STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465095	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. Specifically, a resident was noted to have bruising on his shoulder, but this was not reported as possible neglect or abuse for approximately 2 days. Resident identifier: 217. Findings include: Resident 217 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebrovascular accident, right bundle branch block, heart failure, and major depressive disorder. Resident 217's medical record was reviewed from 7/8/24 through 7/16/24. On 9/30/23, a nurses note documented that at 6:10 PM, aide reported pt's (patient's) L (left) shoulder swollen and bruised. L shoulder very swollen, firm, looks like it/s (sic) further forward than R (right) Shoulder. Bruising on shoulder and down inner and outer upper arm. When I attempted to move arm, pt called out and flinched. An X ray was subsequently ordered. On 10/1/23, a nurses note documented that resident 217 returned from the emergency room with .findings of a fracture of the left humeral surgical neck, including displaced greater and lesser tuberosity . On 10/1/23, the facility submitted form 358 to the State Survey Agency. The form indicated that resident 217 was observed to have bruising on his left shoulder, and the resident had subsequently been sent to the local emergency room for evaluation. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/4/23, the facility submitted form 359 to the State Survey Agency. The form indicated that during the course of the investigation, it was determined that CNA 4 used a sit to stand machine to transfer the resident from a chair into bed. CNA 4 stated that while transferring the resident, the resident was unable to bear weight causing his arms to move upward, but was able to finish the transfer. The resident was not noted to be in any pain at that time. A unit manager indicated that on 9/30/23, she was made aware of bruising to resident 217's left shoulder. The resident had an X-ray completed which showed a fracture and was sent to the local emergency room for evaluation. In the emergency room , resident 217 had a confirmation X-ray completed that indicated a comminuted, impacted, and angulated fracture of the left humeral neck. secondary to CVA resident is non verbal and unable to voice how he is feeling. The resident was discharged back to the facility the same day due to poor prognosis secondary to CVA the hospital stated he is not a candidate for surgery at this time. Resident is to remain on hospice care with comfort measures. The facility determined that abuse/neglect was verified, as upon investigation it was determined that the fracture most likely occurred while [resident 217] was being transferred in the sit to stand and was unable to bear weight. The facility's investigation that accompanied form 359 was reviewed. The facility noted that on 9/28/23 CNA 4 worked with resident 217. Also on that day, CNA 3 reported bruising to SM 2. SM 2 reported that there were no complaints of pain from resident 217, and that he observed resident 217's bruising, but thought it was old. [Note: The weekly skin assessment inaccurately documented that there were no skin issues on 9/29/23 even though bruising had been observed the day prior.] The investigation also indicated that resident 217's bruising was not reported to management until 9/30/23, approximately 2 days after the bruising to resident 217's left shoulder was initially observed. On 7/15/24 at 11:25 AM, an interview was conducted with the DON. The DON stated that SM 2 was provided with education about timely reporting of possible injuries such as bruises.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review, it was found that the facility failed to ensure that a resident received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 1 of 89 sampled residents. Specifically, a resident with a pressure injury was not provided dressing changes for 12 days. Resident identifier: 129. Findings include: Resident 129 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses which included encephalopathy, bacteremia, fistula of intestine, colostomy, severe protein-calorie malnutrition, hypomagnesemia, hypocalcemia, vitamin D deficiency, anemia, chronic kidney disease stage 3, pressure ulcer of sacral region, depression, and adult failure to thrive. Resident 129's medical record was reviewed from 7/8/24 through 7/16/24. