Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465064	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46565 Based on interview, record review, document review, and policy review, the facility failed to protect residents' rights to be free from verbal abuse and physical abuse by staff and by a resident for 2 (Resident #33 and Resident #47) of 13 sampled residents reviewed for abuse. On 08/21/2023, Licensed Practical Nurse (LPN) #29 was heard by staff to verbally abuse Resident #47. In addition, Resident #145 physically abused Resident #33 on two occasions, on 04/17/2024 resulting in knuckle marks to the resident's forehead and on 04/28/2024 resulting in scratches to the resident's face. Findings included: A facility policy titled, Abuse: Prevention of and Prohibition Against, revised in 02/2024, indicated, It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy specified, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Per the policy Physical Abuse includes but is not limited to hitting, slapping pinching, and kicking. It also includes controlling behavior through corporal punishment. The policy indicated, Verbal Abuse includes the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability. 1. An Admission Record revealed the facility admitted Resident #47 on 07/28/2022. According to the Admission Record, the resident had a medical history that included diagnoses of dementia with behavioral disturbance, anxiety disorder, and need for assistance with personal care. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2023, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had adequate hearing and used no hearing aid or other hearing appliance. (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's investigation, Certified Nursing Assistant (CNA) #27 reported she heard a nurse, later identified as LPN #29, yell at a resident. Per the investigation, CNA #27 went in the direction of the yelling and saw Resident #47 swing at the nurse and the nurse yell at the resident. The investigation revealed, another CNA, CNA #28, reported she heard yelling from the nurse, but did not remember what was being yelled by the nurse. Per the investigation, LPN #29 stated the resident would not take their medication and as she started to place the resident back in the bed, the resident tried to punch her. According to investigation, LPN #29 stated she tried to communicate with Resident #47 to get them into bed and to stop hitting her. During an interview on 06/04/2024 at 1:35 PM, CNA #28 stated on 08/21/2023 around 7:00 PM/8:00 PM, as she assisted another resident in a room, she heard yelling and overheard LPN #29 raise their voice at Resident #47. According to CNA #28, Resident #47 had no hearing issues and the nurse, LPN #29, was new to the facility. CNA #28 stated the incident was reported to the Abuse Coordinator. Per CNA #38, she felt the incident was verbal abuse. During an interview on 06/04/2024 at 2:36 PM, CNA #27 acknowledged she heard LPN #29 yell at Resident #47. CNA #27 stated she reported what she heard to the Administrator by way of a text message when she got home from work at 10:15 PM. Per CNA #27, she stated based on her training, what she heard was verbal abuse. During a telephone interview on 06/04/2024 at 7:19 PM, LPN #29 stated she felt she did nothing wrong. During an interview on 06/05/2024 at 11:22 AM, the Administrator, also the Abuse Coordinator, stated he received a call from CNA #27, who reported she heard LPN #29 raise their voice at Resident #47. The Administrator stated LPN #29 did admit that she raised her voice at the resident, but only to make sure the resident heard her. The Administrator stated he did not know if the resident had issues with hearing; however, he informed LPN #29 that she should have just walked away from the resident. 19186 2. An Admission Record revealed the facility admitted Resident #145 on 09/11/2023. According to the Admission Record, the resident had a medical history that included diagnoses of cognitive communication deficit, insomnia, anxiety disorder, major depressive disorder, and unspecified dementia, A quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 03/29/2024, revealed Resident #145 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident had hallucinations, physical behavioral symptoms, and wandering behaviors one to three days during the assessment period. Resident #145's Care Plan included a focus area initiated on 09/12/2023, that indicated the resident used psychotropic medications for behavior management (hallucinations and verbalized aggression). Interventions directed staff to monitor and document the effectiveness of the medication (initiated 09/12/2023). Resident #145's Care Plan included a focus area initiated 09/12/2023 that indicated the resident was at risk for elopement and wandering related to disorientation and impaired safety awareness. Interventions directed staff to provide structured activities and reorientation strategies (initiated on 03/05/2024). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Admission Record revealed the facility admitted Resident #33 on 09/13/2019. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease, major depressive disorder, anxiety, stroke, and vascular dementia. A quarterly MDS, with ARD of 03/09/2024, revealed Resident #33 had a BIMS score of 00, which indicated the resident had severe cognitive impairment. The MDS revealed that the resident exhibited verbal behavioral symptoms directed toward others, rejected care, and exhibited wandering behaviors on one to three days during the seven-day assessment look back period. Resident #33's care plan included a focus area revised 06/07/2023, that indicated the resident had the potential for a psychosocial well-being problem related to Alzheimer's disease, anxiety, depression, and post-traumatic stress disorder. Interventions directed staff to allow the resident time to answer questions and to verbalize feelings, perceptions, and fears (initiated 12/23/2022), provide one on one therapy to help balance mood and behaviors (initiated 12/23/2022), and ensure no triggers related to a diagnosis of post-traumatic stress disorder (initiated 02/20/2024). A Facility