STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465101	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HURRICANE HEALTH AND REHABILITATION	**416 NORTH STATE STREET HURRICANE, UT 84737**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, it was determined, for 2 of 20 sample residents, that the facility did not review and revise the comprehensive care plan. Specifically, two residents who had multiple falls did not have the care plan revised and updated with interventions in an attempt to keep residents safe. Resident identifiers: 3 and 15. Findings include: 1. Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/4/20 resident 3's medical record was reviewed. Resident 3's medical record revealed that resident 3 had 7 falls on 3/20/19, 7/28/19, 8/4/19, 8/8/19, 8/21/19, 8/24/19 and 2/9 20. Resident 3's medical record revealed that he had sustained injuries of a bleeding forehead on 8/4/19 and 2/9/20. Resident 3's fall care plan revealed that there were no updates to the care plan, including fall dates and interventions after each fall. 2. Resident 15 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/4/20 resident 15's medical record was reviewed. Resident 15's medical record revealed that resident 15 had 5 falls on 9/16/19, 11/1/19, 1/17/20, 1/19/20, 1/21/20. Resident 3's medical record revealed that he had sustained injuries of a laceration to his right arm stump on 9/16/19. Resident 15's fall care plan revealed that there were no updates to the care plan, including fall dates and interventions after each fall. On 3/04/20 at 2:10 PM, an interview was conducted with the facility DON. The facility DON stated that facility staff had implemented interventions for each fall. The facility DON stated that facility staff had not documented the interventions that had been put in place for the residents. The facility DON stated that there were previous care plans that had interventions in place, but, that the interventions had been resolved and not carried forward to current care plans. On 3/4/20 at 2:30 PM, the facility Administrator stated that they need to do a better job with our documentation.
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** Based on observation, interview and medical record review, it was determined for 2 of 20 sample residents, that the facility did not ensure that the resident environment remains as free of accident hazards as is possible. Specifically, two residents who had multiple falls, did not have interventions put in place in an attempt to prevent falls. Resident identifiers: 3 and 15. Findings include: 1. Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/4/20 resident 3's medical record was reviewed. Incident reports for resident 3 revealed the following: a. 3/20/19, Nursing Description: Staff was doing round(s) in room [ROOM NUMBER] and found the resident sitting on the floor. Resident Description: Resident stated he was trying to get up to go to the restroom and slipped to the floor. Immediate Action Taken: Two person assist with transfer from floor to the resident recliner. Initiated neuro checks. No bruising or redness noted. No injuries. b. 7/28/19, Nursing Description: SN (skilled nurse) was called to patients room where pt (patient) was sitting on floor. SN and CNA (Certified Nursing Assistant) assisted pt off the floor to his bed. Resident Description: Pt reports he was trying to pick up some nuts off the floor that he spilled and he fell back on to his butt. Pt said he did not hit his head. Pt denied pain. Immediate Action Taken: SN and CNA transferred pt to a safe place to rest on his bed. Head to toe assessment. Neuro's initiated. VSS (vital signs stable), MD (medical doctor), wife and DON (Director of Nursing) notified. c. 8/4/19, Nursing Description: Loud bang heard by CNA, resident found in room sitting against armoire. Blood was dripping from left side of forehead, lip sustained small cut. Staff responded to assist resident. Resident Description: Resident stated that he was having a dream he was at the rodeo and was trying to get on a horse. Recliner was positioned as if resident was trying to get off recliner. When asked if his head hurt, he responded a little. Immediate Action Taken: Vitals taken, forehead cleansed and pressure applied to stop bleeding. Small 1.5 cm (centimeter) long 0.1 cm deep superficial cut on forehead noted. Triple antibiotic ointment applied and covered w (with)/dressing. BP (blood pressure) high 160/100, PCP (primary care physician) notified. d. 8/8/19, Nursing Description: Nurse went to step out of residents room, when resident got up. Nurse heard a crash. She turned to find resident sliding down with his back to the amour (sic). Nurse stated he did not hit his head. Resident Description: Resident stated he was trying to get up, then he slipped and hit his amour (sic). Immediate Action Taken: Nurse and CNA assisted to chair. Nurse performed head to toe assessment. Scrape to back was noted. PERRLA (pupils equal round reactive to light and accommodation). Vitals (sic) signs WNL (within normal limits). Resident denied transport to (Hospital). MD, DON and wife notified. e. 8/21/19, Nursing Description: Staff were at the nurses