STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465064	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST GEORGE REHABILITATION	**1032 EAST 100 SOUTH ST GEORGE, UT 84770**

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 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident 1 was admitted to the facility on [DATE] for a five day hospice respite stay with [DIAGNOSES REDACTED]. On 8/11/20 an abuse log was received from the facility and reviewed. An investigation was conducted for resident 1 on allegations of new excoriation, redness, and blistering on his sacral/coccyx area, and redness to his feet toes, and heel. The investigation was conducted on 6/2/20 by the Director of Nursing (DON), and stated: DON reviewed clinical charting and interviewed all direct care staff including wound nurse, LN's (licensed nurses), and CNA's (certified nursing assistants). It was reported by wound nurse and CNA's that (resident 1) had mild redness on his coccyx/buttocks that was noticed Friday (May 29) through Sunday (May 31) afternoon. The Sunday afternoon CNA reported that they changed (resident 1's) brief and cleaned his peri-area prior to placing him in his recliner around 1600 (4:00 PM). (Resident 1's) coccyx/sacral region was noted to have mild redness at this time. The CNA checked on the resident throughout the shift and was able to convince the resident to get into bed around 0400 (4:00 AM). A brief change was done at that time and it was noted the resident had increased redness with a darker area with blistering. (The CNA) did not report her finding to the nurse or oncoming shift. The DON concluded the investigation with: Upon chart review, staff interviews and other investigations, it was noted that (resident 1) was a confused gentleman that admitted to (the facility) for a hospice respite stay with significant co-morbidities, is a high risk of increased breakdown (Braden of 12) and also has a history of skin breakdown. (Resident 1) was noted to have poor nutritional intake, which would compromise his increased protein needs. The resident was also noted to refuse care and repositioning throughout his stay and preferred to sleep in recliner. He received brief changes and was repositioned as resident would allow, with increased breakdown noted the morning of 6/1/20. In light of this investigation, it is determined the resident breakdown was not preventable due to the items stated above. On 8/12/20 a copy a facility Quality Improvement review was provided, the review was conducted on 6/2/20 and stated Description of Specific Issue: Residents at risk for skin breakdown/Pressure sore are not being repositioned timely or frequently. Interventions listed were Educate direct care staff on importance of repositioning resident identified at high risk for skin breakdown. Provide in-service to staff regarding repositioning protocols and checking for skin alteration. (redness, open skin, DTI (deep tissue injury)). Notification to nurse or wound nurse for immediate up. Continue education regarding repositioning, CNA/LN notification to wound nurse regarding new skin alterations. On 8/12/20 resident 1's medical record was reviewed. A review of resident 1's history revealed no documentation of previous issues with skin breakdown. An admit skin assessment was conducted on 5/27/20 and documented that resident 1 had a skin issue on his scalp, as well as the front and back of his right lower leg r/t (related to) banging on wC (wheelchair). An admit Braden Scale for Predicting Pressure Sore Risk was conducted on 5/27/20 and determined that resident 1 was High Risk for skin breakdown related to sensory perception rating of Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. Skin moisture rating of Very Moist: Skin is often, but not always moist. Linen must changed at least once a shift. Activity rating of Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weights and /or must be assisted into chair or wheelchair. A mobility rating of Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. A nutritional rating of Probably Inadequate and a friction and shear rating of Problem: Requires moderate to maximum assistance in moving. Complete lifting with without sliding against sheets is impossible. Frequently sliding down in bed or chair, requiring frequent repositioning with maximum assistance. [DIAGNOSES REDACTED], contractures or agitation leads to almost constant friction. A bowel and bladder assessment conducted on 5/27/20 documented that resident 1 was completely incontinent of bowel and bladder. A nurses' progress note dated 5/27/20 documented .Patient is mildly confused at times, requires 2 or more persons to transfer r/t weakness. Patient does not have any obvious behaviors or issues and at this time denies pain. A nurses' progress noted dated 5/28/20 documented .