| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **465096** | A. BUILDING _____ B. WING _____ | **08/04/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CANYON RIM CARE CENTER** | **2730 EAST 3300 SOUTH SALT LAKE CITY, UT 84109** |

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 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br><br>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, staff were observed without eye protection and gowns in patient care areas. In addition, personal protective equipment (PPE) was not available for staff. Findings include: On 7/30/2020 at 1:35 PM, the Administrator (ADM) stated that the facility supply room was in the basement. The ADM stated that the facility was currently a COVID-19 positive facility. The ADM stated that all residents at the facility except for one had was COVID-19 positive. On 7/30/2020 at approximately 1:35 PM, an observation was made of the Central Supply area on the first floor of the facility. Supplies of PPE were observed in a locked storage room. The Central Supply Director (CSD) stated that most staff members did not have access to the supply room, but Administration personnel could retrieve the PPE supplies requested by staff members. The CSD stated that he supplied the floors with the supplies that they needed before he left the building for the day or weekend. The CSD stated that he was not in the building after 4:00 PM or on weekends. On 7/30/2020 at 1:40 PM, an observation was made of the staff entrance into the facility. There was a secured gate with a fence in front of the door. The Director of Nursing (DON) opened the gate and there was a resident inside the fenced area. There was a small plastic container with 3 drawers observed outside the door to the facility and inside the fenced area. The DON stated that staff donned their PPE outside the door. The DON stated that PPE was in the plastic container. The top drawer had 5 3m brand N95 masks and another box labeled N95 that was empty. The second drawer was observed to be empty. The bottom drawer had a package of 10 disposable gowns. The DON stated that Laundry restocked the PPE at 2:30 PM every day because shift change for nurses and Certified Nurses Aides (CNAs) was at 2:00 PM. The DON was not observed to don a gown or gloves prior to entering the facility. The DON was observed to wear an N95 mask and face shield. The DON stated that she had not tested positive for COVID-19. On 7/30/2020 at 1:50 PM, the CNA scheduler was interviewed. The CNA scheduler stated that staff donned their PPE outside the facility prior to entering. The CNA scheduler stated that staff entered the memory care unit and self screened inside a room directly inside the unit. The CNA scheduler stated that staff were unable to leave the screening equipment in the hallway because residents with dementia were touching the equipment. The room for screening was observed to be full of resident care equipment. There was no observed area for staff to place their masks or face shields. On 7/30/2020 at approximately 2:00 PM, an observation was made of a plastic container about halfway down the 3rd floor hall. The container was observed to have drawers. The DON stated there were gowns in the drawers for staff to don when entering the facility. There were other resident care supplies observed in the drawers. On 7/30/2020 at 2:10 PM, the DON lead surveyors to the break room and into an antechamber to the west hallway of the 3rd floor. Nurse 1 was observed to be sitting in a chair next to a resident. Nurse 1 was observed to be without eye protection and the resident was not observed to be wearing a mask. Nurse 1 stated, It's hot in here and I needed a break from my goggles. On 7/30/2020 at 2:20 PM, an observation was made a large garbage bag in the stair well on the 3rd floor. The DON stated the bag was full of clean reusable gowns for staff to wear. An observation was made of the east hallway of the second floor. Housekeeper (HK) 1 was observed to have a green colored N95 mask on and no eye protection. HK 1 was observed to ask the DON for a new N95 mask. The DON stated that she would get her one in a minute. On 7/30/2010 at approximately 1:00 PM, an interview was conducted with a Floor Staff (FS1). FS1 stated that she worked in the COVID-19 unit on the third floor of the facility. FS1 stated that staff working in the COVID-19 unit had to retrieve supplies and equipment from the clean area in the basement that included the supply room. FS1 stated that staff needed items quickly and therefore did not have time to doff their PPE before going into the storage room. FS1 also stated that PPE was not always available when staff arrived at work. FS1 stated that staff were required to wait multiple times for working staff to locate the correct PPE in the facility. Wait times were between 30 and 40 minutes, and at one time staff were required to wait approximately an hour while PPE was retrieved from another facility, because the facility did not have the PPE on site. FS1 stated that PPE was frequently not stored on the 3rd floor where staff members were required to enter the building. On 8/3/2020 at 3:11 PM, a phone interview was conducted with Nurse 3. Nurse 3 stated that she was an LPN and had tested positive for COVID-19. Nurse 3 stated that all staff entered through the 3rd floor east side entrance. Nurse 3 stated that staff donned PPE outside the facility. Nurse 3 stated that all staff wore an N95 mask, gloves, gown, and goggles or face shield. Nurse 3 stated that she removed her face shield while on break or away from the facility. Nurse 3 stated that she had to work with a surgical mask instead of an N95 mask because there were no N95 masks available outside the 3rd floor