STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465144	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seasons Healthcare and Rehabilitation	242 North 200 West 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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 31524 Based on interview, record review, and facility policy review, the facility failed to ensure a baseline care plan was completed within 48 hours of admission for 1 (Resident #143) of 1 newly admitted resident reviewed. Findings included: A facility policy titled, Care Plans - Baseline, copyright 2001, indicated, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. An Admission Record revealed the facility admitted Resident #143 on 07/11/2024. According to the Admission Record, the resident had a medical history that included diagnoses of a left femur fracture, type two diabetes mellitus, and stage four chronic kidney disease. As of the time of the survey, Resident #143's admission Minimum Data Set (MDS) assessment was still In Progress. Resident #143's electronic health record (EHR), reviewed on 07/16/2024, revealed the resident's Baseline Care Plan had a status of Errors. The Baseline Care Plan, dated 07/11/2024, was incomplete with no signatures or date and no Lock Date. Resident #143's EHR indicated the resident's Baseline Care Plan was created by Licensed Practical Nurse (LPN) #3 and revised by the MDS Coordinator. During an interview on 07/17/2024 at 10:46 AM, LPN #3 stated she was not sure who was responsible for completing the baseline care plan for new admissions and did not know the time frame for completing the baseline care plan. LPN #3 stated Resident #143 was admitted the week prior, and she initiated the baseline care plan but did not complete it because she was waiting on the Assistant Director of Nursing (ADON) to verify a few things. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/2024 at 11:53 AM, the ADON stated the nurse working at the time of a resident's admission was responsible for initiating the baseline care plan, and each department completed their respective sections. The ADON further stated the baseline care plan was to be completed within 48 hours of admission, and the MDS Coordinator was responsible for locking a resident's baseline care plan once it was completed. The ADON stated when a baseline care plan indicated the status was Errors, it either meant the base line care plan was incomplete or it was not yet locked to indicate it was completed. During an interview on 07/17/2024 at 12:41 PM, the MDS Coordinator stated a resident's baseline care plan should be completed within 48 hours of admission, and he was responsible for ensuring they were complete. The MDS Coordinator stated he was behind on completing care plans and indicated the Director of Nursing (DON) was aware. During an interview on 07/17/2024 at 1:53 PM, the DON stated she expected baseline care plans to be completed. The DON stated the admitting nurse started the baseline care plan, and the MDS Coordinator completed it. During an interview on 07/17/2024 at 2:10 PM, the Administrator stated he did not know the required timeframe for baseline care plan completion but expected them to be completed on time.

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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. 46659 Based on record review, interview, and facility policy review, the facility failed to develop a comprehensive care plan that addressed all triggered care areas from the Minimum Data Set (MDS) for 1 (Resident #4) of 13 sampled residents. Findings included: A facility policy titled, Care Plans, Comprehensive Person-Centered, revised in 03/2022, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. An Admission Record revealed the facility admitted Resident #4 on 10/24/2023. According to the Admission Record, the resident had a medical history that included diagnoses of major depressive disorder, protein-calorie malnutrition, hemiplegia affecting unspecified side, hypertension, overactive bladder, pain, and osteoarthritis. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/31/2023, revealed Resident # 4 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #4 required supervision from staff for eating, was dependent on staff for oral hygiene, toileting, showering/bathing, putting on and taking off footwear, and personal hygiene, and required substantial maximal assistance from staff for upper and lower body dressing. The MDS also indicated Resident #4 was frequently incontinent of bladder and was at risk for developing pressure ulcers/injuries. The MDS also indicated Resident #4 received an antidepressant medication during the assessment look-back period. The MDS Care Area Assessment (CAA) Summary revealed the areas of cognitive loss/dementia, communication, urinary incontinence, psychosocial well-being, activities, falls, nutritional status, pressure ulcer, and psychotropic drug use had triggered and would be addressed in the care plan. Resident #4's care plan for their admission on 10/24/2023 included Focus areas that indicated the resident would live at the facility long term, was dependent on staff for activities/recreation therapy, and had potential for nutritional problems. The areas of cognitive loss/dementia, communication, urinary incontinence, falls, pressure ulcer, and psychotropic drug use were not included on the care plan. During an interview on 07/15/2024 at 11:16 AM, Certified Nurse Assistant (CNA) #9 stated she reviewed care plans to know how to take care of the residents. During an interview on 07/17/2024 at 3:41 PM, the MDS Coordinator stated the admission MDS for Resident #4 indicated the areas would be care planned but they had not been care planned. During a follow-up interview on 07/17/2024 at 12:41 PM, the MDS Coordinator stated he was behind on care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/17/2024 at 1:54 PM, the Director of Nursing (DON) stated she was aware of the issue with care plans not being done. The DON said care plans were very important, because they gave staff a sense of what to do for each resident. During an interview on 07/17/2024 at 2:10 PM, the Administrator stated he expected care plans to be completed timely.