(Resident 1) has been quiet and compliant. Takes meds, tolerates meals, has no complaints. No concerns at this time. A nurses' progress note dated 5/29/20 documented resident pleasant and cooperative at this time, was alert this morning and took meds well with no difficulty, is adjusting well. A nurses' progress noted dated 5/31/20 at 3:33 PM documented (Resident 1) is a five day respite in self isolation from recent admission. He was very tired this morning and refused cares and breakfast. Note: this was the only documentation of resident 1 resisting or refusing cares. A nurses' progress note dated 5/31/20 at 9:51 PM documented Resident adjusting well to facility, compliant with taking medications and obtaining vitals. He expressed that he is looking forward to going home tomorrow. A late entry progress note on 6/1/20, after resident 1 was discharged home, documented (Resident 1's) spouse informed DON of excoriation, redness, and blistering found on his sacral/coccyx area along with redness to his feet, toes, and heel. Discussed findings with Hospice nurse and found to be consistent with what spouse reports. Charts reviewed, Staff interviewed. Resident was noted to have breakdown around 0400 on morning of 06/01. Staff reports mild redness up until 06/01. Note: There was no documentation of resident 1 having any skin breakdown or treatment of [REDACTED]. A review of resident 1's physician orders [REDACTED]. A care plan problem initiated on 5/29/20 stated (Resident 1) has potential for pressure ulcer development r/t impaired mobility and circulation. (Braden score: 12) Interventions initiated on 5/29/20 included Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Weekly head to toe skin at risk assessment. On 8/11/20 at 1:27 PM, an interview was conducted with Nurse Assistant (NA) 2. NA 2 stated that residents should be repositioned every 2 hours, and that staff should remind independent residents to reposition themselves. NA 2 stated that any skin issues that were observed had to be immediately reported to the nurse. On 8/12/20 at 4:34 PM, a phone interview was conducted with the facility Administrator. The Administrator stated that resident 1 had come to the facility for a 5 day respite stay. The Administrator stated that resident 1's family member later came to talk about skin breakdown found on resident 1's buttocks and feet. The Administrator stated that based on the pictures provided by the resident 1's family member, the facility DON determined the skin breakdown to be Kennedy ulcers. Note: A Kennedy Ulcer as defined by https://www.ncbi.nlm.nih.gov/ is an unavoidable skin breakdown which occurs in some patients as part of the dying process. It often appears on the sacrum or coccyx, but can appear elsewhere. On 8/13/20 at 9:31 AM, a phone interview was conducted with resident 1's family member. The family member stated that when resident 1 came home she changed resident 1's brief and found 15 blisters on resident 1's buttocks and heels, stated that resident 1 had no skin issues prior to being admitted to the facility. The family member stated that the facility DON told her they were Kennedy ulcers which meant resident 1 was imminently dying, and that the ulcers were unavoidable. The family member stated that as of 8/13/20 resident 1 was still alive and most of the wounds had healed. The family member stated that resident 1 had no prior history of skin breakdown, and his only previous wounds were skin tears. On 8/17/20 at 9:11 AM, a phone interview was conducted with resident 1's hospice nurse. The hospice nurse stated that she assessed resident 1 on 6/1/20 after he came home from the facility, stated she also called the hospice medical director to come and assess resident 1. The hospice nurse stated that the medical director confirmed that the wounds to resident 1's buttocks and feet were not Kennedy ulcers and were in fact pressure ulcers. The hospice nurse stated that

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