Reported Incidents report dated 04/17/2024, revealed on 04/17/2024 at 5:45 PM there was an altercation between Resident #145 and Resident #33 on the memory care unit. Resident #145's Progress Notes, dated 04/17/2024, revealed a certified nursing assistant (CNA) reported that Resident #145 came into the dining area and began attacking another resident. The note revealed the other resident tried to stop Resident #145 from hitting them; however, Resident #145 hit the resident on the forehead before staff were able to safely separate the residents. The note revealed the residents were separated safely into their own rooms, and the Administrator and Director of Nursing (DON) were notified of the incident. Resident #33's Progress Notes dated 04/17/2023 revealed another resident hit Resident #33 on the forehead resulting in three small marks to the forehead. Resident #33's care plan included a focus area initiated 09/17/2019 that indicated the resident had the potential for a behavior problem related to dementia, Alzheimer's, anxiety, and depression. The care plan revealed that the resident was in a resident-to-resident altercation on 04/17/2024 and was noted with knuckle marks to [the] forehead at initial evaluation. The facility's Resident to Resident Questionnaire for Staff dated 04/19/2024, revealed CNA #28's interview was completed by text message. According to the document, the CNA witnessed the residents in a small altercation. The document revealed CNA #28 and a coworker were in an office when they saw Resident #145 walk into the dining room and start attempting to hit Resident #33. CNA #28 indicated that her and another coworker ran to intervene immediately and pulled them apart. CNA #28 stated once they pulled them apart, Resident #145 and Resident #33 were taken to their respective rooms. During an interview on 06/07/2024 at 11:58 AM, CNA #26 stated she witnessed Resident #145 hit Resident #33 on 04/17/2024. CNA #26 said staff was in an office area in the dining room and Resident #33 was in the dining room sitting in the recliner. CNA #26 stated Resident #145 stated, You [NAME] me and attempted to hit Resident #33. CNA #26 indicated before they separated the residents, Resident #145 hit Resident #33 on the forehead with their fist. CNA #26 said Resident #33 had a mark on their forehead. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Follow-Up Investigation Report, dated 04/19/2024, revealed the investigation results were inconclusive. The facility's report revealed there was not enough information to determine whether abuse could be substantiated. The report revealed no one witnessed what happened before or after the situation or what led to the incident. According to the report, there was contact between the resident, and even though Resident #33's Progress Notes and care plan revealed the resident sustained injury, according to the facility's Follow-up Investigation Report, no injuries were found. A second Facility Reported Incidents report dated 04/28/2024 revealed that on 04/28/2024 at 4:00 PM there was another resident-to-resident altercation between Resident #33 and Resident #145. According to the report, Resident #33 was yelling and pounding at a door trying to get out of the memory care unit. The report revealed Resident #145's room was next to the exit door and Resident #33's behavior annoyed Resident #145. According to the report, Resident #145 swatted at Resident #33 to try to get the resident to stop. A review of Licensed Practical Nurse (LPN) #2's Resident to Resident Questionnaire for Staff dated 04/30/2024 revealed the LPN witnessed the 04/28/2024 incident. LPN #2's statement revealed she saw Resident #33 hitting the door and yelling and Resident #145 came up and hit Resident #33. Resident #145's Progress Notes, dated 04/28/2024 at 5:22 PM, revealed the resident was witnessed standing in the doorway of their room when the resident suddenly started screaming at another resident who was standing at the doors of the unit. The note revealed Resident #145 crossed the hallway towards the other resident and slapped the resident on the face. The note revealed the other resident put their hands up in defense and both parties were separated immediately and moved safely to their rooms. Resident #33's Progress Notes dated 04/28/2024 at 5:45 PM revealed a resident slapped Resident #33 on the face resulting in a scratch to Resident #33's forehead, the right side of their nose, and the right side of their lip. The facility's Follow-Up Investigation Report, dated 04/30/2024 revealed while it was clear the resident [Resident #33] was 'swatted' by the other resident [Resident #145] it was extremely unclear as to what led to the incident. It was also unclear as to how much contact was made. The report revealed there was one witness that saw the incident, but she was to busy running to break up the pair rather than see how hard the patient [resident] was hit. The facility's report revealed there was no injury or bruising, even though Resident #33's Progress Notes revealed the resident sustained scratches to the forehead, the right side of their nose, and the right side of their lip. Further review of the facility's report revealed there had been a pattern of Resident #145 getting frustrated with other residents and the facility had tried a couple of different things to get the resident to be a little nicer to staff and residents. The report revealed the family agreed that this could not keep happening and agreed to take Resident #145 home. During an interview on 06/07/2024 at 1:47 PM, the DON stated she expected close monitoring and interventions to prevent resident-to-resident altercations. During an interview on 06/07/2024 at 1:47 PM, the Administrator stated his expectation was for the facility to implement interventions to prevent resident-to-resident altercations from happening.