STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Ridge Health Care	3706 West 9000 South West Jordan, UT 84088

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision to prevent accidents for 1 of 8 sampled residents (Resident 8). Specifically, facility staff failed to respond to a wander guard alarm, failed to communicate with one another, and failed to implement the facility's elopement procedure when Resident 8, a cognitively impaired resident with known exit-seeking behaviors, eloped from the building. Resident 8 was found by police approximately 1.5 hours later near a fast-food restaurant two miles away, having sustained a self-reported fall and facial bruising. This noncompliance placed Resident 8 at risk for serious injury, serious harm, serious impairment, or death, constituting an Immediate Jeopardy.It was determined the provider's noncompliance with the requirements of participation had caused a situation that constituted Immediate Jeopardy. The noncompliance was related to the State Operations Manual, Appendix PP, S483.25(d)(2) Adequate supervision to prevent accidents, F689, at a scope and severity of J. Notice of the Immediate Jeopardy was given verbally and in writing to the facility Administrator, Director of Nursing, and Clinical Resource Nurse on 6/23/2026 at 10:55 AM. On 6/23/2026 2:33PM the Administrator provided the following additional abatement plan for the removal of the IJ effective on 6/23/2026 10:55AM. The facility's abatement plan, which was developed and implemented by 06/22/2026, included the following measures: Resident 8's care plan and elopement risk assessment were updated, and Resident 8 was placed on 15-minute visual checks; an audit of all exit-seeking residents was conducted to identify individuals with elopement risk; elopement binders were updated with current photographs and face sheets; wander guards and exit doors were inspected to ensure 100% functionality; the elopement policy was revised to require an immediate physical inspection of the location upon any alarm activation; mandatory staff re-education on the revised protocol was initiated; and daily audits along with random mock elopement drills were implemented to monitor compliance. The survey team verified that all these interventions were completed and fully implemented resulting in the removal of the Immediate Jeopardy on 6/22/2026.Resident 8 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, Paranoid Schizophrenia, and Dementia.Review of Resident 8's medical record revealed an elopement assessment dated [DATE], which indicated that the resident was At risk of elopement and had a physician's order for a wander guard.Review of Resident 8's care plan revealed a focus area created on 03/25/2025, which stated, Elopement risk/wanderer r/t [related to] impaired safety awareness, paranoid schizophrenia, dementia. Interventions included: assess for fall risk, document wandering behavior and attempted diversional interventions, identify patterns of wandering, monitor for fatigue and weight loss, monitor wander guard placement, and provide structured activities.Review of a nurse's progress note dated 06/19/2026, revealed that Resident 8 exhibited exit-seeking behaviors and staff notified the medical provider. The facility did not put additional interventions or supervision in place following this behavior.Review of a nurse's progress note dated 6/22/2026 stated, The resident eloped from the facility this morning.She was noted to have some bruising on her right cheek and reports she stumbled. She stated she just wanted to go on a walk. She was not able to provide (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	much more detail.Review of an initial incident report submitted by the facility on 6/22/2026 at 9:05 AM stated, Police came to facility at 7:00am 6/22/2026 that they found [Resident 8] at [fast food restaurant location]. She had her wanderguard band on her when found. Notified family, provider, ombudsman, etc. Further investigating the situation. The resident was taken to the hospital for treatment. The immediate action taken by the facility was reported as confirming that the wanderguard system was working properly and that all other residents were accounted for in the building. During an interview on 06/23/2026 at 8:56 AM, Registered Nurse (RN) 1 stated that she heard the wander guard alarm system sound between 4:00 AM and 5:00 AM on 06/22/2026. RN 1 stated that she pressed the camera button at her nurses station to check the monitor, but the monitor screen displayed monitoring in progress. RN 1 stated she assumed the other nurses station was already viewing the camera feed because only one monitor could be viewed at a time. RN 1 stated she left the alarm sounding and another staff member shut it off shortly after.During an interview on 06/23/2026 at 9:23 AM, RN 2 stated that she heard the alarm sound around 5:30 AM on 06/22/2026. RN 2 stated that she checked her camera monitor and it displayed monitoring in progress. RN 2 stated she thought the other nurse was actively looking at the camera feed, so she silenced the audible alarms at her nurses station.During an interview on 06/23/2026 at 4:45 PM, Licensed Practical Nurse (LPN) 1 stated that she arrived at the facility for work at 6:01 AM on 06/22/2026. LPN 1 stated that she walked past the front entrance door and noticed that the door alarm was actively sounding. LPN 1 stated a hospice Certified Nursing Assistant (CNA) was waiting outside to get into the building. LPN 1 stated she opened the door and the hospice worker stated she might have set off the alarm while trying to get in. LPN 1 stated she assumed the door alarm was due to the visitor trying to enter and not that a resident had eloped. LPN 1 stated she stepped outside the front door to look around the immediate area for residents, did not see anyone, and turned off the alarm.During an interview on 06/22/2026 at 5:00 PM, the Director of Nursing (DON) stated that RN 1 and RN 2 both checked the camera monitors at their respective nurses stations at the exact same time, which caused both screens to read monitoring in progress. The DON stated that RN 1 and RN 2 both assumed the other nurse was following the facility elopement procedure. The DON stated that staff silenced the alarm at the nurses station, but the alarm continued to sound locally at the front door until LPN 1 arrived for work. The DON stated that LPN 1 silenced the front door alarm after assuming it was accidentally triggered by an arriving hospice CNA. The DON stated that local police arrived at the facility at approximately 7:00 AM on 06/22/2026, to inform staff that they had located Resident 8 near a fast-food restaurant approximately 2 miles away from the facility. The DON stated that Resident 8 self-reported a fall to the police and the police observed bruising on the resident's face. The DON stated that the police transported Resident 8 to the hospital, where she was diagnosed with a Urinary Tract Infection (UTI).The facility failed to prevent the elopement due to staff failure to coordinate monitoring responsibilities, communicate alarm statuses, or visually verify the exit perimeters.