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) resident 1 had been bed ridden at home since 4/1/20, and was bed ridden at a previous facility prior to that. The hospice nurse stated that despite the extended time of being bed ridden, resident 1 had not had any pressure ulcers or skin issues of any kind prior to being admitted to the facility for the 5 day respite stay. The hospice nurse stated that after resident 1 came home he required twice weekly nursing care for his wounds, as well as daily wound care by family members. The hospice nurse stated that the nurse and family were able to heal resident 1's wounds and that they resolved on 7/7/20. On 8/17/20 at 11:02 AM, a phone interview was conducted with the DON. The DON stated that a high risk Braden score indicated to staff that the resident needed additional encouragement for repositioning and brief changes. The DON stated that the facility did not have policies for preventative skin breakdown interventions for high risk residents; stated that over time the CNA's learned the residents' needs and who needed assistance with repositioning. The DON stated that resident 1 could move but he didn't want to, stated that resident 1 would tell the CNA's that he was fine and didn't need to move. The DON stated that the last night resident 1 was at the facility (May 31), resident 1 stayed in his recliner from 4:00 PM until sometime the next morning, and the night CNA did not reposition or change resident 1. The DON stated that he interviewed the CNA's and they reported that resident 1 had redness on his bottom prior to the last night of his stay, but the CNA's did not report it or document it anywhere. The DON stated that he suspected resident 1 had Kennedy ulcers because he had seen one once before and resident 1's wound appeared similar. The DON stated that the CNA's were educating resident 1 on repositioning, but stated the facility did not have any documentation of that education and encouragement.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **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** Resident 1 was admitted to the facility on [DATE] for a five day hospice respite stay with [DIAGNOSES REDACTED]. On 8/11/20 an abuse log was received from the facility and reviewed. An investigation was conducted for resident 1 on allegations of concerns regarding the transport driver protocols and the condition of the resident when he was brought home. On 8/12/20 a copy of staff education was provided, this education was given to and signed by the facility transporter. The education stated: Education was given, about proper techniques and protocols for transporting patients to and from the facility. We should have footrests on the wheelchairs to ensure the patients feet are not dragging on the ground or to endure the don't bump into their surroundings. Always ensure the patient is safe to transport. On 8/12/20 resident 1's medical record was reviewed. A Braden assessment conducted on 5/27/20 documented that resident 1 was Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. The assessment also stated that resident 1's mobility was Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. On 8/12/20 at 4:34 PM, a phone interview was conducted with the facility administrator. The administrator stated the facility driver took resident 1 home following resident 1's five day respite stay. The administrator stated that the driver did not have foot rests on resident 1's wheelchair while transporting him home. The administrator stated that resident 1 did begin to slide out of the wheelchair and resident 1's family had to reposition resident 1 back up into the wheelchair. The administrator stated that the driver was educated about the risks of not having foot rests on wheelchairs, such and skin injuries and falls. The administrator stated that footrests should always be on the resident wheelchairs during transportation. On 8/13/20 at 9:31 AM, a phone interview was conducted with resident 1's family member. The family member stated that when resident 1 was returned home the driver pulled resident 1's wheelchair down the van ramp to unload him from the van. The family member stated that resident 1 did not have foot rests on the wheelchair which caused his feet to drag on the ground and his shoes and socks to slide off. The family member stated that resident 1 started sliding out of his chair and the family members present had to hurry and lift resident 1 back into the wheelchair before he could fall. On 8/13/20 at 12:37 PM, a phone interview was conducted with the transport driver. The transported stated that he was supposed to always transport residents with foot rests on the wheelchairs to prevent injury and keep the residents' feet clean. The transporter stated that when he picked up resident 1 from the facility to take him home the transporter could not find resident 1's wheelchair foot rests. The transporter stated that he then had an aide hold resident 1's legs up so that they could load resident 1 into the van. The transporter stated that when they arrived at resident 1's house, resident 1 was slumped down and sliding out of the wheelchair. The transporter stated that he unloaded resident 1 down the van ramp; stated that resident 1's feet dragged on the ground and resident 1's sock had slid off his feet. The transporter stated that resident 1's family member then held up resident 1's legs so they would not drag on the ground while they got resident 1 into the house. The transporter stated that he did not know if resident 1 sustained any injuries to his heels during this time. The transporter stated that he had since been educated by facility management about safe transporting of residents and importance of using foot rests.