Situation Hates self Attention-seeking Boredom" The facility's plan of action included: "Assess situation Refer to Valley Mental Health Refer to Advanced Behavioral Care and notify psychologist Remind resident that behavior is dangerous Review in psychotropic med review" The facility's documented the following desired outcome for resident 40: "Resident will have [zero] episodes of cutting self Ask for help or to speak with psychologist before cuts" From 12/10/02 through 4/26/03, resident 40, had 7 incidents of causing injury to himself. There was no documented evidence in resident 40's medical record to evidence that the facility had re-evaluated resident 40's "Behavioral Care Plan" concerning self injurious behaviors. 2. The facility's policy and procedure regarding "Elopement Assessment and Prevention" was reviewed on 5/13/03 and 5/14/03. The portion of the policy relating to care plans stated, "Plan of Care interventions should address resident's specific behavioral patterns." Review of facility care plans revealed that staff used the same pre-typed care plan for each resident called the "Elopement/Safety Risk Care Plan". The care plan	{F 279}		

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{F 279}	Continued From page 44 listed the same problem, same goal and same approaches for each resident. Please also see tag F - 224.	{F 279}		
{F 312} SS=D	483.25(a)(3) QUALITY OF CARE A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility did not ensure that 2 of 54 residents were given the appropriate services to maintain or improve their dining experience. Specifically: 1. Resident 16 was not assisted with her meal for 20 minutes while her tray sat in front of her. 2. The facility did not assist or make accommodations for resident 23 to comfortably reach her food. Resident identifiers: 16 and 23. Findings include: 1. Resident 16 was observed on 5/12/03 in the dining room during the lunch meal sitting at the total assist table. Resident 16's meal was placed in front of her at approximately 11:50 AM. Resident 16 was observed to watch the aide feed the resident next to her tracking each spoon of food fed to the other resident with her eyes. There was no attempt to feed her until 12:15 PM, 25 minutes after her meal was set in front of her. A review of resident 16's quarterly MDS (minimum data set) dated 4/23/03 documented in section G (physical functioning and structural problems) that resident 16 needs total assistance with eating.	{F 312}	OK SJ In service on proper procedures for feeding and assissting residents in a timely manner to reach foods and accommadate needs. Resident 16 is fed in the dining room on Monday, Wednesday, and Friday during lunch and as many other times as she would like to go. On those days that she dines in the dining room an extra aide will be in the dining room to assist in feeding. Monitoring by the administrator will be done on a weekly basis for the first 90 days for resident 16 and 23 in conjunction with resident dignity monitoring. Topic will be addressed in a monthly quality assurance meeting.	6/25/03

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{F 312}	Continued From page 45 2. Resident 23 was observed on 5/14/03 in the dining room during the breakfast meal. Resident 23 was sitting in her wheel chair at an angle to the table and approximately 18 inches from the table. Resident 23 was observed several times to make attempts to reach the food on her tray. She was able to reach her cereal and milk and was observed to set the items her lap while she ate them. A nurse was observed to bring resident 23 her medication and made no attempt to re-position her chair so she could reach her food. A review of resident 23's quarterly MDS dated 4/17/03 documented in section G (physical functioning and structural problems) that resident 23 needs supervision with eating and help with the set up of the meal.	{F 312}		
{F 324} SS=E	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 observations, interview, and record review, it was determined the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents while being transported in the facility van for 1 of 14 focus residents, one former resident, and 7 additional residents who were observed in an overcrowded van. Residents: 31, 3, 6, 28, 34, 35, 40 and 47 and resident CR2. Observations were made of the interior of the facility van which was used to transport residents to physician's appointments and on recreational outings. On 5/13/03 at 2:15 PM, seven residents, two staff and a driver were observed to be leaving the facility in the	{F 324}		

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{F 324}	Continued From page 46 facility van, which had seat belts and wheelchair tie-down straps to accommodate six people. Three residents were seated in the rear seat and each had a seat belt on. One resident was seated in the front passenger seat and had a seat belt on. Three residents sat in wheelchairs that were not adequately secured to the floor of the van and two other people in the van were not secured by any type of safety device. In the center of the van, one resident sat in his wheelchair on the left side of the van in front of the rear seat. His wheelchair was fastened at the left rear corner and the right front corner with tie-down straps. A second wheelchair was folded and wedged between his wheelchair and the wheel well. Directly behind the drivers seat, another resident was seated in a wheelchair. His wheelchair was fastened in the right rear corner and the left front corner with tie-down straps. Directly behind the passenger seat, another resident was seated in a wheelchair. His wheelchair was fastened with one tie-down strap at the right front corner. One staff member who was accompanying the residents, was able to sit on a small footstool between the wheelchairs. Another person who was accompanying the residents positioned himself partially on the wheel well. The staff member said that they could manage because they were not traveling very far. When the van driver returned to the facility, at 2:50 PM, two surveyors interviewed the driver and	{F 324} OK SJ	Infinia at Granite Hills van driver, was in serviced on 5/25/03 in regards to safe driving including slowing down and securing the residents and not just the wheelchairs. The facility van driver was also in serviced on the maximum number of passengers in the vehicle has to be equal to the number of safety restraints and gait belts available.The administrator will monitor any accident/incident reports with regards to the transportation of residents and speak with the van driver one on one with detailed description of what happened and how it could have been prevented. Van safety will be addressed in monthly quality assurance meetings. The van driver will be in serviced every six months in regards to van safety and upon any new hire. The administrator will monitor weekly for the first 60 days the securing of residents in the van prior to transport.	5/25/03

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{F 324}	Continued From page 47 observed the tie-down straps inside the van. Four tie-down straps were secured to the floor and a fifth tie-down strap was hooked loosely to a wedge on the floor. The fifth tie-down strap slid across the wedge and came free when lightly touched. The van driver was asked how he secured the wheelchairs for safety of the residents during transport. The van driver demonstrated that if one resident in a wheelchair was being transported, the wheelchair could be fastened tightly at all four corners with the tie-downs that were secured to the floor of the van. The van driver stated that when there was more than one resident in a wheelchair to be transported, he used the tie-down straps that were available and that he always drove slowly and carefully to prevent any accidents. The van driver stated, further, that he kept a gait belt (one) to strap a resident into his/her wheelchair, in leu of a seat belt, during transport. The van driver stated there had never been any problems with the wheelchairs while he was driving. In an interview with resident 31, the resident stated that he had been tipped over while being transported to an appointment in the facility van. Resident 31 stated that a tie-down strap had broken as the van was making a turn, and the resident and his wheelchair tipped completely over. The facility's accident / incident reports were reviewed. It was documented that on 4/1/03 at 11:10 AM, resident 31 had fallen over in his wheelchair as the van was making a turn at the normal speed. It was documented that resident 31's right side was up against the passenger side of the van and his chair was half way on its right side. It was documented that resident 31 was having neck pain from falling to the side with his head against the side of the vehicle.	{F 324}		