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed resident 129 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated a cognitive status of no impairment. It further indicated the presence of 1 unhealed stage 3 pressure ulcer. An Initial Admission Record Section 12 Skin Integrity dated 3/11/24 at 3:42 PM indicated an, open wound to coccyx. A wound consult titled, [Company Name Redacted] Progress Note Details document dated 3/13/24 indicated, Wound Assessment(s) Wound #2 Sacral is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 2.27cm [centimeters] length x 1.31cm width, with an area of 2.974 sq cm. There is a Small amount of sero-sanguineous drainage noted which has no odor. Wound bed has 76-100% slough. The periwound skin texture is normal. The periwound skin moisture is normal. The periwound skin color is normal. The temperature of the periwound skin is WNL. Periwound skin does not exhibit signs or symptoms of infection. It further indicated, Procedures Wound #2 (Pressure Ulcer) is located on the sacral. A selective debridement with a total area debrided of 2.86 sq cm. was performed by [Name Redacted], NP [Nurse Practitioner]. to remove devitalized tissue: slough. The following instrument(s) were used: curette. A time out was conducted prior to the start of the procedure. A minimal amount of bleeding was controlled with pressure. The procedure was tolerated well. Post Debridement Measurements: 2.2cm length x 1.3cm width; with an area of 2.86 sq cm. Post debridement Stage noted as Unstageable Pressure Injury Obscured full-thickness skin and tissue loss. It further indicated, Plan Wound Orders: Wound #2 Sacral Wound Cleansing & Periwound Skin Care Clean wound with: - Vashe and allow area to soak for 5 min the pat dry. Apply skin prep to peri-wound and allow to dry then small amount of calmoseptine. Dressing Other: - Apply medihoney to wound bed then cover with cutimed sorbact wcl [wound contact layer]. Then cover with silicone bordered foam. If excess drainage noted then apply calcium alginate overtop of cutimed prior to covering with bordered foam. Dressing to be changed 3x's a week and prn [as needed]. OFF LOAD Off-Loading Facility pressure injury prevention/relief protocol. Other: - Air mattress if she agrees Dietary Other: - RD [Registered Dietitian] to eval [evaluate] and tx [treatment]. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Treatment Administration Record (TAR) dated 3/1/24-3/31/24 indicated, WOUND TO SACRUM: Cleanse w/ Vashe and allow to soak for 5 minutes and pat dry, apply skin prep to periwound and allow to dry. Apply Calmosteptine to periwound. Apply mMedihoney to wound bed cover with Cutimed (cut to size) then cover w/ Mepilex dressing. To be changed QD and PRN. every day shift for WOUND CARE-Order Date-03/27/2024 0933-D/C Date-04/04/2024 1122. The TAR further indicated no dressing changes were documented for the dates of 3/25/24, 3/26/24 or 3/27/24. The TAR dated 4/1/24-4/30/24 indicated, WOUND TO SACRUM: Cleanse w/ Vashe and allow to soak for 5 minutes and pat dry, apply skin prep to periwound and allow to dry. Apply Calmosteptine to periwound. Apply mMedihoney to wound bed cover with Cutimed (cut to size) then cover w/ Mepilex dressing. To be changed 3x/week and PRN. every day shift every Mon, Wed, Fri for WOUND CARE -Order Date- 04/04/2024 1122-Hold Date from 04/30/2024 2135 to 05/01/2024 0000-D/C Date- 05/02/2024 1008. The TAR further indicated no wound care was documented for the dates of 4/18/24, 4/20/24, 4/21/24, 4/23/24, 4/25/24, 4/27/24, 4/28/24 or 4/30/24. A wound consult titled, [Company Name Redacted] Progress Note Details document dated 4/17/24 indicated, Plan Wound Orders: Wound #2 Sacral Wound cleansing with: Vashe and allow area to soak for 5 min the pat dry. Apply skin prep to peri-wound and allow to dry then small amount of calmoseptine. Dressing Other: Apply medihoney to wound bed then lightly pack with calcium alginate. Cover entire area with silicone bordered foam, This is to be changed daily due to location. OFF LOAD. Off-Loading Facility pressure injury prevention/relief protocol. Other: Air mattress if she agrees. A wound consult titled, [Company Name Redacted] Progress Note Details document dated 4/24/24 indicated, Wound Orders: Wound #2 Sacral .Dressing .This is to be changed DAILY due to location . On 7/16/24 at 1:29 PM, an interview was conducted with Unit Manager (UM) 1. UM 1 stated resident 129's wound progression has been up and down since she had been admitted . The UM stated she was seen by the wound consult team every week. The UM stated the unit managers reviewed and updated the orders provided on the wound consult in the electronic medical record and facility staff provided wound care according to those orders. On 7/16/24 at 2:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 129 was readmitted to the facility on [DATE] and that she was unable to locate physician orders for wound care upon readmission. The DON stated wound care orders came in on 3/28/24.