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46565 Based on interview, record review, document review, and policy review, the facility failed to ensure an allegation of verbal abuse was reported immediately to the Administrator for 1 (Resident #47) of 13 sampled residents reviewed for abuse. Specifically, on 08/21/2023 at approximately 7:00 PM/8:00 PM, Certified Nursing Assistant (CNA) 27 and CNA #28 heard Licensed Practical Nurse (LPN) #29 verbally abuse the resident; however, the staff did not report the allegation of abuse to the Administrator until 10:15 PM. Findings included: A facility policy titled, Abuse: Prevention of and Prohibition Against, revised in 02/2024, indicated, 1. All allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. An Admission Record revealed the facility admitted Resident #47 on 07/28/2022. According to the Admission Record, the resident had a medical history that included diagnoses of dementia with behavioral disturbance, anxiety disorder, and need for assistance with personal care. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2023, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had adequate hearing and used no hearing aid or other hearing appliance. According to the facility's investigation, CNA #27 reported she heard a nurse, later identified as LPN #29, yell at a resident. Per the investigation, CNA #27 went in the direction of the yelling and saw Resident #47 swing at the nurse and the nurse yell at the resident. The investigation revealed, another CNA, CNA #28, reported she heard yelling from the nurse, but did not remember what was being yelled by the nurse. Per the investigation, LPN #29 stated the resident would not take their medication and as she started to place the resident back in the bed, the resident tried to punch her. According to investigation, LPN #29 stated she tried to communicate with Resident #47 to get them into bed and to stop hitting her. During an interview on 06/04/2024 at 1:35 PM, CNA #28 stated on 08/21/2023 around 7:00 PM/8:00 PM, as she assisted another resident in a room, she heard yelling and overheard LPN #29 raise their voice at Resident #47. According to CNA #28, Resident #47 had no hearing issues and the nurse, LPN #29, was new to the facility. CNA #28 stated the incident was reported to the Abuse Coordinator. Per CNA #38, she felt the incident was verbal abuse. During an interview on 06/04/2024 at 2:36 PM, CNA #27 acknowledged she heard LPN #29 yell at Resident #47. CNA #27 stated she reported what she heard to the Administrator by way of a text message when she got home from work at 10:15 PM. Per CNA #27, she stated based on her training, what she heard was verbal abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/05/2024 at 11:22 AM, the Administrator stated when staff witnessed abuse, he expected them to first make sure the resident was safe and then call him immediately day or night to report the abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 46565 Based on interview, record review, document review, and policy review, the facility failed to implement their abuse policy for 2 (Resident #47 and Resident #395) of 13 sampled residents reviewed for abuse. Specifically, the facility failed to remove the accused staff member rom care of any resident after staff reported to the Administrator they heard Licensed Practical Nurse (LPN) #29 verbally abuse Resident #47 on 08/21/2023. The facility also failed to interview the alleged perpetrator and other residents when it was alleged that Resident #396 poked Resident #395 in the breast in the hallway on 04/09/2023. Findings included: A facility policy titled, Abuse: Prevention of and Prohibition Against, revised in 02/2024, indicated, 2. After receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. Per the policy, 4. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee. The policy indicated, 5. The investigation will include the following: * An interview with the person(s) reporting the incident; * An interview with the resident(s); *Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; * A review of the resident's medical record; * An interview with staff members (on all shifts) who may have information regarding the alleged incident; * Interviews with other residents to who the accused employee provides care or services or who may have information regarding the alleged incident; * An interview with staff members (on all shifts) having contact with the accused employee; and * A review of all circumstances surrounding the incident. According to the policy, 8. The investigation, and the results of the investigation, will be documented, The policy specified, 3. If the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves an employee, the Facility will: * Immediately remove the employee from the care of any resident. 1. An Admission Record revealed the facility admitted Resident #47 on 07/28/2022. According to the Admission Record, the resident had a medical history that included diagnoses of dementia with behavioral disturbance, anxiety disorder, and need for assistance with personal care. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2023, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. The MDS revealed the resident had adequate hearing and used no hearing aid or other hearing appliance. According to the facility's investigation, Certified Nursing Assistant (CNA) #27 reported she heard a nurse, later identified as LPN #29, yell at a resident. Per the investigation, CNA #27 went in the direction of the yelling and saw Resident #47 swing at the nurse and the nurse yell at the resident. The investigation revealed, another CNA, CNA #28, reported she heard yelling from the nurse, but did not remember what was being yelled by the nurse. Per the investigation, LPN #29 stated the resident would not take their medication and as she started to place the resident back in the bed, the resident tried to punch her. According to investigation, LPN #29 stated she tried to communicate with Resident #47 to get them into bed and to stop hitting her. (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview on 06/04/2024 at 1:35 PM, CNA #28 stated on 08/21/2023 around 7:00 PM/8:00 PM, as she assisted another resident in a room, she heard yelling and overheard LPN #29 raise their voice at Resident #47. According to CNA #28, Resident #47 had no hearing issues and the nurse, LPN #29, was new to the facility. CNA #28 stated the incident was reported to the Abuse Coordinator. Per CNA #38, she felt the incident was verbal abuse.