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{F 324}	Continued From page 48 A previous incident had been reported on 3/13/03 at 11:20 AM. At that time, resident CR2 had been seated in his wheelchair in the facility van. The wheelchair had been secured to the van, but resident CR2 had not been secured with a seat belt. As the van driver slowed to turn into the facility's driveway, resident CR2 slipped out of his wheelchair and landed on the floor of the van.	{F 324}		
{F 329} SS=E	483.25(l)(1) QUALITY OF CARE Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for 3 of 14 sample focus residents and 2 additional residents, the facility did not ensure that the residents were free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring, or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Residents: 27, 31, 38, 35 and 40. Findings include: 1. Resident 31 was a 35 year old male who was	{F 329}	Tracking sheet was completed for resident 31 including target bahaviors of verbal and physical aggression and it will be reviewd quarterly by the IDT team and the psychotropic drug commitee. The MD has requested that resident 31 stay on the Mellaril medication because behaviors are not stable and seizure activity is minimal. Ambien was discontinued per MD order for resident 38. MD has been notified. MD is aware of suggested amount of seroquel for resident 40. Resident 40 is not stable for his self injurous behavior or suicidal idiation therefore the MD has ordered the current dosage of seroquel in attempt to stabilze the bahavioral problems with resident 40. Tracking sheets will be filled out appropriately. Diagnosis clarification received per use of seroquel. Medication given per MD order for resident 27.	3/16/03

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{F 329}	Continued From page 49 admitted to the facility on 2/19/03 with diagnoses which included traumatic brain injury with depression and aggression, seizure disorder, hemiparesis, and history of cerebral vascular accident. Resident 31 was admitted following his hospitalization for a suicide attempt by a self-inflicted drug overdose. The medical record of resident 31 was reviewed on 5/13/03 and 5/14/03. Review of the physician's orders for resident 31 revealed he was receiving Mellaril, an anti-psychotic medication, 25 mg (milligrams) every evening. Mellaril is used to treat schizophrenic patients who don't show an acceptable response to treatment with other anti-psychotic drugs and should be used cautiously in patients with seizure disorders, according to Lippincott's Nursing 2003 Drug Handbook. Further review of resident 31's medical record revealed there was no tracking of behaviors that indicated a need for the medication. The psychotropic drug committee notes for resident 31, dated 4/23/03, documented that resident 31 was receiving an anti-psychotic medication, Mellaril 25 mg (milligrams), every evening for anoxic brain damage with aggression. The members of the psychotropic drug committee did not list any target behaviors for the use of the anti-psychotic medication (Mellaril) being given to resident 35. Review of the February, March and April 2003 medication administration records (MAR) for resident 31, revealed that nurses had not identified and were not tracking target behaviors for the use of the anti-psychotic medication, Mellaril, being given to resident 31. The pharmacist's drug review reports for February 2003 and April 2003 documented the concern that "psych tracking" for resident 31's Mellaril was	{F 329}	Tracking sheet will be filled out to document target behaviors. AIMS sheets are completed Q 6 months with all residents with psychotropis medications. The tracking sheets will be filled out documenting behaviors of verbal and physical agression. Psychotropic drug committee will continue to meet quaterly to address residents on psychotropic medications. Medical records will insure that all tracking sheets have target bahaviors filled out upon redoing the MAR on a monthly basis. Tracking sheets and behaviors related to residents will be addressed in a monthly quality assurance meeting. All medications given per MD order.	

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{F 329}	Continued From page 50 required. Review of resident 31's MAR dated May 2003 revealed that on 5/7/03, the nurses began documenting on an anti-psychotic tracking record. In the section for documenting "Behavior Description / Data Collection, the nurses documented, at the end of each shift, the number (#) of episodes when resident 31 exhibited the "target behavior" (resident's behavior for which medication was being administered). The target behavior for resident 31 was listed as: "# behaviors", and the nurses had documented the resident had "0" (zero) episodes. On 5/16/03, staff who worked with resident 31 were interviewed regarding the resident's behaviors. At 3:15 PM one nurse stated that she didn't know resident 31 but that he might get Mellaril for agitation. A second nurse stated that she didn't remember much about resident 31 but that she understood he fabricated stories. At 3:25 PM, another nurse stated that resident 31 is borderline depressed but is mostly pleasant. The nurse stated that resident 31 has had a couple of physical altercations with one other resident "when provoked". The nurse stated that the two residents had an on-going disagreement. The nurse stated that, "Sometimes we just put the number of behaviors to watch for because we don't know what they're going to be." At 3:40 PM, a nurse aide stated that resident 31 had no physical behaviors, but that he had made an inappropriate statement to her that was sexually suggestive. At 3:45 PM, a nurse aide stated that resident 31 had no behaviors, that he was really nice, and that he tried	{F 329}		

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{F 329}	Continued From page 51 hard to be independent. The social services person was interviewed on 5/19/03. She stated that resident 31 had issues with another resident. The social services person stated that resident 31 could be verbal and could be non-compliant with asking for assistance. She stated that resident 31 had been sexually inappropriate but that was not a current issue. The facility had not identified an appropriate or specific target behavior exhibited by resident 31 to warrant the use of an antipsychotic. 2. Resident 38 was a 28 year-old male who was admitted to the facility on 3/19/02 with diagnoses which included cerebellar ataxia, major depression with psychotic features, cognitive dysfunction and double vision. The medical record for resident 38 was reviewed on 5/17/03. Review of the physician's orders for resident 38 revealed an order, dated 12/31/02, for the resident to receive Ambien 5 mg every evening bedtime, for insomnia. An order, dated 1/31/03, increased the dose of Ambien to 10 mg every bedtime. In addition to the Ambien, an order by a second physician, dated 4/24/03, documented resident 38 was to receive Seroquel (an antipsychotic) 25 mg at bedtime for insomnia which was not relieved by Ambien. Ambien is a rapid-onset hypnotic medication used for short-term, usually 7 to 10 days, treatment of insomnia and the maximum daily dosage is 10 mg, according to Lippincott's Nursing 2003 Drug Handbook. The medication record for resident 38 revealed the resident had received the hypnotic medication every night for	{F 329}		