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F 0689 Level of Harm - 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** 22992 Based on interview and record review, the facility did not ensure that 1 of 89 residents received adequate supervision and assistance devices to prevent accidents. Specifically, a resident was transferred with the help of one staff member using a sit to stand device. This was determined to have occurred at a harm level. However, based on the facility's investigation and corresponding correction, this was cited at past non-compliance. Resident identifier: 217. Findings include: 1. Resident 217 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebrovascular accident, right bundle branch block, heart failure, and major depressive disorder. Resident 217's medical record was reviewed from 7/8/24 through 7/16/24. On 9/27/23, the facility completed a Functional Performance Evaluation for resident 217. The evaluation indicated that the resident was unable to stand up from a seated position due to medical condition or safety concerns. The evaluation also indicated that the resident was dependent on staff to help him transfer to and from a bed to a chair. On 9/29/23, a Weekly Skin Evaluation was completed for resident 217. The resident's skin was observed to have no bruising or wounds, and was documented to be warm, dry and intact. On 9/30/23, a nurses note documented that at 6:10 PM, aide reported pt's (patient's) L (left) shoulder swollen and bruised. L shoulder very swollen, firm, looks like it/s (sic) further forward than R (right) Shoulder. Bruising on shoulder and down inner and outer upper arm. When I attempted to move arm, pt called out and flinched. An X ray was subsequently ordered. On 10/1/23, a nurses note documented that resident 217 returned from the emergency room with .findings of a fracture of the left humeral surgical neck, including displaced greater and lesser tuberosity . On 10/1/23, the facility submitted form 358 to the State Survey Agency. The form indicated that resident 217 was observed to have bruising on his left shoulder, and the resident had subsequently been sent to the local emergency room for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/4/23, the facility submitted form 359 to the State Survey Agency. The form indicated that during the course of the investigation, it was determined that CNA 4 used a sit to stand machine to transfer the resident from a chair into bed. CNA 4 stated that while transferring the resident, the resident was unable to bear weight causing his arms to move upward, but was able to finish the transfer. The resident was not noted to be in any pain at that time. A unit manager indicated that on 9/30/23, she was made aware of bruising to resident 217's left shoulder. The resident had an X-ray completed which showed a fracture and was sent to the local emergency room for evaluation. In the emergency room , resident 217 had a confirmation X-ray completed that indicated a comminuted, impacted, and angulated fracture of the left humeral neck. secondary to CVA resident is non verbal and unable to voice how he is feeling. The resident was discharged back to the facility the same day due to poor prognosis secondary to CVA the hospital stated he is not a candidate for surgery at this time. Resident is to remain on hospice care with comfort measures. The facility determined that abuse/neglect was verified, as upon investigation it was determined that the fracture most likely occurred while [resident 217] was being transferred in the sit to stand and was unable to bear weight. The facility's investigation that accompanied form 359 was reviewed. The facility noted that on 9/28/23 CNA 4 worked with resident 217. Also on that day, CNA 3 reported bruising to SM 2. SM 2 reported that there were no complaints of pain from resident 217, and that he observed resident 217's bruising, but thought it was old. [Note: The weekly skin assessment inaccurately documented that there were no skin issues on 9/29/23 even though bruising had been observed the day prior.] The investigation also indicated that resident 217's bruising was not reported to management until 9/30/23, approximately 2 days after the bruising to resident 217's left shoulder was initially observed. The following investigation was provided by the facility: Investigation [resident 217]. admitted : 10/2/2023, Admission DX (diagnoses): CVA (cerebrovascular accident), Right bundle branch block, heart failure, MDD (major depressive