accepted POC 9/20/05
Completion Date 9/29/05

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

PRINTED: 09/02/2005
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465142 | A. BUILDING _____ B. WING _____ | C 09/01/2005 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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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) COMPLETION DATE |
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| F 309 SS=J | 483.25 QUALITY OF CARE<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, the facility did not ensure that medications were secured in a medication cart and a resident with a history of drug overdose, was able to obtain Motrin from the medication cart. Subsequently, the resident was hospitalized for a drug overdose. (Resident 1)<br><br>This resulted in a finding of Immediate Jeopardy and Sub Standard Quality of Care.<br><br>Findings include:<br><br>On 8/31/05, the State Survey Agency received a complaint that resident 1 had been rushed to the hospital on 8/30/05, due to an overdose of Motrin. The complainant also stated that resident 1 had obtained the Motrin from the facility medication cart.<br><br>Resident 1 was originally admitted to the facility 3/21/96 with diagnoses that included depression. | F 309 | On 08/30/05 it was reported to Administrator that one of the two med carts had a drawer which would not remain securely locked. Administrator instructed Maintenance Supervisor to repair drawer. When tested the repaired drawer remained locked.<br><br>On 08/31/05, a Surveyor tested the same med cart and found that it could be opened with a forced pull. The following actions were taken by facility management that same day:<br><br>1) A new, replacement, med cart was ordered.<br><br>2) An inservice training was conducted by ADON with all nurses, who were all informed and retrained as regards the med cart / med pass policy, practices and protocol.<br><br>3) Meds were taken out of the two faulty drawers and redistributed to other locking drawers or into the locked med room.<br><br>9/01/05 – Nurses reported that all med passes could not be effectively done without the space provided by all drawers in the med carts.<br>Therefore, another nursing inservice training was held in which a temporary protocol, following good nursing practices and guidelines, was introduced. (See A) All nurses signed that each had read, understood, and must follow without exception. | 9/29/05 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D Lamer — TITLE: administrator — (X6) DATE: 9/15/05

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

Utah Department of Health
266717
SEP 19 2005
Bureau of Health Facility Licensing, Certification and Resident Assessment

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| F 309 | Continued From page 1<br>Resident 1 was re-admitted to the facility on 2/18/05.<br><br>A review of resident 1's medical record was done on 9/1/05.<br><br>On 1/31/05, resident 1 was admitted to an acute care hospital from the facility for "Acetaminophen (Tylenol) toxicity...Likely secondary to acute ingestion." A history and physical completed on 1/31/05 for this admission indicated the following medical conditions: "acetaminophen toxicity...likely secondary to acute ingestion" and "respiratory failure secondary to acetaminophen toxicity". The document also indicated, "It seems that the patient has had chronic ingestion (of acetaminophen).<br><br>An Interdisciplinary care plan for suicide for resident 1 was reviewed. The care plan had been completed by facility staff and was dated 8/29/05. The problem listed was, "Potential for harm to self as evidenced by suicide attempts, suicide ideation and ex-Tylenol overdose. The goal was, "Will avoid impulsive behaviors that could harm self, aeb (as evidenced by) no attempts of or verbalization of suicide ideation." Some interventions were, "Assess for presence of risk factors...provide for safe environment... and provide close supervision.<br><br>In a nurses' note dated 8/30/05 at 1:30 PM, a facility nurse documented, "@ (at) 1130 went to rm (room) as CNA's (certified nurse assistants) report she ref. (refused) breakf. (breakfast) (and) is refusing lunch. When I went to rm. I asked her to go to lunch (and ) she replied 'My stomach hurts (and) I'm Sick'. As she talked I noticed what appeared to be pills. I saw them on night table | F 309 | A second new med cart was added to the original order.<br><br>9/2/05 – A State Monitoring Surveyor conducted a spot check and found all med cart / med pass protocol was in order.<br><br>9/3/05 - A State Monitoring Surveyor conducted a spot check and found that med cart / med pass protocol was continuing. However, one nurse had left her med cart against the wall, just down the hall, but unattended, while she went to visit with the Surveyor.<br>Administrator was informed of infraction of the policy, and that nurse was placed immediately on suspension, pending possible termination of employment by facility. That nurse was later terminated.<br><br>09/04/05 - A State Monitoring Surveyor conducted a spot check and found all med cart / med pass protocol was in order.<br><br>09/05/05 – a State Monitoring Surveyor conducted a spot check and found all med cart / med pass protocol was in order.<br><br>09/06/05 – a State Monitoring Surveyor conducted a spot check and found all med cart / med pass protocol was in order.<br>The two new med carts arrived and were placed into service. | |