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{F 329}	Continued From page 52 ninety nights. In addition to the hypnotic medication, resident 38 received a second medication, Seroquel, an anti-psychotic medication prn (given as needed), to augment the sleeping pill. The effectiveness of the medications was not monitored adequately during May 2003, when inconsistencies in the charting made it unclear how much resident 38 had been sleeping. Review of the MAR and the sedative / hypnotic monthly record for resident 38 revealed the resident did receive Ambien every evening at 8:00 PM. The number of hours resident 38 slept during the days (7:00 AM to 3:00 PM), afternoons (3:00 PM to 11:00 PM) and nights (11:00 PM to 7:00 AM) were tracked by the nurses. It was documented that, with the exception of 2/27/03 which was not clearly legible, and 2/28/03 which was left blank, resident 38 slept 8 hours during each night. It was documented that resident 38 did not sleep during the days or afternoons in February. The MARs, dated March 2003 documented by the facility nurses, revealed that resident 38 did not sleep the nights of 3/5/03 and 3/6/03, and the resident slept only 7 hours during the nights of 3/10/03, 3/21/03, 3/22/03 and 3/23/03. Every other night during March 2003, resident 38 slept 8 hours. The MAR documented that on 3/1/03 through 3/31/03, resident 38 began to sleep 1 to 3 hours during the afternoons (with the exceptions of 3/19/03 and 3/20/03). The MAR documented that from 3/11/03 through 3/31/03, resident 38 began to sleep 1 to 3 hours during the days (with one exception on 3/24/03). From 3/14/03 through 4/9/03, resident 38's hypnotic order was changed to Ambien 5 mg at bedtime and an additional 5 mg if he awakened. During March 2003 there were 9 nights that resident 38 received Ambien 5	{F 329}		

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{F 329}	Continued From page 53 mg without a repeat dose. During April 2003 there were 5 nights that resident 38 received the Ambien 5 mg without a repeat dose. Resident 38 received Seroquel on four nights during April 2003, in addition to Ambien 10 mg. The MARs, dated April 2003, documented that resident 38 slept 8 hours every night. It was documented that from 4/1/03 through 4/19/03, resident 38 began to sleep more, 2 to 5 hours, during the day (from 4/22/03 through 4/30/03, resident 38 did not sleep during the day). It was documented that resident 38 continued to sleep 1 to 3 hours every afternoon. In addition to Ambien 10 mg, resident 38 received Seroquel on four nights in May. The number of hours resident 38 slept was documented for each shift on both the sedative / hypnotic monthly record and the anti-psychotic monthly record for resident 38. On 9 of the 18 days charted on resident 38's monthly records for May 2003, the hours he slept were documented differently on the two records for the day shift and / or the afternoon shift. Although documentation on resident 38's MAR was inconsistent for May 2003, it continued to track that resident 38 slept 1 to 3 hours each day and 0 to 4 hours each afternoon. The sedative / hypnotic monthly record for resident 38 tracked that the resident had slept 8 hours every night through 5/18/03. The anti-psychotic monthly record for resident 38 tracked he did not sleep at all during the first 6 nights in May, but he had slept 8 hours every night from 5/7/03 through 5/18/03. 3. Resident 40 was admitted to the facility on 9/4/02, with diagnoses of insulin dependent diabetes mellitus, degenerative joint disease, hypertension, schizophrenia, subdural hematoma, chronic obstructive pulmonary disease, borderline personality	{F 329}		

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{F 329}	Continued From page 54 disorder, major depression and seizure disorder. Resident 40 was admitted to the facility with orders for Seroquel (an antipsychotic) 250 mg three times a day and an additional 50 mg every 6 hours as needed. The admitting orders for resident 40 did not indicate the use of the Seroquel nor did it list target behaviors to be monitored by facility staff. Review of the medical record revealed the following concerning the Seroquel 50 mg as needed dose: 1. "March 2003 Antipsychotic Monthly Record" tracking sheet, did not identify any target behaviors to indicate the use for the as needed Seroquel. A. Resident 40 received the 750 mg scheduled daily dose of Seroquel 18 of the 31 days. B. Resident 40 received the 750 mg scheduled daily dose of Seroquel plus an additional 50 mg, 11 of the 31 days. C. Resident 40 received the 750 mg scheduled daily dose of Seroquel plus an additional 100 mg (2 doses of the 50 mg), 1 of the 31 days. D. Resident 40 received the 750 mg scheduled daily dose of Seroquel plus an additional 100 mg, 1 of the 31 days. A facility nurse documented that she gave the additional 100 mg of Seroquel at one time. There was no physician order to give an additional 100 mg of Seroquel as needed. E. Four of the fourteen times, resident 40 received the additional Seroquel, the facility staff documented the reason being, "C/O (complain of) nerves". One of the fourteen times, resident 40 received the additional Seroquel the facility staff documented the reason as being, "feeling agitated". Eleven of the fourteen times, resident 40 received the additional Seroquel the facility staff did not document on the tracking sheet any reason as to why it was being given.	{F 329}		