During an interview on 06/04/2024 at 2:36 PM, CNA #27 acknowledged she heard LPN #29 yell at Resident #47. CNA #27 stated she reported what she heard to the Administrator by way of a text message when she got home from work at 10:15 PM. Per CNA #27, she stated based on her training, what she heard was verbal abuse.

During a telephone interview on 06/04/2024 at 7:19 PM, LPN #29 stated she felt she did nothing wrong. LPN #29 stated after the incident, she continued on with her medication pass and continued to watch the staff and other residents for the remainder of her shift.

LPN #29's time card for the time period 08/20/2023 to 08/27/2023, revealed on 08/21/2023, she clocked in on 08/21/2023 at 5:59 PM and clocked out on 08/22/2023 at 3:16 AM, then clocked back in 3:47 AM and clocked out at 6:25 AM.

During an interview on 06/05/2024 at 11:22 AM, the Administrator, also the Abuse Coordinator, stated he received a call from CNA #27, who reported she heard LPN #29 raise their voice at Resident #47. The Administrator stated LPN #29 did admit that she raised her voice at the resident, but only to make sure the resident heard her. The Administrator stated he did not know if the resident had issues with hearing; however, he informed LPN #29 that she should have just walked away from the resident. According to the Administrator, once an allegation of abuse was made, the accused staff member should be suspended and sent home until the investigation was completed.

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2. An Admission Record revealed the facility admitted Resident #395 on 01/22/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of unspecified dementia.

A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2023, revealed Resident #395 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment.

Resident #395's Care Plan included a focus area, initiated on 01/24/2023, that indicated the resident was at risk for re-traumatization r/t [related to] history of trauma (Neglect and emotional).