station when a crash was heard. Staff entered into 17 to find the resident sitting in front of the open bathroom door on the floor. Resident Description: Resident stated he was trying to find the restroom and lost his balance and fell to the floor. Immediate Action Taken: Two person assist with transfer from floor to standing position. Upon assessment no injuries were noted. Initiated neuro checks. The resident was toilet(ed) and ambulated with staff back to his bed. f. 8/24/19, Nursing Description: Aide called nurse to dining room. Walked in to find resident laying on his back on the floor. Wife and laundry worker was standing there with him with several residents in the area as well. Patient Description: Resident stated he got light headed and passed out. He stated he wasn't in any pain. Immediate Action Taken: Wife stated that he stopped and looked sort of dazed and then started to go to the floor. He layed down on the floor afterwards. Checked resident for injuries, none found. Assisted resident into a wheelchair. Started neurovascular checks. Notified (Resident's physician) and DON. g. 2/9/20, Nursing Description: SN was called to patients room. Pt was on the floor and was bleeding from the Left side of his forehead. Patient Description: Pt reports that he was having a dream and next thing he knew he rolled out of his bed and hit his head on the bedside drawer. Immediate Action Taken: SN implemented a head to toe assessment. Pressure applied to hematoma on L (left) side of his forehead which was bleeding. SN with the assistance of staff transferred pt to his recliner. Traumatic wound on L side of forehead cleansed and Steri strips applied. Neuro's initiated. VSS. Pt refused to go to the hospital. 2. Resident 15 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/4/20 resident 15's medical record was reviewed. Incident reports for resident 15 revealed the following: a. 9/16/19, Nursing Description: Resident found walking in room by CNA with blood running down stump on L arm. Resident was not using walker. CNA applied pressure and called for assistance from RN. RN asked resident how he started bleeding and he said it happened when he fell out of bed 10 minutes prior. Resident Description: RN asked what caused the fall and resident said he was tangled in his blanket. Resident said he did not hit his head. Resident denies pain. Immediate Action Taken: Head to toe assessment performed, no other injuries found at this time. VS and neuro checks initiated. Resident's stump cleaned small laceration found, and Band-aid applied. DON and MD notified. VS and neuros have been stable. b. 11/1/19, Nursing Description: CNA call nurse to room. Resident was laying on the floor on his left

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

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.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) side. Resident Description: Resident stated 'I was parking my walker, I felt weak, and fell back against the wall, I slid down the wall and then rolled to my side. Immediate Action Taken: Nurse performed head to toe assessment. Redness noted on his back. Nurse and CNA assisted resident from floor to bed. Vitals and neuro signs initiated: both WNL. No other injuries noted. Resident denied hitting his head. Resident also denied transportation to (hospital) for further evaluation. MD, DON and family notified. c. 1/17/20, Nursing Description: Staff was doing rounds as he entered the room, he found the resident on the floor in front of the door. Resident Description: The resident stated he was trying to walk to his bed and he fell on the floor. Immediate Action Taken: Three person assist with transfer from floor to his bed. Initiated neuro checks. Upon assessment noted a(n) abrasion on the residents left elbow and left lumbar back. Wound on elbow was cleaned with wound cleaner and a band aid was applied. d. 1/19/20, Nursing Description: Housekeeper notified nurse that resident was on the floor. Nurse entered room to find resident face down on the floor next to his bed. Resident Description: Resident stated that he was trying to get out of bed to go to the bathroom. Immediate Action Taken: Nurse and CNA assisted resident off of floor and into bed. Nurse performed assessment. Bruising and an abrasion was noted to residents R side. Resident stated he hit his head. Vital signs were initiated and were WNL. Neuros were initiated and were WNL. Resident refused transport to (hospital) for further evaluation. Family, DON and MD notified. e. 1/21/20 Nursing Description: Nurse called to patient room by CNA. Patient was found on floor next to bed. Resident Description: Patient said he 'rolled over to get comfortable and fell off the edge of his bed.' He said his left elbow hurt. He declined Tylenol when offered. No new injuries noted. Immediate Action Taken: Patient offered and refused Tylenol. Staff frequently checked on patient for the rest of the night. Patient educated about feeling for the edge of bed before rolling. On 3/04/20 at 2:10 PM, an interview was conducted with the facility DON. The facility DON stated that facility staff had implemented interventions for each fall. The facility DON stated that facility staff had not documented the interventions that had been put in place for the residents. The facility DON stated that there were previous care plans that had interventions in place, but, that the interventions had been resolved and not carried forward to current care plans. On 3/4/20 at 2:30 PM, the facility Administrator stated that they need to do a better job with our documentation.