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{F 329}	Continued From page 55 2. "April 2003 Antipsychotic Monthly Record" tracking sheet, did not identify any target behaviors to indicate the use for the as needed Seroquel. A. Resident 40 received the 750 mg scheduled daily dose of Seroquel 7 of the 30 days. B. Resident 40 received the 750 mg scheduled daily dose of Seroquel plus an additional 50 mg, 15 of the 30 days. C. Resident 40 received the 750 mg scheduled daily dose of Seroquel plus an additional 100 mg (2 doses of the 50 mg), 8 of the 30 days. D. Six of the thirty-one times, resident 40 received the additional Seroquel, the facility staff documented the reason as being "anxiety". Five of the thirty one times, resident 40 received the additional Seroquel the facility staff documented the reason as being "pt (patient) request". One of the thirty-one times, resident 40 received the additional Seroquel the facility staff documented the reason as being "rejecte" [sic]. Ten of the thirty-one times, resident 40 received the additional Seroquel the facility staff documented the reason as being, "agitation". Two of the thirty-one times, resident 40 received the additional Seroquel the facility staff documented the reason as being, "upset". One of the thirty-one times, resident 40 received the additional Seroquel the facility staff documented the reason as being, "C/O (complain of) depression-cut off wanderguard". Six of the thirty-one times, resident 40 received the additional Seroquel the facility staff did not document on the tracking sheet any reason as to why it was being given. 3. "May 2003 Antipsychotic Monthly Record" tracking sheet, did not identify any target behaviors to indicate the use for the ass needed Seroquel. A. Resident 40 received the 750 mg scheduled daily dose of Seroquel 17 of the 19 days. B. Resident 40 received the 750 mg scheduled daily dose of Seroquel plus an additional 50 mg, 2 of the 19	{F 329}		

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{F 329}	Continued From page 56 days. C. Two of the two times, resident 40 received the additional Seroquel, the facility staff documented the reason as being "quiet-cautious". On 5/16/03 at 10:15 AM, a facility nurse stated that she would give resident 40 the as needed dose of Seroquel with any personality change that is extreme. She further stated that if resident 40 acts suspicious she would give the Seroquel. On 5/19/03 at 3:45 PM, resident 40's psychologist stated that he thought resident 40 had an as needed Seroquel order and he felt it was okay for resident 40 to ask for it when needed because "it seems to work". When the psychologist was asked what the target behaviors were for the as needed Seroquel, he did not answer the question but replied "yeah, okay". The 2003 PDR (physician's desk reference) Nurses's Drug handbook indicates that Seroquel is used for psychosis and the daily dose range is 150 mg to 750 mg per day. Resident 40 received a scheduled dose of Seroquel 250 mg three times a day which equals 750 mg per day. When resident 40 received the as needed 50 mg dose of Seroquel, he was receiving more than the indicated dose range according to the PDR. There was no documentation by the physician or a psychologist to provide evidence that resident 40 was safe to receive more than the recommended daily dose of 750 mg. The 2003 PDR (physician's desk reference) Nurses's Drug handbook documented that Seroquel should be used with caution in those with a history of seizures.	{F 329}		

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{F 329}	Continued From page 57 It should be noted that resident 40 had a diagnoses of seizure disorder. On 5/14/03 at 9:00 AM, resident 40 stated he had blacked out and fell a few weeks ago. On 5/9/03 at 10:45 AM, a facility nurse documented the following, "[Resident 40] came to nsg (nursing) station [at] 1035 [and] said "something's wrong, I fell in my room"...He said [after] questioning he became dizzy when he stood [up and] just fell..." There was no documentation in the medical record by the physician or a psychologist to provide evidence that Seroquel was an appropriate medication for this resident in light of his seizure disorder. 4. Resident 27 was admitted to th facility on 7/26/02 with the diagnoses of spina bifida, limb amputation, urostomy, osteoporosis, chronic pain, depression, narcotic abuse, alcohol abuse and anxiety. The medical record of resident 27 was reviewed on 5/15/03 through 5/19/03. The preadmission screening for resident 27, dated 8/2/02, documented that she had severe major depression. The preadmission screening did not document that she had any other serious mental illnesses. Review of the physician's orders for resident 27 revealed that she was receiving Seroquel, an antipsychotic, 200 mg at hour of sleep every night. The physician order for resident 27 did not indicate the use of the Seroquel nor did it list target behaviors to be monitored by facility staff. The psychotropic drug committee meeting minutes for	{F 329}		

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	465142	A. BUILDING _____ B. WING _____	R 05/27/2003

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

(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 329}	Continued From page 58 resident 27 documented that she received the Seroquel 200 mg at hour of sleep every night for the diagnoses of stress reaction emotional. The members of the psychotropic drug committee listed the target behaviors for the use of the antipsychotic medication Seroquel as delusions and number of hours slept. Review of the medical record for resident 27, did not reveal indications which would warrant the use of an antipsychotic medication. On 5/16/03 at 10:15 AM, a facility nurse was interviewed. The facility nurse stated that she considered resident 27 as having delusions when the resident would state her family had been in the facility and then later when she followed up she would determine that the residents family had not been in the facility. The facility nurse further stated that she would also mark delusions if she saw the resident talking to herself. On 5/16/03, two CNAs were interviewed. Both aides stated that the only behaviors resident 27 exhibited were crying out and attention seeking. Observation of resident 27 during all days of the survey revealed a wheelchair bound resident who was often crying or upset. Surveyors did not witness any behaviors which would warrant the use of an antipsychotic medication. 5. Resident 35 was a 38 year old male who was admitted to the facility on 4/1/03 with diagnoses which included history of multiple motor vehicle accidents and traumatic brain injury with depression. The medical record of resident 35 was reviewed on 5/15/03, 5/16/03 and 5/19/03. The preadmission screening for resident 35, dated	{F 329}		

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{F 329}	Continued From page 59 4/1/03, documented that he did not have a serious mental illness. Review of the physician's orders for resident 35 revealed that he was receiving Zyprexa, an antipsychotic, 5 mg every evening. The psychotropic drug committee meeting minutes for resident 35 documented that he received Zyprexa 5 mg every evening for the diagnosis of "TBI (traumatic brain injury) w/ (with) aggression". The members of the psychotropic drug committee did not list any target behaviors for the use of the antipsychotic medication (Zyprexa) being given to resident 35. Review of the April and May 2003 medication administration records for resident 35 revealed that nurses were not tracking any target behaviors or possible side effects for the use of Zyprexa. The medical record of resident 35 contained a blank AIMS (abnormal involuntary movement scale). AIMS tests are used to measure possible side effects that could be caused by the use of an antipsychotic. On 5/19/03, the social service person was interview and asked why resident 35 was receiving an antipsychotic. The social service person stated "I don't know. It was probably given to him to offer more clarity to his traumatic brain injury situation." She also added that resident 35 "tries to get along" with others. On 5/19/03, two CNAs (certified nurse aides) were interviewed. Both aides felt resident 35 was cooperative and pleasant. They both denied that resident 35 exhibited behaviors which were dangerous to himself or others.	{F 329}		