disorder). REPORT: [Staff member (SM) 1] phoned to this DON (Director of Nursing) on 9/30/2023 1833 (6:33 PM) Left shoulder with bruising and swollen, change in ROM (Range of Motion). Provider and family made aware order in place for hospital transfer to verify the X ray result. He did come back on 10/1/2028 (sic) with written report of fracture to the left humeral surgical neck. He is not a surgical candidate at this time secondary to poor health condition. He will remain on hospice care PRN (as needed) pain medication and change of condition charting in place. INVESTIGATION: DON came to the building on Sunday 10/1/2023. Multiple staff members were interviewed that worked with resident. [Certified Nursing Assistant (CNA) 3) CNA reported that on Tuesday morning they went into [resident 217's] room where the sit to stand was noted to be in the room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Monday 9/25/2023 staff members were interviewed [CNA 4] stated that on 2-10 shift that did he did use a sit to stand lift to transfer resident. Resident is unable to bear weight his plan of care requires a hoyer transfer. [CNA 4] reported that he (resident 217) did not complain of pain or show any signs of pain at the time he was able to finish the transfer into his bed. He (CNA 4) did report that his (resident 217's) arms moved up while he was in the sit to stand lift. [CNA 4] did not report this to the nurse because he did not believe any injury had occurred. ((CNA 4) was suspended during this investigation). Residents were interviewed to see if they had any care concerns with [CNA 4] they had no concerns. The following residents were interviewed. [Name of 5 residents]. 9/26/2023 . [CNA 3] reported the sit to stand was in the room. No bruising no co (complaints of) pain. 9/28/2023 . [CNA 3] reported bruising to [SM 2]. [SM 2] reports no co pain, no change in ROM . He thought brusing (sic) was old. 9/30/2023 . [SM 3] reported to [SM 4 and SM 1]. Assessment complted (sic) X-ray ordered. Conclusion: Team believes that the fracture occurred when he was transferred with a sit to stand on Monday 9/25/2023 with [CNA 4]. Secondary to [resident 217's] current condition he is a hoyer lift for all transfers. He is not able to bear weight because of his CVA. [CNA 4] reported that he thought he had a change and was able to use the sit to stand. He did transfer him with a one person transfer. [CNA 4] has prior educated on this (sic). [Resident 217] has Q (every) shift monitoring in place with pain monitoring and management. His condition remains poor prior to the incident and stable after. Family and provider are aware of the updated POC (plan of care). 10/4/2023 [CNA 4) was terminated from St. [NAME] Villa secondary to using a sit to stand with a hoyer lift resident and performing the transfer with 1 person. [SM 2] was given 1:1 education regarding following up on change of condition and reports of the bruise. [SM 5] was given 1:1 education regarding skin check that was performed on 9/29. Performance Improvement plan: 1. Audit of all residents with current sit to stand transfers are being evaluated by therapy. This will ensure the current lift that is being used are (sic) appropriate for the resident status. 2. Re education is being performed 1:1 in huddles or over the phone regarding COC (change of condition), bruising ROM. Which lift is appropriate for resident current condition. 3. Audits are being completed with department heads on spot checking rooms to ensure staff members are using the appropriate lift with two-person transfer. 4. Unit managers were made aware of any changes with therapy evaluation with the lifts. Update 10/23/2023 Resident condition remains baseline at this time. Staff audits have been conducted along with re education. No further transfers with one person, staff audits have been completed they are using two person with transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Attached to the investigation was a document entitled St. Joes Education Sheet which stated, . If you're (sic) resident is not able to stand up and assist with the transfer, they are NOT able to use a sit to stand lift. The sit to stand lift is only for residents that can help stand. TWO people are required with the sit to stand lifts and hoyer lifts. If you use a lift with one person you will be terminated. If you have a resident with bruising, change in range of motion, complaining of pain you must notify your nurse immediately. Nurses it is your responsibility to do the assessment. You must notify the unit manager of the bruise to ensure that we know how it happened. Any unknown bruise must be reported to [Administrator] and [DON] immediately . On 7/15/24 at 11:25 AM, an interview was conducted with the DON. The DON stated that resident 217 could shake his head yes or no and answer yes and no questions. The DON also stated that resident 217 stated that resident 217 could indicate if he was in pain, but was unable to describe anything specific. The DON stated that resident 217 was supposed to be transferred using a hoyer lift with 2 people. The DON stated that each CNA receives a document that is informally referred to as a brain that they can reference for specific instructions on what assistance each resident requires. The DON stated that resident 217 was listed on the CNA brain as requiring a hoyer lift, and she was unsure why resident 217 was transferred by CNA 4 using a sit to stand instead. The DON stated that she had reviewed video footage, and confirmed that CNA 4 did enter resident 217's room with a sit to stand machine. The DON also confirmed that the Weekly Skin Assessment that was completed on 9/29/23 was inaccurate.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on observation, interview and record review it was determined, for 1 of 89 sampled residents, that the facility did not provide or obtain outside resources for routine and emergency dental services to meet the needs of the residents. Specifically, a resident was not provided dental services after requesting to see one. Resident identifier: 38. Findings include: Resident 38 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fibromyalgia, systemic lupus erythematosus, chronic pain syndrome, depression, generalized anxiety, and cognitive communication deficit. On 7/10/24 at 1:32 PM, an interview was conducted with resident 38. Resident 38 stated that she has not seen a dentist and would like to see one. Resident 38 stated that she has several missing teeth, and it is hard for her to chew. Resident 38's medical record was reviewed 7/8/23 through 7/16/24. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that resident 38 had a broken or loosely fitting full or partial denture, and mouth or facial pain, discomfort or difficulty with chewing. On 3/11/24 at 8:39 AM, a MDS progress note revealed . She has missing her own natural upper teeth, missing upper partial plate, her own lower teeth and having chewing difficulty Requesting to see dentist. Will inform UM [unit manager] & SS [social service] . On 7/16/24 at 1:05 PM, an interview was conducted with registered nurse (RN) 1. RN 1 stated if a resident makes a request for a dental appointment, she would contact Social Services (SS). RN 1 stated that SS is the one that would set up any dental appointment. On 7/16/24 at 3:00 PM, an interview was conducted with Social Services Director (SSD). The SSD stated that she was not aware of the MDS progress note from 3/11/24, where resident 38 was requesting to see the dentist. The SSD stated that, the MDS coordinator should have sent her a message. The SSD stated she, can't say who dropped the ball on this, but the referral was missed and resident 38 did not get a dental appointment set up.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43212 Based on interview, the facility did to employ a clinically qualified full-time dietitian or another clinically qualified nutrition professional to serve as the director of nutrition services. Specifically, the facility did not employ a full time Registered Dietitian (RD) and the Dietary Manager (DM) did not meet the requirements to serve as the director of food and nutrition services. Findings include: On 7/8/24 at 8:48 AM, an interview was conducted with the DM. The DM stated she had not completed the required certification to work as the dietary manager. The DM stated the facility had a contracted RD that was at the facility on Mondays, Tuesdays, and Thursdays, and that she was always available by phone. On 7/16/24 at 4:02 PM, a second interview was conducted with the DM. The DM stated she had not completed a course in food service safety and management, a Certified Dietary Manager course, a certified food service manager course, or a nationally recognized certification or associates degree or higher in food service and safety.