STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465095	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOSEPH VILLA	451 EAST BISHOP FEDERAL LANE SALT LAKE CITY, UT 84115

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 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep residents' personal and medical records private and confidential.** Based on observation and interview it was determined that the facility did not ensure that the resident's medical records were secured and confidential. Specifically, observations were made of computer screens left unattended and displaying resident personal information. In addition, residents were observed in the area with the unattended computer screens. Findings include: On 3/3/20 at 8:03 AM, Registered Nurse (RN) 2 was observed to walk away from a computer that was on the medication cart located in the hallway on the northeast side of the 3rd floor. The computer screen was observed to have resident information open and visible. There were five residents observed sitting around the area of the unattended open computer screen. On 3/4/20 at 7:08 AM, RN 1 was observed to walked away from a computer on a medication cart with a residents medical record open and visible. The computer was by the North West nurses' station on the 2nd floor. The open computer screen was observed to be unattended for 3 minutes. On 3/4/20 at 7:35 AM, RN 3 was observed to leave person identifying information on a computer screen. The computer was located on the medication cart in the public hallway on the first floor. There were no staff observed in the hallway or near the open computer. On 3/4/20 at 7:51 AM, an interview was conducted with Director of Nursing (DON) and RN 3. The DON and RN 3 stated that staff were to protect resident personal identifying information by securing the computer screen before walking away from the computer.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, interview, and record review it was determined that the facility did not ensure that the drugs were label according to accepted professional principles and stored in a locked compartment. Specifically, medications were found in resident's rooms, and medication carts were not kept secured. Findings include: 1. On 3/2/20 at 7:30 AM, an observation was made of room [ROOM NUMBER] with a bottle [MEDICATION NAME] nasal spray on the resident's bedside table. 2. On 3/2/20 at 7:34 AM, an observation was made of room [ROOM NUMBER] with an unlabeled medication cup on the resident's shelf; the cup contained a white powder. 3. On 3/4/20 at 7:32 AM, an observation was made of Registered Nurse (RN) 1. RN 1 left the medication cart unlocked and unattended while administering medications to a resident. RN 1 stated he was going to wash his hands. RN 1 was observed to go into the bathroom. RN 1 returned to the cart at 7:34 AM. 4. On 3/4/20 at 8:03 AM, an observation was made of the third East medication cart. RN 4 was observed to walk away from the medication cart to administer medication to a resident, the medication cart keys were observed to be left on top of the cart behind a bottle of hand sanitizer. RN 4 returned to the medication cart at 8:09 AM. 5. On 3/4/20 at 8:04 AM, an observation was made of room [ROOM NUMBER]. There was a [MED] inhaler in the resident bedside table. The resident stated I know I'm not supposed to keep it in here, but I do so that I have it whenever I need it. On 3/4/20 room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]'s medical records were reviewed. There was no documentation that residents were assessed to administer their own medications. On 3/4/20 at 10:24 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that there were not any residents that she was aware of that were safe to administer their own medications. CNA 2 stated that if medications were found in a resident room, then they needed to be taken to the nurses. On 3/4/20 at 10:25 AM, an interview was conducted with RN 1. RN 1 stated that there were not any residents that he was aware of that were safe to administer their own medications. RN 1 stated that if medications were found in a resident room, they needed to be removed. RN 1 stated that medications in a resident's room were a risk because the resident could overdose or take the medication incorrectly. RN 1 stated that medication carts were to be locked any time the nurse was not at the cart. RN 1 stated that there should be no unlabeled medication cups with creams or powders left in resident rooms because no one would know what the creams or powders were or if they were harmful. RN 1 stated that staff should only take in enough cream or powder for one time use and then throw the rest away. On 3/4/20 at 10:50 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the resident in room [ROOM NUMBER] had been administering her own inhaler, but that it was not documented or assessed that she was safe to do so. The DON stated that there were not any other resident's that were assessed as safe to administer their own medication. The DON stated that if a medication was found in a resident room, the medication should be removed, and the family should be called to come pick it up. The DON stated that the risk of resident's having medications in their rooms was that they could over medicate. The DON stated that medication carts should be locked any time they were out of the nurses' line of sight. The DON stated that there should not be any unlabeled cups of creams or powers in resident rooms because there would be no way of knowing what was in the cups.