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{F 329}	Continued From page 60 On 5/19/03, a facility registered nurse was interviewed. She denied seeing resident 35 exhibit behaviors which were dangerous to himself or others. She stated he tried to get along. The medical record did document one incident in which resident 35 and another resident got into a brief fight, but nothing to evidence that any instances had occurred since then. Observation of resident 35 during all days of survey revealed a pleasant, wheelchair bound resident. Surveyors did not witness any behaviors which would warrant the use of an antipsychotic medication.	{F 329}		
{F 364} SS=B	483.35(d)(1)&(2) DIETARY SERVICES Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, individual and group interviews, and temperature results obtained from a breakfast test tray, it was determined that the facility did not serve food by methods that conserved the proper temperature of the food. Findings include: 1. On 5/14/03 at 2:30 PM, a confidential group interview was conducted. Seven of fifteen residents who participated in the group interview stated the facility did not serve hot foods hot and that the food was not palatable because of this.	{F 364} OK LB	Food temperature is monitored each meal in the kitchen by the cook. Three dining room trays will be monitored weekly for holding temperatures of hot foods. Inservice nursing staff on correct holding temperature and the reheating of food if necessary. The food service manager will monitor that temperature logs are up to date and within the proper range.Temperature logs are implemented into a monthly quality assurance meeting and discussed.	6/2/03

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{F 364}	Continued From page 61 2. On 5/15/03, a test tray was obtained during the breakfast meal. The test tray was received at the end of breakfast after most of the residents had been served. The eggs were 94 degrees Fahrenheit .The eggs tasted cold and were not palatable. The plate was not warm and there was no warming pellet under the plate. 3. During observations of the breakfast meal on 5/13, 5/14, and 5/16 there were no offers from staff to warm up meals. 4. On 5/14/03 at 9:00 AM, a confidential individual interview was conducted. During the confidential interview the resident stated that his meals were served cold most of the time and the food was not palatable because of this.	{F 364}		
{F 366} SS=B	483.35(d)(4) DIETARY SERVICES Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observations during the breakfast meals on 5/14/03 and 5/15/03, it was determined that the facility does not always offer substitutes of similar nutritive value to residents who refuse food. Resident identifiers: 9 and 23. Findings include: 1. On 5/14/03 at 8:35 AM, resident 9 was observed to have her breakfast tray picked up by a facility aide. Resident 9 was not observed to had eaten any of her meal. The facility aide was not observed to ask resident 9 if she was finished nor was the aide observed to ask resident 9 if she would like something	{F 366}	Alternative meals are posted in elevator and outside dining room. CNA's inserviced to offer alternative meal if resident has not consumed 50% of the meal. Dining room monitoring three times weekly per meal time by food service manager. Subject will be addressed in monthly quality assurance meetings.	6/3/03

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{F 366}	Continued From page 62 else to eat. 2. Resident 23 was observed on 5/14/03 at 8:20 AM sitting at the dining room table drinking the milk from her cereal bowl. She made no attempt to eat the eggs or the toast on her tray or drink the juice. An aide checked her tray, marked her meal ticket and removed her meal without asking her if she wanted anything else to eat.	{F 366}		
{F 371} SS=E	483.35(h)(2) DIETARY SERVICES The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility did not store, prepare, distribute and serve food under sanitary conditions as evidenced by multiple food items not being labeled or dated in the reach-in freezers, outdated food items stored in the walk-in refrigerator, bags of meat in the freezer which were not labeled, an open bag of meat in the freezer, a dietary staff member not properly washing her hands or changing gloves after touching oven mitts, staff serving food were not wearing aprons, the area above the stove and ice machine was in need of cleaning, the dry storage area ceiling was moldy with flaking paint, vinegar stored with chemicals, towels stored in improper sanitation fluid and standing water in the dish room. Findings include: The following observations were made during the initial kitchen tour made 5/12/03: In the dry storage room:	{F 371}	A daily cleaning and assignment check list was developed and is being completed by AM cook and monitored daily by Food Service Manager. In service done with kitchen staff in regards to cleaning and assignment list. Ceiling in storage room will be scraped and repainted. Aprons are provided and worn by kitchen staff. Implemented into a monthly quality assurance meeting.	6/25/03

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{F 371}	Continued From page 63 1. The ceiling was moldy and the paint was flaky in several areas over open boxes of food. In freezer #3: 1. There was a torn bag of sausage exposing the meat. 2. There was a bag of breaded meat, rolls of ground meat and a meat roast that was un-identifiable with no labels. In freezer #2: 1. There were seven brown bags with no labels or dates. Walk-In refrigerator: 1. There was one container of hi-protein pudding with a date of 5/2. 2. There was ¾ of a case of healthshakes partially thawed with no date. In the kitchen area the following observations were made: 1. During an observation of the tray line staff were not wearing aprons during the handling of food. A staff member was observed to place oven mitts over her gloved hands to pull items from the oven. She did not change the gloves after removing the mitts and continued to handle food on the resident's trays with her hands. 2. The top of the oven and the top of the ice machine were dirty and sticky to the touch.	{F 371}		

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{F 371}	Continued From page 64 During an inspection of the kitchen on 5/14/03 at 7:45 AM the following observations were made: 1. There were two large areas of standing water, one under the dish machine and the other under the pot sink. There were no dishes being washed at the time of the observation. 2. A bucket with towels stored in it was tested with chlorine test strips supplied by a staff member. The test strip remained white when dipped in the bucket indicating a ppm below 10. In order for the sanitizing solution to be effective it must measure between 50 ppm and no more than 200 ppm. 3. The staff was not wearing aprons during the handling of food. During an inspection of the kitchen on 5/14/03 the following observations were made. 1. There were two large areas of standing water, one under the dish machine and the other under the pot sink. 2.There was a gallon of vinegar marked "for cooking only" on a cart stored with disinfectant and bleach. 3. A bucket with towels stored in it was tested with a chlorine test strip. The test strip turned black indicating a ppm (parts per million) exceeding 200.	{F 371}		
{F 444} SS=D	483.65(b)(3) INFECTION CONTROL The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.	{F 444}		