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on interview and record review it was determined, for 52 of 89 sampled residents, that the facility did not keep confidential all information contained in the resident's records, regardless of the form or storage method of the records. Additionally, the facility did not maintain the medical records on each resident that were complete, accurately documented, and readily accessible. Specifically, residents' names were included in a different residents medical records, and a resident's medical records from the hospital were not included in the residents electronic medical records at the facility. Resident identifiers: 2, 3, 4, 6, 8, 13, 16, 22, 23, 25, 26, 28, 29, 36, 45, 55, 63, 66, 68, 69, 70, 71, 81, 85, 88, 89, 91, 93, 100, 103, 105, 109, 111, 112, 113, 117, 119, 137, 138, 139, 141, 145, 217, 218, 219, 220, 221, 222, 223, 224, 225 and 363. Findings Included: 1. The following form entitled Orders dated 1/15/24 was located in resident 4, 221, 145, 91, 6, 3, 88, 8, 222, 109, 22, 66 and 103's electronic medical record (EMR). a. (Resident 4): CBC [complete blood count], serum iron, ferritin, total iron binding capacity, CMP [comprehensive metabolic panel], TSH [thyroid stimulating hormone], lipid panel, vitamin B12, hemoglobin A1c. [glycated hemoglobin] b. (Resident 221): CBC, CMP, TSH, vitamin B12, hemoglobin A1c, valproic acid level. Increase donepezil to 10 mg [milligrams] daily at bedtime. c. (Resident 145): CBC, CMP, TSH, lipid panel, vitamin B12, hemoglobin A1c, carbamazepine level, serum iron, fenitin, total iron binding capacity. d. (Resident 91): TSH, vitamin B12, hemoglobin A1c. e. (Resident 6): Reduce lisinopril to 20 mg daily. TSH, T3 [triiodothyronine], free T4 [thyroxine], CBC, serum iron, ferritin, total iron binding capacity. Reduce to Pantoprazole to 40 mg once daily. f. (Resident 3): TSH, lipid panel, hemoglobin A1c, CBC, CMP, serum iron, ferritin, total iron binding capacity. g. (Resident 88): CBC, CMP, vitamin B12, hemoglobin A1c, TSH, phenobarbital. h. (Resident 8): Decrease Tylenol to 650 mg TID [three times a day]. i. (Resident 22): Hemoglobin A1c, CBC, CMP, vitamin B12. j. (Resident 222) : CBC, CMP, vitamin B12, TSH, hemoglobin A1c. k. (Resident 109): Start tramadol 25 mg twice a day when necessary. (continued on next page)

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	465095	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	l. (Resident 66): Discontinue Nexium. Start famotidine 20 mg daily. m. (Resident 103): CBC, CMP, vitamin B12, PSA [prostate specific antigen] 2. The following form entitled Orders dated 1/29/24 was located in resident 105, 218, 219, 6, 112, 89, 63, 70, 2, 139, 68, 71, 45, 13, 100, 69, 220, and 137's EMR. a. (Resident 105): Hemoglobin A1c. Start alloputinol 200 mg daily. b. (Resident 218): CBC, CMP, TSH, lipid panel, vitamin B12, hemoglobin A1c. Start lisinopril 5 mg daily. Discontinue Insulin lispro sliding scale. Decrease omeprazole to 20 mg daily. c. (Resident 219): CBC, CMP, TSH, lipid panel, vitamin B12, hemoglobin A1c. d. (Resident 6): TSH, free T4, T3, CBC, serum iron, ferritin, total iron binding capacity in 4 weeks. Decrease Protonix to 40 mg once daily in 30 days. e. (Resident 112): Vitamin B12, folate, CBC, serum iron, ferritin, total iron binding capacity in 4 weeks. f. (Resident 89): CBC, CMP, vitamin B12, uric acid level. g. (Resident 63): CBC, CMP. h. (Resident 70: TSH, lipid panel, vitamin B12, hemoglobin A1c. Discontinue Macrobid and nitrofurantoin. Start Keflex 500 mg once daily for UTI [urinary tract infection] prophylaxis. i. (Resident 2): CBC, CMP, vitamin B12, hemoglobin A1c. j. (Resident 139): Start lisinopril 10 mg daily. k. (Resident 68): CBC, CMP, TSH, vitamin B12, hemoglobin A1c, serum iron, ferritin, total iron binding capacity, valproic acid level. l. (Resident 71): Decrease Keppra to 750 mg twice a day due to excessive sedation. [handwritten] Spoke to Dr [Name Redacted]. Do Not decrease Keppra, continue current dose .] m. (Resident 45): CBC, CMP, TSH, vitamin B12, hemoglobin A1c. Start tramadol 25 mg TID PRN [as needed]. n. (Resident 13): Continue scheduled Tylenol 1000 mg TID and discontinue the when necessary Tylenol order. Start tramadol 25 mg TID PRN. CBC, serum iron, ferritin, total iron binding capacity. o. (Resident 100): Start fluticasone/salmeterol 250/50 one inhalation twice a day. p. (Resident 69): Discontinue aspirin. CBC, serum iron, ferritin, total iron binding capacity. Decrease pantoprazole to 20 mg daily. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	q. (Resident 220): TSH, vitamin B12, PSA. EKG [electrocardiogram]. r. (Resident 137) : Start Pioglitazone 30 mg daily. Discontinue ibuprofen, redundant with Celebrex. 3. The following form entitled Orders dated 3/26/24 was located in resident 223, 16, 26, 93, 111, 85, 141, 81, 224, 28, 23, 225, 25, 363, and 117's EMR. a. (Resident 223): Discontinue multivitamin, CBC [complete blood count], serum iron, ferritin, total iron binding capacity in 4 weeks. Start vitamin-D 2000 units daily. b. (Resident 16): Discontinue Insulin glargine 10 units subcutaneous q.h.s [once a day at bedtime]. c. (Resident 26): Clarify Tylenol to 1000 mg [milligrams] t.i.d.