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| F 309 | Continued From page 2<br>(and) on floor (and) underbed. I did voluntary rm (check) (and) found house stock bottle of Motrin 200 mg. (Resident) claims she has had it for '3 or 4 days' ...Rm mate volunteers that she saw (resident) eat a 'handful yesterday'.<br><br>Resident 1 was transported to a local hospital on 8/30/05 at 12:20 PM by ambulance. Resident 1 was admitted to the hospital.<br><br>On 9/1/05 at 9:30 AM, an interview was held with the facility nurse that had provided care to resident 1 on 8/30/05. The nurse stated that on 8/30/05, just before lunch, a nursing assistant reported to her that resident 1 had refused breakfast and was now refusing lunch. The nurse stated that she went to resident 1's room to see why she was refusing to eat. The nurse stated that while she was talking to resident 1 she noticed that there were pills on the night stand, on the floor and under the bed. She stated that the pills were house stock Mortin and had been in the medication cart.<br><br>The nurse surveyor asked how resident 1 had gotten the house stock medication. The nurse replied that the medication cart had been broken and that she had not been aware that it would not lock. She further indicated that the medication cart had been broken and repaired several times for the same thing. The nurse stated that she suspected resident 1 had been able to get the medications out of the medication cart due to the lock being broken. | F 309 | All nurses review med carts when retrieved from locked med room.<br><br>Charge Nurse reviews each med cart at each shift change / med check.<br><br>DON (or designee) reviews both med carts daily, audits Med Pass Protocol, and reports daily at Standards of Care Meeting (held weekdays).<br><br>DON (or designee) reports all med cart / med pass findings at monthly Quality Assurance Meeting. | |
| F 432 SS=J | 483.60(e) STORAGE OF DRUGS AND BIOLOGICALS<br><br>In accordance with State and Federal laws, the | F 432 | | 9/9/05 DG |

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| F 432 | Continued From page 3<br>facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.<br><br>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and observation, it was determined that the facility did not store all drugs and biologicals in locked compartments. The facility did not ensure that the medication carts had working lock mechanisms. Subsequently, a resident obtained a bottle of house stock Motrin from the medication cart and had to be hospitalized due to an overdose. (Resident 1)<br><br>This resulted in the finding of Immediate Jeopardy and Sub Standard Quality of Care.<br><br>Findings include:<br><br>On 8/31/05, the State Survey Agency received a complaint alleging that the facility medication carts had broken locks. The complainant also reported that a resident had obtained house stock Motrin from the cart and had to be hospitalized for an overdose. | F 432 | On 08/30/05 it was reported to Administrator that one of the two med carts had a drawer which would not remain securely locked. Administrator instructed Maintenance Supervisor to repair drawer. When tested the repaired drawer remained locked.<br><br>On 08/31/05, the Complaint Surveyor tested the same med cart and found that it could be opened with a forced pull. The following actions were taken by facility management that same day:<br><br>1) A new, replacement, med cart was ordered.<br><br>2) An inservice training was conducted by ADON with all nurses, who were all informed and retrained as regards the med cart / med pass policy, practices and protocol.<br><br>3) Meds were taken out of the two faulty drawers and redistributed to other locking drawers or into the locked med room.<br><br>9/01/05 – Nurses reported that all med passes could not be effectively done without the space provided by all drawers in the med carts.<br>Therefore, another nursing inservice training was held in which a temporary protocol, following good nursing practices and guidelines, was introduced. (See A) All nurses signed that each had read, understood, and must follow without exception. | |