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{F 444}	Continued From page 65 This REQUIREMENT is not met as evidenced by: Based on observations, it was determined that dietary aide staff failed to wash their hands or to use sanitizer as indicated when direct contact with residents occurred. The observations occurred during meal times as staff were assisting residents with their meals. Findings include: Observations of facility staff were made on 5/12/03, during the lunch meal. The observations were made in the dining room and revealed the following: An aide serving the residents their meal trays was observed to lick her finger while sorting the meal tickets. She was observed to repeat this several times and then continue to serve the trays without washing her hands. An aide was observed to be feeding a resident his meal when she was asked to assist in the positioning of another resident. She lifted the legs of the resident onto a chair and then returned to the feeding of the first resident. She was not observed to wash her hands after the direct contact.	{F 444}	In service was done on 6/3/03 with regards to washing hands after direct contact with residents. In service will be redone on 6/25/03 and quarterly there after. Random checking by nursing administrative staff. Implemented into a monthly quality assurance meeting.	6/3/03
{F 460} SS=E	483.70(c)(1)(iv&v) PHYSICAL ENVIRONMENT Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.	{F 460}		

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{F 460}	Continued From page 66 This REQUIREMENT is not met as evidenced by: Based on observations, it was determined the facility was not quipped to provide full visual privacy for each resident in 10 of 29 resident rooms which were not provided with ceiling suspended privacy curtains that extended around their beds to provide full visual privacy. Findings Include: Observation of resident rooms on 5/12/03 and 5/13/03 and 5/16/03, revealed the following in relationship to the privacy curtains. Room 206. There was no privacy curtain at the foot of Bed B. Two residents shared room 206 during part of the survey. Room 207. The privacy curtain at the foot of Bed B allowed approximately 2 feet of visualization of the resident. Room 209. The bed in the southeast corner of the room has no privacy curtain across the west side. Room 106. The curtains along the length of Bed A and Bed B were each approximately 1 foot short, allowing 2 feet of visualization where the two curtains should have met. Observation of resident rooms on 5/12/03, revealed the following in relationship to the privacy curtains. Room 115. The privacy curtain at the foot of Bed A allowed approximately 2 feet of visualization of the resident. Room 113. The privacy curtain at the foot of Bed B allowed approximately 2 feet of visualization of the resident.	{F 460}	An audit was done on every resident room with regards to privacy curtains. Measurements were taken and necessary track replacements were also identified. The bid is in the process of being finalized and approved. All rooms identified for not meeting the requirement have been corrected. All tracks and curtains are part of the bid and are planning to be replaced. When the bid is finalized and approved the facility will purchase 1/4 of the necessary track and curtains every month untill all track and curtains are acceptable. The housekeeping supervisor will monitor in monthly quality assurance rounds that privacy curtains allow for full visual privacy for every resident room. A waiver has been requested to extend the time of completion.	6/11/03

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{F 460}	Continued From page 67 Room 205. The privacy curtain on Bed A did not pull close at the end of the bed due to a screw that was hanging down on the track. The curtain only closed approximately 1 foot. Room 214. The privacy curtain at the foot of Bed A allowed approximately 2 feet of visualization of the resident. Room 217. The privacy curtain was missing for Bed B, which allowed full visualization of the resident.	{F 460}		
{F 465} SS=E	483.70(h) PHYSICAL ENVIRONMENT The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined the facility did not provide a safe, sanitary and comfortable environment for residents and staff in the back yard and back patio areas of the facility. Findings include: Observations were made of the exterior areas of the facility on 5/12/03, 5/13/03, 5/14/03, 5/15/03, 5/16/03 and 5/19/03. Areas that did not appear safe, sanitary and/or comfortable for the residents in the south and west fenced area included: On the lawn, directly south of the patio, an old toilet and an old heating unit had been discarded. A dirty, old refrigerator was at the bottom of the west stairs to the patio.	{F 465}	A toilet, heating unit, refrigerator and bed parts were all removed from the south lawn area. The soffit and fascia for the entire building was bid out to replace it with aluminum (a variance has been requested to extend the time of completion). The telephone wires have been rolled up and placed on the side of the building. The ladders have been locked and chained to the generator on the side of the building. The concrete patio has been cleaned and scrubbed and the paint will be purchased. The paint has been purchased and work has begun on repainting the back patio benches. The administrator wspoke to staff and residents about using the ash trays and trash cans provided.	6/25/03

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{F 465}	Continued From page 68 Discarded bed parts were located in the southwest corner of the yard, near a storage shed. There were two holes in the soffit on the west side of the building. The plaster from an area of the soffit, approximately 9 inches by 13 inches, had fallen to the sidewalk below and birds had built a nest inside. The soffit on the east side of the building leaked water over the sidewalk in two areas near the entrance to the facility. Telephone wires were hanging from the building along the west wall and laying in piles along the sidewalk. A strand of approximately 20 feet of the wire was coiled loosely on the sidewalk and the lawn. A ladder was laying across the lawn on the west side of the building. The concrete patio had cigarette butts and discarded wrappers scattered over it daily. The patio was dirty with some stain areas, but other areas had a build up of a black substance that needed to be washed off. The patio was swept of some of the leaves and cigarette butts by a resident on 5/13/03, but there was new trash scattered over the patio daily. The patio had not been washed off during the survey. The benches on the patio had paint pealed and rough, bare wood was exposed on the backs and the seats.	{F 465}	The administrator will monitor daily for the first 30 days the cleanliness of the back patio and continue to speak with staff and residents about keeping it clean. The administrator will mointor the cleanliness of the back patio and the facility grounds in monthly quality assurance rounds.	
{F 490} SS=H	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable	{F 490}		