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility did not ensure safe and secure storage of drugs and biological's in accordance with accepted professional principles; or include the appropriate accessory and cautionary instructions, and the expiration date on the medication. Specifically, multiple medications in the medication or treatment carts were found to be expired. Findings include: 1. On [DATE] at 7:48 AM, the treatment cart in the Medicare unit was inspected. The medication cart contained twenty seven 0.18 ounces (oz) packets of Petroleum Jelly that expired on ,[DATE]. The cart also contained ten 0.18 oz packets of Petroleum Jelly that expired on ,[DATE] and fifteen packets that expired on ,[DATE]. 2. On [DATE] at 7:57 AM, the medication administration cart in the Medicare unit was inspected. The cart contained one bottle of 600 milligrams (mg) Calcium tablets that expired on ,[DATE] and bottle of 400 mg Folic Acid tablets that expired on ,[DATE]. The cart also contained 100 tablet bottle of Calcium [MEDICATION NAME]+Vitamin D 3 that expired on ,[DATE] and one 37.5 gram (gr) tube of Glucose 15 for treating low blood sugar that expired on ,[DATE]. An interview was immediately conducted with Registered Nurse (RN) 1. RN 1 stated that the medications were expired and still available for use. 3. On [DATE] at 8:12 AM, the medication storage cabinet in the Medicaid unit was inspected. The cabinet contained one bottle of 24 caplets of Laxative that expired on ,[DATE] and one bottle of Fleet Mineral Oil Enema that expired on ,[DATE] per the manufacturing date. The Fleet Enema had a pharmacy label with an expiration date of [DATE]. 4. On [DATE] at 8:20 AM, the medication administration cart in the Medicaid unit was inspected. The cart contained 1 tube of Glucose 15 that expired on ,[DATE]. On [DATE] at 8:28 AM, Registered Nurse (RN) 3 was interviewed. RN 3 stated that when comes to expiration dates on medications, she would go with whichever date comes first. RN 3 stated that she was not sure why the pharmacy had a different expiration date from the manufacturing expiration date. On [DATE] at 8:38 AM, RN 2 was interviewed. RN 2 stated that she always followed the date on the pharmacy sticker. RN 2 stated that she followed the manufacturing expiration date on over-the-counter (OTC) medications. RN 2 stated that if she had medication with different pharmacy and manufacturing dates, she would need to do some verification with the pharmacy before administering medication. RN 2 stated that she usually followed the the information on the pharmacy sticker and that she was not sure why the manufacturing and the pharmacy expiration dates were different. On [DATE] at 9:23 AM, RN 1 was interviewed. RN 1 stated that when related to expiration dates, she followed the date on the pharmacy sticker. RN 1 stated that the manufacturing expiration date and the pharmacy expiration date were supposed to be same. RN 1 was not sure why these 2 dates did not match on some of the medications in her cart. On [DATE] at 10:09 AM, the Director of Nursing (DON) was interviewed. The DON that for both, the OTC (over the counter) and pharmacy medications, they followed the manufacturing expiration date. The DON stated that he did not know that the dates on the pharmacy labels were different from the manufacturing date. The DON stated that he never questioned the pharmacy about the expiration dates. The DON stated that the dates should be the same. The DON stated that they assigned two staff members who inspected each storage room and each medication administration cart once per week. The DON stated that all of the products that were in the cart and expired should not be there. The DON stated that the treatment cart in the Medicare unit was new and he was not sure how the Petroleum Jelly found there expired in 2016 when the cart was not even ready for use just 2 months ago. The DON stated that it was possible that the pharmacy or the online supplier sent them expired products and that the staff did not check the dates assuming that the products were brand new. The DON stated that he remembered that he had an in-service with the staff about medications expiration dates but he did not have any documentation and did not remember when that in-service was. The DON stated that during the in-service he was not very specific about which date to follow. The DON stated that they did not have a specific protocol regarding the expiration dates. On [DATE] at 10:43 AM, the Administrator was interviewed. The Administrator stated that they ordered some medications through their online supplier. The Administrator stated that Petroleum Jelly had not been ordered for awhile and he was not sure how the packages from 2016 ended up being in the treatment cart.