An Admission Record revealed the facility admitted Resident #396 on 04/06/2023. According to the Admission Record, the resident had a medical history that included diagnoses of history of traumatic brain injury (TBI), cognitive communication deficit, major depressive disorder, and unspecified dementia. Per the Admission Record, Resident #386 was discharged to another facility on 04/10/2023.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #396's Care Plan, included a focus area, initiated on 04/06/2023, that indicated the resident was at risk for impaired cognitive function/dementia or impaired thought processes related to adjustment to the facility, medications, age, dementia, history of TBI, and cognitive communication deficit. Another focus area, initiated on 04/08/2023, indicated the resident had the potential for a behavior problem related to a history of TBI and dementia. An Initial Report, dated 04/09/2023, completed by the Administrator, revealed the facility reported an allegation of sexual abuse involving Resident #395 and Resident #396 to the state survey agency. Per the report, on 04/09/2023 at 4:30 (AM or PM not specified), Resident #395 reported Resident #396 poked [Resident #395] in the breast. The report indicated the alleged incident occurred in the hallway of the facility. An undated Follow-up Investigation Report revealed that for the portions of the report specific to Summary of interview(s) with the alleged victim, Summary of interview(s) with witness(es), Summary of interview(s) with the alleged perpetrator(s), Summary of interview(s) with other residents who may have had contact with the alleged perpetrator, Summary of interview(s) with staff responsible for oversight and supervision of the location where the alleged victim resides, and Summary of interview(s) with staff responsible for oversight and supervision of the alleged perpetrator reflected, See Attached Paperwork. The attached paperwork, undated, revealed, the 2. Summary of Interviews reflected that as part of their investigation, the facility interviewed Resident #395 (alleged victim), Licensed Practical Nurse (LPN) #3, Certified Nursing Assistant (CNA) #4, and Therapist #7. There was no indication the facility interviewed Resident #396 (alleged perpetrator) or other residents in the area of the alleged incident as directed by the facility's abuse policy. During an interview on 06/06/2024 at 10:24 AM, the Administrator said that when he was notified of abuse allegations, he immediately started an investigation. The Administrator said the investigation process included speaking with staff members, residents, alleged victims, alleged perpetrators, and those who may have seen the incident. The Administrator said they tried to talk with other residents in the same area to determine if they had experienced any similar concerns. During a follow-up interview on 06/06/2024 at 10:24 AM, the Administrator reported he did not interview any of the surrounding residents as per their facility protocol; however, the Administrator said he asked Resident #396 if they touched Resident #395, and Resident #396 denied the allegation, although this information was not reflected in the facility's summary of interviews. During an interview on 06/07/2024 at 9:00 AM, the Director of Nursing (DON) said her expectation regarding abuse investigations was to follow the facility's policy.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39714 Based on observation, interview, record review, and facility policy review, the facility failed to develop a care plan to address the supplemental oxygen usage for 2 (Resident #37 and Resident #76) of 2 sampled residents reviewed for respiratory care. Findings included: An undated facility policy titled, Care Planning, indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident and care plans will be updated as necessary with resident changes to help promote optimal care to the resident. 1. An Admission Record revealed the facility admitted Resident #37 on 09/05/2023. According to the Admission Record, the resident had a medical history that included diagnoses of acute respiratory failure with hypoxia and chronic respiratory failure with hypercapnia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/02/2024, revealed Resident #37 received oxygen therapy. Resident #37's Order Summary Report, for active orders as of 06/04/2024, revealed an order dated 09/05/2023, for supplemental oxygen by way of nasal cannula at 2 liters/minute if oxygen saturation was less than 90%, as needed. Resident #37's comprehensive care plan, with an admitted [DATE], revealed no evidence to indicate the resident had a care plan that addressed their supplemental oxygen usage. An observation on 06/03/2024 at 11:48 AM, revealed Resident #37 lying in their bed with a nasal cannula properly placed around the resident's head. During an interview on 06/05/2024 at 8:33 AM, Certified Nursing Assistant #9 stated Resident #37 always wore their oxygen nasal cannula while in bed. 2. An Admission Record revealed the facility readmitted Resident #76 on 05/16/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of acute and chronic respiratory failure with hypoxia. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/22/2024, revealed Resident #76 received oxygen therapy. Resident #76's Order Summary Report, for active orders as of 06/04/2024, revealed an order dated 05/16/2024, for supplemental oxygen by way of nasal cannula at 2 liters/minute if oxygen saturation was less than 90%, as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465064	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St George Rehabilitation	1032 East 100 South St George, UT 84770

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #76's comprehensive care plan, with an admitted [DATE], revealed no evidence to indicate the resident had a care plan that addressed their supplemental oxygen usage. An observation on 06/03/2024 at 10:40 AM, revealed Resident #76 lying in bed with a nasal canula properly placed around their head. During an interview on 06/07/2024 at 11:17 AM, Registered Nurse Supervisor #20 stated if a resident had a physician order for supplemental oxygen, they should have a care plan that listed the resident's diagnosis, a rational for why they received supplemental oxygen, how many liters the resident received, and instructions for changing the nasal cannula tubing. During an interview on 06/06/2024 at 9:44 AM, the Assistant Director of Nursing (ADON) stated every resident who had an order for supplemental oxygen should have a care plan that listed the diagnosis for the use of the supplemental oxygen. The ADON stated the care plan should include interventions related to the monitoring of resident's vital signs, change in condition, respiratory concerns, and instructions for care of the supplemental oxygen machine. During an interview on 06/07/2024 at 11:46 AM, the Director of Nursing stated she would expect a care plan be in place for a resident who had supplemental oxygen.