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{F 490}	Continued From page 69 physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a recertification survey with subsequent extended survey, conducted 5/12/03 through 5/20/03, and resultant finding of Immediate Jeopardy and Sub-Standard Quality of Care, it was determined that the facility was not being administered in a manner that enabled it to use its resources effectively or efficiently to ensure that residents were provided the opportunity to attain or maintain their highest practicable physical, mental and psychosocial well-being. Specifically, the facility neglected to implement a systemic process, which insured that residents with a history of elopement behaviors were monitored to ensure their safety. Eight residents with a history of elopement or AWOL (absence without leave) behaviors were reviewed. Six of the eight residents were found to have experienced actual harm and the other two resident were found to have experienced a potential for serious harm, as a result of their AWOL behavior. (Resident identifiers- 4, 13, 32, 33, 35, 41, 42 and CR1) In addition, the facility failed to adequately monitor an individual with known self injurious behaviors (Resident identifier- 40). Findings include: On 5/12/03, a recertification survey was initiated. On 5/13/03 and again on 5/16/03, facility administration were noticed of the elements of Immediate Jeopardy and Sub-Standard Quality of Care. The determination of Immediate Jeopardy and Sub-Standard Quality of Care was based on the findings of significant non-compliance in the areas of Resident Behavior and Facility Practices [42 Code of Federal Regulations (CFR) 483.13 (c) Tag F-224]. 1. Facility administration failed to ensure that	{F 490}	Facility administration will insure through quality assurance meetings, QA rounds, future in services and the submitted plan of correction for the May 2003 recertification survey that facility resources are used effectively and effeciently to attain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility administrator will insure the plan of correction submitted for the following tags is completed effectively and in a timely manner. See POC for the following defeciencies F 157, F 224, F 225, F 226, F 241, F 242, F 253, F 279, F 312, F 329, F 364, F 366, F 371, F 444, F 460, F 465, F 520.	6/25/03

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{F 490}	Continued From page 70 residents were free from neglect. (Scope and Severity "K", refer to Tag F-224) a. Per facility documentation, resident 4 left the facility, unsupervised on 1/7/03. An automobile struck resident 4 as he was crossing the street. Resident 4 was transported via ambulance to an acute care hospital emergency department. He sustained lacerations to his forehead. Facility staff had assessed resident 4 as an elopement and safety risk. Resident 4 was found to have experienced actual harm as a result of his AWOL behavior. b. Per facility documentation, resident 13 attempted to climb the back chain link fence. Resident 13 sustained a laceration to his right hand and left first toe. Resident 13 was transported to an acute care hospital emergency department and received sutures to his toe injury. Facility staff assessed resident 13 as an elopement and safety risk. Resident 13 was found to have experienced actual harm as a result of his AWOL behavior. c. Resident 32 was observed on 5/12/03 at approximately 1:45 PM, to be standing in the median area of 3300 South, a busy four-lane street. While standing in the median, a vehicle was observed to slowly pull up to resident 32, stopping immediately adjacent to the resident. The vehicle moved into the resident's path blocking him from walking forward. The driver of the vehicle honked the horn. The resident continued to stand in the median. During this time, a certified nurse aide (CNA) was observed providing assistance to another resident. She and the other resident were on the sidewalk between the facility and 3300 South. The CNA waved at resident 32 and proceeded to assist the other resident into the building. No staff came to assist resident 32	{F 490}		

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	465142	A. BUILDING _____ B. WING _____	R 05/27/2003

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 490}	Continued From page 71 across the street. Without regard to traffic, resident 32 proceeded to cross 3300 South. Note: There was no crosswalk where resident 32 crossed 3300 South. Resident 32 was found to have experienced a potential for serious harm as a result of his AWOL behavior. d. Per facility documentation,, on 3/10/03 at 6:00 PM, resident 33 was noted to be missing. Upon the resident's return, he had two scratches to his left upper extremity and one on his left lower extremity. On 3/22/03, resident 33 had another AWOL. Facility staff documented that resident 33 had jumped the fence. Facility staff had assessed resident 33 as an elopement and safety risk. Resident 33 was found to have experienced actual harm as a result of his AWOL behavior. e. Per facility documentation, on 4/4/03, resident 35 was found to be AWOL. At 6:30 PM, resident 35 was located in the parking lot of a grocery store with a wanderguard bracelet attached to his wheelchair. A wanderguard is a device, utilized by the facility, to signal an audible alarm and lock the facility doors when a resident attempts to leave the facility. Resident 35 had been adjudicated an incapacitated person and a guardian was appointed. Resident 35 was found to have experienced a potential for serious harm as a result of his AWOL behavior. f. Per facility documentation, on 3/25/03, resident 41 went AWOL. Facility staff documented they noted the resident missing at 5:15 AM and that the door to the business office was open. The outside door of the business office was propped open. The resident was observed approaching the facility at 5:45 AM. The resident's "skin was cold" and facility staff provided him a sweater. Facility staff had assessed resident 41 as an elopement and safety risk. Resident 41 was found to have experienced actual harm as a result of	{F 490}		

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{F 490}	Continued From page 72 his AWOL behavior. g. Per facility documentation, resident 42 was AWOL four times during the month of April 2003. On one occasion, resident 42 returned to the facility with bruising on both sides of his face. Facility staff assessed resident 42 as an elopement and safety risk. Resident 42 was found to have experienced actual harm as a result of his AWOL behavior. h. Per facility documentation, on 5/5/03 resident CR1 returned to the facility from an unsupervised leave of absence, at 1:00 AM, reporting to staff that he had consumed a large amount of alcohol. Resident CR1 reported that he had blood in his urine. Facility staff documented that the resident had vomited 500 CC (cubic centimeters) of coffee ground emesis. Resident CR1 was discharged to an acute care hospital emergency department. Facility staff assessed resident CR1 as requiring supervision in the community. Resident CR1 was found to have experienced actual harm as a result of his AWOL behavior. i. Resident 40 was admitted to the facility with a documented history of self-injurious behaviors. Facility staff have documented multiple incidents of self injurious behavior. During an interview with resident 40, he stated he had cut his wrist multiple times since admission to the facility. He further stated that he had obtained the item, such as, bic razor blades from the shower room, thumb tacks and utensils, from inside the facility. Resident 40 was found to have experienced actual harm as a result of his self-injurious behaviors. 3. In addition to the area of Immediate Jeopardy and Sub-Standard Quality of Care stated above, the facility administration failed to effectively and efficiently use its resources to ensure that each resident attained or	{F 490}		