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, there were cracked tiles in the dishmachine area that had pooling water, there was pealing paint above the food preparation area, and there were soiled areas behind the equipment. Findings include: 1. On 3/2/20 at 7:40 AM, an initial tour of the kitchen was conducted. The following was observed: a. There were 2 spots of pealing paint on the ceiling in the kitchen. Food was observed to be transported under the pealing paint. b. There was dust and debris behind the ovens, stove, steamer and griddle. c. There were 4 broken tiles in the dishmachine area. There was water pooling in the area that pieces of tiles were missing. 2. On 3/4/20 at approximately 12:30 PM, a follow up kitchen tour was conducted. The following was observed: a. There were 2 spots of pealing pain on the ceiling in the kitchen. Food was observed to be transported under the pealing paint. b. There was dust and debris behind the overs, stove, steamer and griddle. c. There were 4 broken tiles in the dishmachine area. There was water pooling the the area that the pieces of tiles were missing. An interview was immediately conducted with the Dietary Manager (DM). The DM stated that there was a work order for the tiles to be replaced. The DM stated that staff cleaned weekly behind the ovens, stoves, steamers and griddles. The DM stated that she would fill out a work order for the pealing paint on the ceiling. The DM provided a work order for the broken tiles. The work order was started on [DATE]. The DM stated that it has been a while since the work order had been placed. The DM stated that special tile had to be ordered and it took a while.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.**

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 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility did not establish and 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 to cross contamination while serving residents in the dining room. In addition, hygiene products in shared bathrooms were not labeled. Resident identifiers: 46, 48 Findings include: 1. On 3/2/20 at 8:00 AM, Certified Nursing Assistant (CNA) 2 was observed in the 3rd floor dining room assisting two residents with eating. CNA 2 was observed to finger sweep of resident 48's mouth with her index finger to remove a large amount of chewed but unswallowed food. CNA 2 was not observed to use a glove, CNA 2 was observed to wrap a cloth napkin around her index finger prior to placing her finger in resident 48's mouth. After removing the unswallowed food CNA 2 placed the napkin on the table and began feeding resident 46. CNA 2 was observed to switch between the two residents without sanitizing or washing her hands. On 3/4/20 at 12:45 PM the Director of Nursing (DON) was interviewed. The DON stated that she expected staff to use gloves when putting fingers in residents mouth and then wash their hands before assisting another resident. The DON stated staff should not use a cloth napkin to remove food from a residents mouth and not wash their hands after. 2. On 3/2/20 at 7:49 AM, an observation was made of CNA 3 assisting a resident to eat. CNA 3 used the resident's spoon and fork after the resident had already touched them. CNA 3 then went to assist another resident without sanitizing or washing hands her hands. The other resident then touched her utensils after CNA 3 had assisted her. 3. On 3/2/20 at 7:52 AM, an observation was made of Certified Nursing Assistant (CNA) 4. CNA 4 was observed to assist a resident with eating. CNA 4 touched her hair and scrubs then resumed assisting the resident without sanitizing or washing her hands. 4. On 3/2/20 at 7:58 AM, an observation was made of CNA 6. CNA 6 was observed to grab a resident's juice cup by the top rim to pass it to a resident. 5. On 3/2/20 at 12:06 PM, an observation was made of CNA 4. CNA 4 was observed to stir and blow a resident's soup. 6. On 3/2/20 at 12:06 PM, an observation was made of CNA 3 stirring soup for 2 separate residents and then giving the residents their utensils to use themselves; CNA 3 did not sanitize or wash her hands prior to touching the resident's utensils. 7. On 3/2/20 at 7:31 AM, an observation was made of room [ROOM NUMBER]'s bathroom. The bathroom was shared with multiple residents and contained unlabeled resident toothbrushes. 8. On 3/2/20 at 7:34 AM, an observation was made of room [ROOM NUMBER]'s bathroom. The bathroom was shared with multiple residents and contained unlabeled resident toothbrushes. 9. On 3/2/20 at 10:23 AM, an observation was made of room [ROOM NUMBER]'s bathroom. The bathroom was shared with multiple residents and contained unlabeled resident toothbrushes. On 3/4/20 at 10:20 AM, an interview was conducted with CNA 3. CNA 3 stated that hygiene products in shared resident bathroom had to be labeled with the resident name and room number on them. CNA 3 stated that when assisting residents in the dining room, CNA's had to wash their hand first, and use Alcohol based Hand Sanitizer (ABHR) in-between helping 2 residents. CNA 3 stated that if a CNA touched their hair or clothes, they had to wash hands again prior to assisting residents with meals. CNA 3 stated that staff must hold all plates and cups by the bottom, so staff did not touch anywhere that the resident would touch. CNA 3 stated that to cool off resident food you could just give it time or stir it, but never blow on it. On 3/4/20 at 10:46 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident hygiene products in shared bathrooms had to be labeled with the resident's name. The DON stated that when CNA's were assisting residents to eat, the CNA should never touch their hair or clothes, and should always use ABHR in-between helping residents. The DON stated that CNA's should not touch the rim of the resident's drinking cup. The DON stated that staff should not blow on the resident's food.