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| F 432 | Continued From page 4<br><br>On 9/1/05 an onsite investigation was conducted.<br><br>On 9/1/05 at 9:30 AM, an interview was held with the facility nurse that had provided care to resident 1 on 8/30/05. The nurse stated that on 8/30/05, just before lunch, a nursing assistant reported to her that resident 1 had refused breakfast and was now refusing lunch. The nurse stated that she went to resident 1's room to see why she was refusing to eat. The nurse stated that while she was talking to resident 1, she noticed that there were pills on the night stand, on the floor and under the bed. She stated that the pills were house stock Motrin and had been in the medication cart.<br><br>The nurse surveyor asked how resident 1 had gotten the house stock medication. The nurse replied that the medication cart had been broken and that she had not been aware that it would not lock. She further indicated that the medication cart had been broken and repaired several times for the same thing. The nurse stated that she suspected resident 1 had been able to get the medications out of the medication cart due to the lock being broken.<br><br>The facility nurse stated that the maintenance department had repaired the medication cart on 8/30/05, when the incident occurred. The nurse surveyor asked if the medication cart was locked at the time of the interview and the nurse replied affirmatively. The surveyor verified that the lock on the cart was in the locked position and then attempted to open all the drawers on the cart. The cart had 7 drawers; 4 on the left had side of the cart and 3 on the right side of the cart. The surveyor was able to open the 2 middle drawers | F 432 | A second new med cart was added to the original order.<br><br>9/2/05 – A State Monitoring Surveyor conducted a spot check and found all med cart / med pass protocol was in order.<br><br>9/3/05 - A State Monitoring Surveyor conducted a spot check and found that med cart / med pass protocol was continuing. However, one nurse had left her med cart against the wall, just down the hall, but unattended, while she went to visit with the Surveyor.<br><br>Administrator was informed of infraction of the policy, and that nurse was placed immediately on suspension, pending possible termination of employment by facility. That nurse was later terminated.<br><br>09/04/05 - A State Monitoring Surveyor conducted a spot check and found all med cart / med pass protocol was in order.<br><br>09/05/05 – a State Monitoring Surveyor conducted a spot check and found all med cart / med pass protocol was in order.<br><br>09/06/05 – a State Monitoring Surveyor conducted a spot check and found all med cart / med pass protocol was in order. | |

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| F 432 | Continued From page 5<br>on the left hand side of the cart. The facility nurse then unlocked the cart, shut all the drawers and re-locked the cart. The nurse surveyor again tried all the drawers on the cart and was able to open the 2 middle drawers on the left hand side of the cart.<br><br>The nurse surveyor then left the area where the medication cart was located. After approximately 10 minutes, two nurse surveyors returned to where the medication cart was located. The cart was up against the wall with the drawers facing the wall. The facility nurse was assisting a resident who had fallen on the patio outside and was out of eyesight of the cart. The nurse surveyors were able to move the medication cart away from the wall and open the 2 drawers on the left hand side of the cart. The lock on the medication cart was in the locked position. There were no staff in the area to observe the medication cart. | F 432 | 09/06/05 - The two new med carts arrived and were placed into service.<br><br>All nurses review med carts when retrieved from locked med room.<br><br>Charge Nurse reviews each med cart at each shift change / med check.<br><br>DON (or designee) reviews both med carts daily, audits Med Pass Protocol, and reports daily at Standards of Care Meeting (held weekdays).<br><br>DON (or designee) reports all med cart / med pass findings at monthly QA. | DG |

A, 1

# ATTENTION NURSING STAFF

Effective immediately the following will be done, if it is not completed immediate write-ups will be given, up to and including *termination.*

1) When received, All medications will be put away in ITS PROPER LOCATION!
2) All medications not in use, will be put in the locked med room.
3) Under no circumstance are you allowed to leave your med cart un-attended for any period of time. Lock it in the med room when not in use.

Until the new med carts arrive, this policy on the med carts will be enforced and strictly monitored. ***NO EXCEPTIONS!***

Effective, 9/1/2005 at 1100 hours until further notice. Please sign below noting that you have read this policy and accept the consequences for failure to comply. ***NO EXCEPTIONS!***

Administrator
9/1/05