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{F 490}	Continued From page 73 maintained their highest practicable, physical, mental and psychosocial well-being in the following areas of deficient practice cited during the annual and extended survey completed 5/20/03. a. Facility administration did not ensure that the medical physician was notified each time a resident had self injurious behaviors. This was cited at an actual harm level. (Scope and Severity "G", refer to Tag F-157) b. Facility administration did not thoroughly investigate and report to appropriate agencies bruising of unknown origin. (Scope and Severity "D", refer to Tag F-225) c. Facility administration did not implement a written policy regarding identification of possible instances of abuse. (Scope and Severity "D", refer to Tag F-226) d. Facility administration did not ensure each resident was treated with dignity and respect. (Scope and Severity "E", refer to Tag F-241) e. Facility administration did not ensure that each resident was able to make choices about his or her life that are significant to the resident. (Scope and Severity "D", refer to Tag F-242) f. Facility administration did not ensure that housekeeping and maintenance were provided to maintain a sanitary, orderly and comfortable interior. (Scope and Severity "E", refer to Tag F-253) g. Facility administration did not ensure that the plan of care reflected each individual resident. (Scope and Severity "E", refer to Tag F-279) h. Facility administration did not ensure that care and	{F 490}		

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{F 490}	Continued From page 74 services were provided to residents who were unable to provide their own care and services independently. (Scope and Severity "D", refer to Tag F-312) i. Facility administration did not ensure that residents were free from unnecessary drugs. (Scope and Severity "E", refer to Tag F-329) j. Facility administration did not ensure that residents received their meals at appropriate temperatures. (Scope and Severity "B", refer to Tag F-364) k. Facility administration did not ensure that residents were offered meal substitutions. (Scope and Severity "B", refer to Tag F-366) l. Facility administration did not ensure that food was stored, prepared and distributed under sanitary conditions. (Scope and Severity "E", refer to Tag F-371) m. Facility administration did not ensure that staff washed their hands when direct resident contact occurred. (Scope and Severity "D", refer to Tag F-444) n. Facility administration did not ensure that resident rooms were equipped to ensure full visual privacy. (Scope and Severity "E", refer to Tag F-460) o. Facility administration did not ensure that the environment was safe, functional, sanitary and comfortable to residents, staff and the public. (Scope and Severity "E", refer to Tag F-465) p. Facility administration did not ensure that the medical director attended quarterly quality assurance meetings. This was cited at an actual harm level. (Scope and Severity "H", refer to Tag F-520)	{F 490}		

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{F 490}	Continued From page 75	{F 490}		
{F 520} SS=H	483.75(o)(1) ADMINISTRATION A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on interview with the acting administrator, it was determined that the facility did not maintain a quality assessment (QA) and assurance committee which consisted of all required members. Findings include: During interview with the acting administrator on 5/20/03 at approximately 5:30 PM, two survey nurses requested documentation to evidence that a physician had been involved, at least quarterly, with the facility's QA committee. The acting administrator could not provide evidence that the physician had been involved in the facility's QA process or attended any of the meetings for the last six months.	{F 520}	OK A quality assurance meeting will be held quarterly with the required staff members present including the director of nursing the in house medical physician and three other members of the facility staff. The meeting was held on 6/16/03.	6/16/03

Addendum to the May 20, 2003 re-certification/complaint investigation for Granite Hills.

OK
VB

F 253-

The electrical outlet was replaced. The side rail in room 104 was fixed. A vacuum breaker was placed on the shower hose. The material for the window sills in 109 has been ordered. The window sill in 204 is not broken. The window sills will be looked at for disrepair in monthly quality assurance rounds by the maintenance supervisor and be replaced as needed.

OK
VB

F 225-

Staffed in serviced on 6/25/03 on the Abuse policy and procedure. Investigations will be done on all bruising of unknown origin. The facility social worker was in serviced on the abuse policy and procedures on 6/11/03 and about reporting all injuries of unknown origin. Resident 40 has a bruise like birthmark on his back that could have been mistaken for a bruise. The DON will review and sign all incident reports. Incident reports will be brought to the AM administrative meeting and reviewed to make sure the physician was notified. If the incident is of unknown origin the DON will notify the administrator and investigate and turn the investigation into the administrator. All necessary agencies will be notified upon receiving the incident of unknown origin and upon completion of the investigation.

OK
VB

F 226-

The abuse policies and procedures were updated to address identification of suspicious or unknown origin of bruising of residents that may constitute abuse. The abuse policy has been placed at the North and South's nurse station and is available in the administrators and Director of Nursing's office. All injuries of unknown origin will be addressed in am AM administrative meeting. The staff was in serviced on the abuse policies and procedures on 6/25/03. The nurse will fill out the incident report on all incidents and injuries or bruising of unknown origin. The reports will be given to the DON and signed and investigated if the incident and injury is of unknown origin. Incidents will be addressed at a daily AM administrative meeting

OK
Change
LB.

F 329-

Nursing staff was in serviced on the new behavioral tracking procedures on 6/25/03 and staff will be reinserviced again on 8/10/03. All residents that come up on the IDT schedule will be reviewed in the mean time the DON will review all residents on psychotropic medications and their tracking of behaviors. Then all residents on psychotropic drugs will be tracked to be able to see the increase or decrease of each category of drug and this will be repeated during the psychotropic meetings and totals during the monthly QA meeting. The DON will review all tracking of behaviors as patients come up for psychotropic review, for example hours slept on all sleepers-hypnotics. All patients returning from the hospital for psychotropic medications that they did not admit to the hospital will be reviewed by the nursing staff along with pain medications and foley catheters in case they were used for control in hospital or convenience due to being out. The behaviors might be attributed to a change in their environment. The DON will in service the entire nursing staff by ~~8/10/03~~ on proper documentation of MAR's, psychotropic sheet proper target behaviors, incident reports and the proper way to note physician orders to assure quality nursing care is maintained. The medical records clerk will audit MAR's, psychotropic sheets so orders are properly noted on a weekly basis for the next week 90 days and give the audits to the DON for teaching and counseling purposes. The DON will monitor all new patients psychotropic drugs for appropriate target behaviors. If needed clarification will be obtained from the physician for what target behaviors they want tracked for the psychotropic medication At times when possible the nurse will ask the physician. Resident 35's psychotropic medication will be reviewed by the physician and resident 35's medication will be followed by the psychotropic drug committee. The AIMS sheet was filled out and placed in his medical record.

6/25/03
Changed per Adm Permission to say "6/25/03 and again by 8/10/03
LBrisenbark RN

OK
6/3
LB

F 460-

The completion date for this deficiency will be no later than 10/25/03

OK
LB

F 465-

The completion date for this deficiency will be no later than 10/25/03