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, one staff member was observed providing care to residents in isolation without proper Personal Protective Equipments (PPE's) and using the equipments between residents without cleaning it. In addition, the receptionist at the front entrance had her face mask over her mouth and not the nose and one staff member did not have face mask on her mouth and nose while talking to resident and when she was in close proximity to residents face. Findings include: An abbreviated complaint survey and an infection control focused survey was conducted on 8/11/2020. The survey team entered the facility on 8/11/2020 at 12:40 PM. It was observed that the receptionist who opened the door had mask on her mouth but not on her nose. On 8/11/2020 at 1:15 PM the surveyor started tour of isolation unit. It was observed that resident in room [ROOM NUMBER] was on isolation from 7/31/2020 to 8/14/2020. The yellow sign Droplet/ Contact was placed next to the door with instructions which PPE to wear when providing the care. The sign noted that surgical mask, gloves and gown were required before providing the care to resident. The sign noted that expanded precaution above are to be used along with standard precautions. The sign also noted that before exiting room: remove PPE: gown, gloves and mask. Wash hands. It was further observed that resident in room [ROOM NUMBER] was on isolation from 7/30/2020 to 8/3/2020. The same Droplet/ Contact sign was posted by the door. Resident in room [ROOM NUMBER] was on Droplet/ Contact precaution from 7/30/2020 to 8/13/2020. The cart with PPE's was placed in the front of the room and the sign was on the wall by the room. Resident in room [ROOM NUMBER] was on Droplet/ Contact precaution from 8/10/2020 to 8/24/2020. Residents in rooms [ROOM NUMBERS] were on Droplet/ Contact precaution from 8/4/2020 to 8/18/2020. There was no cart with PPE's in a front of either room. On 8/11/2020 at 1:20 PM, Nurse Assistant (NA) 1 was observed walking into 407 room. NA 1 had face mask on her mouth and nose; she did not have gloves or gown on. NA 1 was observed taking resident's vitals signs (VS). NA 1 walked out of the room, left the VS machine in a front of the room, went back to residents room and picked up the lunch tray. NA 1 walked out of the room, placed lunch tray onto a meal cart in the hall. NA 1 wrote meal consumption on the meal ticket and placed meal ticked on the top of the cart. NA 1 picked VS machine she left in front of room [ROOM NUMBER] and went to room [ROOM NUMBER]. NA 1 took vitals on resident in room [ROOM NUMBER]. NA 1 took VS machine out of the room and left it in a front of the room. NA 1 went back to room to picked up the lunch tray. NA 1 placed the lunch tray into a meal cart, wrote meal consumption on the meal ticket and placed it on the top of the cart. NA 1 walked toward the nursing station. NA 1 was observed talking to certified nursing assistant (CNA) 1. NA 1 walked toward the supply area where she picked the bucket of bleach wipes. NA 1 left the bucket with the bleach wipes in the basket attached to the VS machine. On 8/11/2020 at 1:30 PM, NA 1 was interviewed. NA 1 stated that she started to work for the facility a week ago and that she was currently taking the class to become a CNA. NA 1 stated that she received training's regarding the infection control when she started to work. DNA 1 stated that her co-worker just reminded her that she needed to clean the VS machine between each resident. NA 1 stated that she did not provide any other care besides taking VS's to these 2 residents. NA 1 stated that she thought that she did not need to wear gown and gloves when taking someone's VS's. NA 1 was not sure if cleaning the equipments or wearing the PPE's when taking residents VS's was part of infection control training she received when she started to work. On 8/11/2020 at 1:37 PM, CNA 1 was interviewed. CNA 1 stated that she worked for the facility since January 2019. CNA 1 stated that the staff members received infection control training's almost daily. CNA 1 stated that 400 hall was their isolation unit and all new admits or residents with respiratory infection were placed there. CNA 1 stated that VS's of each resident in isolation were checked every 4 hours. CNA 1 stated that all residents in