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NAME OF PROVIDER OR SUPPLIER St George Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 East 100 South St George, UT 84770	

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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. 28193 Based on interview, record review, and facility policy review, the facility failed to revise the care plan to include added new interventions after a fall for 1 (Resident #86) of 4 sampled residents reviewed for accidents. Findings included: An undated facility policy titled, Care Planning, indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident and care plans will be updated as necessary with resident changes to help promote optimal care to the resident. The policy indicated, 7. Care plans will be updated with resident changes to promote optimal resident care. An Admission Record indicated the facility admitted Resident #86 on 03/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (stroke) due to embolism of right middle cerebral artery and essential primary hypertension (high blood pressure). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/05/2024, revealed Resident #86 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required partial/moderate assistance with toileting. Resident #86's care plan, initiated on 03/29/2024, indicated the resident was at risk for falls related to weakness, decreased mobility, abnormalities of gait and mobility, and a history of falls. An incident report dated 04/19/2024 at 6:35 PM, revealed as a certified nursing assistant assisted Resident #86 onto the toilet, the resident slid on their buttocks off the wheelchair. Per the incident report, the resident stated their socks were slippery. Resident #86's Fall Committee IDT note dated 04/26/2024 at 1:26 PM, revealed Resident #86 sustained a witnessed fall when they slipped during a transfer to the bathroom. Per the note, the IDT met and the resident's care plan was updated to anticipate and meet the resident's needs with reminders for appropriate footwear with transfers. Resident #86's care plan, initiated on 03/29/2024, indicated the resident was at risk for falls related to weakness, decreased mobility, abnormalities of gait and mobility, and a history of falls. There was no evidence the intervention to anticipate and meet the resident's needs with reminders for appropriate footwear with transfers was added to the resident's care plan. An incident report dated 05/02/2024 at 2:53 PM, revealed Resident #86 attempted to come back inside from the smoking area and their wheelchair rolled out from underneath them. Per the incident report, the resident stated they could not get the brakes on their wheelchair to work and they landed on their buttocks. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St George Rehabilitation	1032 East 100 South St George, UT 84770

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #86's Fall Committee IDT note dated 05/09/2024 at 11:05 AM, revealed Resident #86 sustained a witnessed fall coming back from smoking. Per the note, the IDT met and the resident's care plan was updated to indicate a non-slip pad was added to the seat of the resident's wheelchair to prevent further slipping. Resident #86's care plan, initiated on 03/29/2024, indicated the resident was at risk for falls related to weakness, decreased mobility, abnormalities of gait and mobility, and a history of falls. There was no evidence the intervention to add a non-slip pad to the resident's wheelchair to prevent further slipping was added to the resident's care plan. During an interview on 06/06/2024 at 11:16 AM, the Director of Nursing (DON) reviewed Resident #86's care plan and stated the intervention to use appropriate footwear and the intervention to add a non-slip pad to the resident's wheelchair were not added to the resident's care plan, but they should have. During an interview on 06/06/2024 at 11:27 AM, the Administrator stated the fall program was a nursing program and he deferred the specifics to the DON; however, he expected the staff to follow the policy.

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NAME OF PROVIDER OR SUPPLIER St George Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1032 East 100 South St George, UT 84770	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 28193 Based on observation, interview, record review, and facility policy review, the facility failed to follow a physician's order to hold a nicotine patch when the resident was smoking for 1 (Resident #86) of 4 sampled residents reviewed accidents. Findings included: An Admission Record indicated the facility admitted Resident #86 on 03/29/2024. According to the Admission Record, the resident had a medical history that included diagnoses of cerebral infarction (a stroke) due to embolism of right middle cerebral artery and essential primary hypertension (high blood pressure). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/05/2024, indicated Resident #86 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had severe cognitive impairment. Resident #86's care plan, initiated on 04/16/2024, indicated the resident had the potential for injury related smoking. Resident #86's Medication Administration Record [MAR], for June 2024, revealed a transcription of an order dated 05/22/2024, for nicotine patch 24 Hour, 7 milligrams (mg) 24 hour, apply one patch one time a day for smoking cessation, hold if smoking. Licensed Practical Nurse (LPN) #1 initialed the MAR to indicate she placed a patch on the resident's right arm on 06/03/2024 at 7:29AM. During an observation on 06/03/2024 at 1:12 PM, Resident #86 was observed outside smoking with a nicotine patch present on their right arm. During an interview on 06/04/2024 at 10:30 AM, Resident #86 stated they smoked one to two times a day. The resident stated they tried to stop smoking, but did not want to stop. During an interview on 06/04/2024 at 11:14 AM, LPN #1 stated on 06/03/2024 was the first time she caught the resident smoking with a nicotine patch on. During an interview on 06/06/2024 at 10:48 AM, the Director of Nursing (DON) stated Resident #86 wore a nicotine patch since 05/22/2024, smoked one to two times a day, and the patch was not held. The DON stated Resident #86 smoked at random times, so staff would not have always been aware the resident smoked while wearing the nicotine patch. During a follow-up interview on 06/06/2024 at 12:59 PM, the DON stated she expected the nurses to administer medication as ordered. During an interview on 06/06/2024 at 12:59 PM, the Administrator stated his expectation was for the medications to be given according to physician orders.