[three times daily] scheduled. Start Flonase 1 nasal spray each nostril daily. d. (Resident 93): Start metformin ER [extended release] 500 mg q.h.s. e. (Resident 111): TSH [thyroid stimulating hormone], vitamin B12, CMP [complete metabolic panel], lipid panel, uric acid level. EKG [electrocardiogram], routine (History of atrial fibrillation, no anticoagulation). f. (Resident 85): TSH, lipid panel, vitamin B12. Discontinue Tradjenta. g. (Resident 141): Vitamin B12, hemoglobin A1C. Decrease omeprazole to 40 mg once daily. h. (Resident 81): TSH, lipid panel. i. (Resident 224): Decrease pantoprazole to 40 mg once daily. j. (Resident 28): Valproic acid level. k. (Resident 23): TSH, vitamin B12, hemoglobin A1c, magnesium level. Discontinue Simvastatin. Start atorvastatin 40 mg daily. Decrease omeprazole to 40 mg daily. l. (Resident 225) : Clarify all Tylenol orders to 1000 mg t.i.d. scheduled. m. (Resident 25): A.M.[before noon] cortisol level. Start mirtazapine 7.5 mg q.h.s. n. (Resident 363): TSH, lipid panel, vitamin B12, hemoglobin A1c, CBC [complete blood count], serum iron, ferritin, total iron binding capacity. Discontinue clonidine. Discontinue lisinopril. Decrease metoprolol tartrate 25 mg b.i.d. [twice daily]. Discontinue omeprazole. Start famotidine 20 mg daily. o.[name redacted] Resident 117: TSH, lipid panel, vitamin 12, hemoglobin A1c. Discontinue clonidine. Decrease omeprazole to 20 mg once daily. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The following form entitled Orders dated 4/22/24 was located in resident 138, 4, 71, 119, 105, 29, 6, 36, 55, and 113's EMR: a. (Resident 138): CBC, CMP, TSH, lipid panel, vitamin B12, hemoglobin A1c. b. (Resident 4): TSH, lipid panel, vitamin B12, hemoglobin A1c, CBC, serum iron, ferritin, total iron binding capacity, CMP. Discontinue vitamin-D 50000 units weekly. Start vitamin-D 2000 units daily. c. (Resident 71): CBC, CMP, TSH, vitamin B 12, hemoglobin A1c, pre albumin, serum iron, ferritin, total iron binding capacity. Keflex 500 mg q.i.d. [four times a day] for 10 days total treatment, then reduce to 500mg once daily. CMP, TSH, vitamin B12, hemoglobin A1c, pre albumin. [handwritten](Dup.) d. (Resident 119): TSH, lipid panel, vitamin B12, hemoglobin A1c, CBC, serum iron, ferritin, total iron bindingcapacity, TSH, T3, free T4. Increase Torsemide to 40 mg q.a.m. [every morning] and q.noon [every day at noon] for 5 days, then reduce to torsemide 40 mg daily. Decrease omeprazole to 20 mg once daily. Start DuoNeb nebulized q.i.d. PRN. e. (Resident 105): CBC, CMP, TSH, vitamin B12, hemoglobin A1c. Clarify Tylenol to 1000 mg q.8 hours PRN. Discontinue Percocet. Start oxycodone 10 mg q.h.s. [every night]scheduled and oxycodone 10 mg q.8 hours PRN. f. (Resident 29): Increase metformin to 1000 mg b.i.d. [twice a day]. Start Tradjenta 5 mg daily. Follow up hemoglobin A1c, CBC, serum iron, ferritin, total iron binding capacity. Decrease Protonix to 20 mg daily. g. (Resident 6): Vitamin B12, hemoglobin A1c, TSH, T3, free T4. Discontinue glipizide. Start Tradjenta 5 mg daily. Discontinue ferrous sulfate. Decrease Protonix to 20 mg daily. h. (Resident 36): CBC, ESR [erythrocyte sedimentation rate], CRP [C-reactive protein]. i. (Resident 55): Lipid panel, vitamin B12, PSA. j. (Resident 113): Start DuoNeb q.i.d. for 7 days. 43212 22992 5. Resident 217 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebrovascular accident, right bundle branch block, heart failure, and major depressive disorder. Resident 217's medical record was reviewed from 7/8/24 through 7/16/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/23, a nurses note documented that at 6:10 PM, aide reported pt's (patient's) L (left) shoulder swollen and bruised. L shoulder very swollen, firm, looks like it/s (sic) further forward than R (right) Shoulder. Bruising on shoulder and down inner and outer upper arm. When I attempted to move arm, pt called out and flinched. An X ray was subsequently ordered. On 10/1/23, a nurses note documented that resident 217 returned from the emergency room with .findings of a fracture of the left humeral surgical neck, including displaced greater and lesser tuberosity . No records from of resident 217's emergency room visit could be located in resident 217's medical record. On 7/15/24 at 10:26 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she had obtained resident 217's medical records at the surveyor's request that same day. The DON confirmed that the records were not in resident 217's EMR prior to the surveyor's request.