entrance. Nurse 3 stated that she called a nurse in the facility to get an N95 mask and the nurse told her that management was aware but there were no N95s in the hall. Nurse 3 stated that she had also worked half of a shift without a gown because there were no clean gowns. On 8/3/2020 at 3:14 PM, a phone interview was conducted with Nurse 4. Nurse 4 stated she was an LPN. Nurse 4 stated that all staff entered through an east side door onto the 3rd floor memory care unit. Nurse 4 stated that she entered the 3rd floor, did hand sanitation, filled out a form, checked her temperature, and had another staff member sign the form. Nurse 4 stated that she donned a gown, mask, gloves and placed a face shield on. Nurse 4 stated that she would remove PPE when taking a break or leaving the facility. Nurse 4 stated that she reused her masks for 3 shifts. Nurse 4 stated there were not enough N95s stored at the staff entrance. Nurse 4 stated that she had to wait outside till staff obtained an N95 mask for her and brought it outside. Nurse 4 stated that masks were not available and she had to wait for a staff member to find one and bring it out to her at least once a week. Nurse 4 stated that she usually had to wait an hour before staff brought a mask. On 8/4/2020 at 12:40 PM, an interview was conducted with Floor Staff 2 (FS2). FS2 stated that it had been difficult getting PPE since the plastic walls were established to designate COVID-19 areas in the facility. FS2 stated that staff were not fit tested for N95 masks for several weeks after starting to work in the facility's COVID-19 units. FS2 stated that floor staff were told that there was equipment or PPE in the COVID-19 units, but nobody knew where it was. FS2 stated that staff were still having difficulty receiving the PPE that they needed within the past two weeks. FS2 stated that the N95 masks were taken home by staff or stored in staff members' cars because FS2 and other staff were not aware that there was a space to keep them in the facility. FS2 stated that wait times to get PPE before starting a shift were often 40 minutes, and screening for shifts occurred on the COVID-19 unit. FS2 stated that there were storage drawers for PPE outside the third floor, but they were not always stocked. On 8/3/2020 at 3:28 PM, a phone interview was conducted with Nurse 2. Nurse 2 stated that if there were inadequate supplies on the COVID-19 units, the nursing staff would go down to Central Supply to retrieve items. Nurse 2 stated that staff working on the COVID-19 units had been in Central Supply multiple times. Nurse 2 stated that the screening process occurred on the COVID-19 unit, instead of before staff entered the facility. Nurse 2 stated that staff had to wait for PPE to be brought to the entrance before they could enter the facility. Nurse 2 stated that the facility had shortages in available of PPE, but someone had always brought it over to the facility or it had been misplaced. On 8/3/2020 at 4:00 PM, a phone interview was conducted with the ADM. The ADM stated that the facility staff were using KN95s until the week of 6/15/2020, when all staff changed to N95s. The ADM stated that all staff were fit tested |

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 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>with N95s and all staff were to be wearing N95s. On 8/4/2020 at 9:40 PM, a follow up phone interview was conducted with the CSD. The CSD stated that there were 4 types of N95 masks used by the staff. The CSD stated that he did not know how many staff required which type of masks. The CSD stated that he had a total count of how many N95 masks he had but did not divide them out into each type. The CSD stated that staff for the COVID-19 unit entered through the 3rd floor east side. The CSD stated that a laundry staff member delivered reusable gowns to the 3rd floor about 2:00 PM everyday. The CSD stated that staff requested N95 masks and he delivered them to the antechamber on the 3rd floor. The CSD stated that he sent 30-60 N95 masks to the 3rd floor at a time. The CSD stated that he thought staff took their N95 masks home with them. The CSD stated staff were to use a mask for 3 shifts before disposing of them and getting a new mask.<br><br>On 8/4/2020 at 11:02 AM, a phone interview was conducted with the ADM, DON, Administrator in Training (AIT), and a Regional Nurse Consultant (RNC). The ADM stated that all staff should wear full PPE (N95 mask, eye protection, a gown, and gloves) while in the areas with COVID-19 positive residents. Staff should store their N95 face masks in the break rooms, located in the center of each hallway on the second and third floors. The ADM stated that the masks can be used for 2 1/2 days because taking them off during an employee break counted as 1 use. The ADM stated that staff should not retrieve items from Central Supply if they are working with COVID-19 residents. The ADM stated that there were not always masks at the entry site for the staff, because if we leave masks out, they get stolen. We have to keep them secure. The AIT stated that she and one of the unit managers would go to the facility at approximately 1:00 AM to retrieve items for the staff on the night shift if staff needed items that were unavailable on the floors, but they had not been called in the past few weeks. On 8/5/2020 at 2:25 PM, a follow up interview was conducted with the ADM and AIT. The AIT stated that staff members were provided a plastic shoe box container in which to store their face shields and N95 mask. The AIT stated that the containers were stored in the antechamber on the third floor. The AIT stated that staff who were working brought the container to the on-coming staff at the 3rd floor east side entrance. |