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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 0759

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

28193

Based on observation, interview, and review of manufacturer's information, the facility failed to ensure they maintained a medication error rate of less than 5 percent (%). The facility had 2 errors out of 34 opportunities, resulting in a medication error rate of 5.88 %, affecting 1 (Resident #14) of 3 residents observed during medication administration.

Findings included:

An Admission Record indicated the facility admitted Resident #14 on 03/04/2021. According to the Admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus with diabetic neuropathy.

Resident #14's Order Summary Report, listing active orders as of 06/07/2024, contained an order, dated 07/25/2023, for insulin glargine subcutaneous solution 100 units per milliliter (units/mL), inject 75 units subcutaneously every morning and at bedtime for type two diabetes mellitus. The Order Summary Report also contained an order, dated 03/04/2021, for NovoLog Solution 100 units/mL, inject as per sliding scale (a progressive increase in insulin dose, based upon predefined blood glucose levels): less than 81= no insulin required, 81-150 = 5 units, 151-200 = 9 units, 201-250 = 13 units, 251-300 = 17 units, 301-350 = 21 units, 351-400 = 25 units, and greater than 400 = call physician.

Manufacturer's information for insulin glargine revealed Instructions for Use of the prefilled pen specified, after attaching the needle, Step 3. Perform a Safety Test Always perform a safety test before each injection. Performing the safety test ensures that you get an accurate dose by: -ensuring that pen and needle work properly -removing air bubbles A. Selects a dose of 2 units by turning the dosage selector. B. Take off outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the inject button all the way in. Check if insulin comes out of the needle tip. You may have to perform the safety test several times before insulin is seen. -If no insulin comes out, check for air bubbles and repeat the safety test two more times to remove then. -If still no insulin comes out, the needle may be blocked. Change the needle and try again. -If no insulin comes out after changing the needle, your [insulin glargine prefilled pen] may be damaged. The manufacturer's information further specified that when administering the prescribed dose, C. Deliver the dose by pressing the injection button in all the way. The number in the dose window will return to 0 as you inject. D. Keep the injection button pressed all the way in. Slowly count to 10 before you withdraw the needle from the skin. This ensures the full dose will be delivered.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St George Rehabilitation	1032 East 100 South St George, UT 84770

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manufacturer's information for NovoLog FlexTouch Pen revealed Instructions for Use of the prefilled pen specified, after attaching the needle, Priming your NovoLog FlexTouch Pen: Step 7: -Turn the dose selector to select 2 units. Step 8: -Hold the Pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Step 9: -Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The 0 must line up with the dose pointer. -A drop of insulin should be seen at the needle tip -If you do not see a drop of insulin, repeat steps 7 to 9, no more than 6 times. -If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9. The manufacturer's information further specified then when administering the prescribed dose, Step 13: -Press and hold down the dose button until the dose counter shows 0. -The 0 must line up with the dose pointer. You may then hear or feel a click. -Keep the needle in your skin after the dose counter has returned to 0 and slowly count to 6. -When the dose counter returns to 0, you will not get your full dose until 6 seconds later. During an observation of medication administration on 06/05/2024 beginning at 7:31 AM, Licensed Practical Nurse (LPN) #2 was observed administering medications for Resident #14. When administering Resident #14's insulin glargine and NovoLog, LPN #2 did not prime either insulin pen prior to injection, and LPN #2 immediately removed the needles after administration, instead of waiting the amount of time specified by the manufacturers. During an interview on 06/05/2024 at 10:24 AM, LPN #2 acknowledged there were errors during insulin preparation and administration. During an interview on 06/06/2024 at 12:59 PM, the Director of Nursing (DON) stated she expected the nurses to follow protocol for effective administration of medications. The DON agreed the nurse should have waited after injecting the insulin, instead of immediately removing the needles. The DON further stated she would have to review the manufacturer's information regarding the requirements for priming the insulin pens.