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) isolation unit were on Droplet/ Contact precaution and that the staff were required to wear proper PPE's before entering the rooms. CNA 1 stated that the staff were required to wear gown, mask and gloves before entering isolation rooms. CNA 1 stated that the staff wear the masks all the time while in the facility. CNA 1 stated that one isolation cart is shared between few rooms. CNA 1 stated that they had hand sanitizers in each residents room and throughout the halls. CNA 1 stated that the PPE's used for residents care were discarded in residents rooms when the staff were done providing the care. CNA 1 stated that the staff were supposed to wash or sanitize their hands before exiting any room on isolation. CNA 1 stated that only one meal cart was used for the isolation unit and this meal cart was not shared with any other unit so the trays and the cart were cleaned and sanitized in the kitchen separately from other trays and carts. On 8/11/2020 at 1:45 PM, the Director of Nursing (DON) was interviewed. The DON stated that their 400 unit was designed for new admits who would stay in this unit for 14 days after admission. The DON stated that all staff members were required to wear the face covering throughout the building. The DON stated that in the isolation unit, in addition to face masks, the staff were required to wear the gloves and the gown when providing care to residents. The DON stated that the staff were required to wear the mask, gown and gloves when taking vitals of residents in isolation. The DON stated that they provided multiple infection control training's to their staff. The DON stated that all equipments used in isolation, including VS machine, required cleaning after each resident's use. The DON stated that the equipments were cleaned with the bleach wipes. The DON stated that they did not have isolation cart for each isolation room, but that they shared the carts from where the staff could pull the gown, gloves and masks as necessary. The DON stated that each isolation room had hand sanitizer dispenser on the wall as well as proper canisters/ bags for used PPE's disposal. On 8/11/20 at 12:54 PM, an observation was made of the facility receptionist. The receptionist had her KN95 face mask pulled below her nose, covering her mouth only. The receptionist was at the facility front desk and several residents were within six feet of her while her mask was pulled down. On 8/11/20 at 1:19 PM, an observation was made of Registered Nurse (RN) 1. RN 1 was observed in resident room [ROOM NUMBER] talking to a resident. RN 1 was observed to pull her mask down below her chin, uncovering the RN's mouth and nose, to talk to the resident. RN 1 was observed to be within six feet of the resident when talking to her. RN 1 was then observed to leave the resident room, grab crackers for the resident, and return to the same resident's room without performing hand hygiene. RN 1 was observed to leave the resident's room again and go to the nurses' station; RN 1 again did not perform hand hygiene. On 8/13/20 at 12:03 PM, a phone interview was conducted with the facility receptionist. The receptionist stated the she had been educated on hand washing and hand sanitizing. The receptionist stated that all staff were instructed to wear a mask and face shield around residents, and that mask had to cover the mouth and nose. The receptionist stated that she wore a mask and face shield if residents were up by the reception desk. The receptionist stated that she sometimes pulled her mask down under her nose so she could breathe, stated that the mask made her feel claustrophobic. On 8/13/20 at 12:10 PM, a phone interview was conducted with RN 1. RN 1 stated that she pulled her mask down to talk to the resident in room [ROOM NUMBER] because the resident was having trouble hearing RN 1. RN 1 stated that pulling her mask down to talk to residents was not usual practice. RN 1 stated that all staff were educated about wearing a mask and face shield all day while in the facility. RN 1 stated that not wearing a mask put the staff and residents at risk for catching and spreading infectious diseases. RN 1 stated that she did not use hand hygiene because she did not touch the resident in room [ROOM NUMBER], stated that she thought hand hygiene was only required if staff performed direct patient care such as wound care or nebulizer treatments. On 8/17/20 at 11:34 AM, a phone interview was conducted with the Director of Nursing (DON). The DON stated that staff were educated that they had to always wear a face mask and shield in patient rooms, and the mask had to cover their nose and mouth no ifs, ands, or buts.