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	465064	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St George Rehabilitation	1032 East 100 South St George, UT 84770

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37683 Based on observation, interview, and facility policy review, the facility failed to store, prepare, and serve food in a sanitary manner for 1 of 2 nourishment refrigerators and 1 of 1 kitchen. Specifically, the staff failed to date foods brought in from visitors to be stored in the nourishment refrigerators and discard opened food items that were undated and had been in the nourishment refrigerators for an indeterminate amount of time. Additionally, the staff failed to change gloves and wash their hands after touching high-contact surfaces and before touching food items. This had the potential to affect 96 of 96 residents who received food from the dietary department. Findings included: 1. A facility policy titled, [Facility Name] Policy / Procedure, revised 11/2016. specified, Food or beverage brought in from outside sources for storage in facility pantries, refrigeration units, or personal/resident room refrigeration units will be monitored by designated facility staff for food safety. An undated facility policy titled, Food Storage, specified, Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded. An observation of the nourishment refrigerator outside of the 100 Unit on 06/03/2024 at 2:57 PM revealed an opened, undated resealable plastic bag of five hotdogs and an opened, undated jar of pasta sauce. During an interview on 06/04/2024 at 2:22 PM, the Dietary Manager stated that nursing staff were responsible for labeling and dating food items brought in from visitors. During an interview on 06/05/2024 at 11:19 AM, Certified Nursing Assistant (CNA) #18 stated that whoever puts the food in the nourishment refrigerator was responsible for labeling and dating them. During an interview on 06/05/2024 at 11:26 AM, CNA #10 stated that the CNA staff were responsible for labeling and dating foods for the nourishment refrigerators. CNA #10 stated that the dietary staff were responsible for cleaning the refrigerators, including discarding food items that had been in the refrigerator for longer than three days. An observation of the nourishment refrigerator outside of the 100 Unit on 06/06/2024 at 2:27 PM revealed an open, undated resealable bag of three hotdogs. An observation of the nourishment refrigerator outside of the 100 Unit on 06/07/2024 at 8:33 AM revealed a fully cooked rotisserie chicken that had been opened but not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/06/2024 at 4:56 PM, the Director of Nursing (DON) revealed that dietary staff were responsible for cleaning and maintaining the nourishment refrigerators. She stated that all staff were responsible for labeling and dating food items in the nourishment refrigerators. She did not know if it was a concern that an open undated resealable bag of hotdogs had been in the nourishment refrigerator since 06/03/2024. During an interview on 06/06/2024 at 5:01 PM, the Dietary Manager stated that nobody had told her the dietary department was responsible for maintaining the nourishment refrigerators. 2. An undated facility policy titled Meat and Vegetable Preparation, specified, All raw vegetables are thoroughly washed before being cooked or served. An undated facility policy titled Food Safety, specified, Train staff to wash hands prior to working with food, after using the restroom or soiling hands in any way. During an observation of food preparation on 06/04/2024 at 10:30 AM, Dietary Aide (DA) #16 touched her microphone button to call for someone and then, without changing gloves or washing hands, continued to touch the meat to prepare seven sandwiches. At 10:31 AM, DA #16 changed gloves without washing her hands. She then opened the walk-in refrigerator and emerged with three tomatoes. She grabbed a knife and began cutting them. DA #16 did not wash the tomatoes. At 10:32 AM, DA #16 put lettuce on a sandwich without changing gloves or washing her hands. At 10:33 AM, the backdoor rang and DA #16 answered the backdoor. She changed her gloves but did not wash her hands. She then opened the walk-in refrigerator went in and came back out. After this, she touched sandwiches to cut and to wrap them. During an observation of food service on 06/04/2024 at 12:05 PM, DA #17 touched a drawer beneath the food line to retrieve a scoop for serving mashed potatoes. Without changing gloves or washing hands, he handled four rolls of bread. During an interview on 06/04/2024 at 2:15 PM, DA #17 stated he should have washed his hands and changed gloves after touching a high-contact surface and before touching food. During an interview on 06/04/2024 at 2:19 PM, DA #16 stated she should not have touched food/lunchmeat after using the microphone button without changing gloves or washing her hands. She also confirmed she should have washed her hands and changed gloves after opening the walk-in refrigerator and before touching the tomatoes. She did not know if tomatoes should be washed prior to food preparation. During an interview on 06/04/2024 at 2:22 PM, the Dietary Manager stated DA #16 should have washed her hands and changed gloves after touching the microphone button and after touching the refrigerator handle and before touching food items. She also indicated that DA #17 should have used tongs to serve the bread rolls rather than his hands, especially since he had just opened the drawer to get a scoop for serving mashed potatoes. During an interview on 06/05/2024 at 3:31 PM, the Dietary Manager indicated that tomatoes should be washed before being prepared. During an interview on 06/07/2024 at 8:58 AM, both the Administrator and the Director of Nursing (DON) said they expected staff to change gloves and wash their hands after touching high-contact surfaces and before touching foods.