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 31524 Based on interview, record review, and facility document and policy review, the facility failed to ensure as-needed (PRN) orders for psychotropic medications specified the duration of use and the residents' records reflected documentation of the rationale for use beyond 14 days for 2 (Resident #11 and Resident #23) of 5 residents reviewed for unnecessary medications. Findings included: A facility policy titled, Psychotropic Medication Use, revised in July 2022, indicated, 12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. 1. An Admission Record revealed the facility admitted Resident #11 on 09/27/2022 and readmitted the resident on 06/26/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of Alzheimer's disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/23/2024, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS also indicated the resident had active diagnoses of anxiety disorder and depression and had not received an anti-anxiety medication during the seven days prior to assessment. Resident #11's Order Summary Report, listing active orders as of 07/16/2024, contained an order started on 03/05/2024 for lorazepam intensol oral concentrate (antianxiety medication) 2 milligrams per milliliter (mg/mL), give 0.25 mL by mouth every four hours PRN for anxiety/agitation related to generalized anxiety disorder. The order did not specify the duration of use or a stop date. The Scheduling Details for Resident #11's lorazepam intensol oral concentrate 2 mg/mL revealed a start date of 03/05/2024 and an end date of Indefinite. Resident #11's Psychoactive Medication Therapy Informed Consent Form, dated 03/05/2024, indicated Ativan (lorazepam) was being used to treat agitation and anxiety with a proposed course of therapy as prolonged treatment/unknown. Resident #11's Medication Administration Record (MAR) for the timeframe from 07/01/2024 through 07/17/2024 revealed staff had documented the administration of the lorazepam once on 07/01/2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 07/17/2024 at 12:15 PM, Pharmacist #5 stated they followed the Centers for Medicare and Medicaid (CMS) guidelines for extending PRN psychotropic use past the allotted 14 days with the physician's documented rationale on a form the facility used. Resident #11's Psychotropic Committee Medication Review form, dated 06/27/2024, for the resident's PRN Ativan revealed the physician signed and dated the form on 07/16/2024 and agreed to continue the PRN medication; however, there was no documented rationale for extending the use beyond 14 days. During an interview on 07/17/2024 at 11:54 AM, the Assistant Director of Nursing (ADON) stated the facility followed the physician's orders for PRN psychotropic medications and that PRN psychotropic medications should only be used 14 days, unless specified differently by the physician. During an interview on 07/17/2024 at 1:58 PM, the Director of Nursing (DON) stated the facility discussed PRN psychotropic use at their monthly psychotropic medication review meetings. The DON stated Pharmacist #5, the facility's physician, herself, and the ADON attended the meetings, discussed the medications, and made recommendations. The recommendations were then sent to the primary physician to agree or disagree. The DON stated the facility tried to limit PRN psychotropic use to 14 days per the guidelines, but the physicians did not like having to re-order a PRN medication every 14 days. 46659 2. An Admission Record revealed the facility admitted Resident #23 on 10/06/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of generalized anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/14/2024, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS also indicated the resident received antianxiety medication during the seven-day assessment look-back period. Resident #23's care plan included a Focus area, initiated on 01/16/2024, that indicated the resident used anti-anxiety medications related to anxiety. Resident #23's Order Summary Report, listing active orders as of 07/17/2024, contained an order started on 05/13/2024 for lorazepam oral concentrate (antianxiety medication) 2 milligrams per milliliter (mg/mL), give 0.5 mL by mouth every four hours as needed for agitation or restlessness related to generalized anxiety disorder. The order did not specify the duration of use or a stop date. The Scheduling Details for Resident #23's lorazepam oral concentrate 2 mg/mL revealed a start date of 05/13/2024 and an end date of Indefinite. Resident #23's Medication Administration Record (MAR) for the timeframe from 07/01/2024 through 07/17/2024 revealed staff had documented administration of the lorazepam once on 07/10/2024. During a telephone interview on 07/17/2024 at 12:15 PM, Pharmacist #5 stated they followed the Centers for Medicare and Medicaid (CMS) guidelines for extending PRN psychotropic use past the allotted 14 days with the physician's documented rationale on a form the facility used. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23's Psychotropic Committee Medication Review form, dated 06/27/2024, for the resident's PRN lorazepam revealed the physician signed and dated the form on 07/09/2024 and agreed to continue the PRN medication; however, there was no documented rationale for extending the use beyond 14 days.

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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. 46659 Based on observation, interview, and review of the United States Food and Drug Administration (FDA) 2022 Food Code, the facility failed to ensure staff wore hair restraints in the dietary department to prevent potential contamination of food and food preparation equipment. This had the potential to affect 42 of 42 residents who received meals from the dietary department. Findings included: The United States FDA 2022 Food Code, dated 01/18/2023, revealed, Chapter 2. Management and Personnel, section 2-4 Hygienic Practices, 2-402 Hair Restraints 2-402.11 Effectiveness specified, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that cover body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. During a tour of the kitchen on 07/15/2024 beginning at 9:08 AM, the Dietary Supervisor (DS) was observed not wearing a hairnet while working with food items. An observation on 07/15/2024 at 9:26 AM, revealed Certified Nurse Assistant (CNA) #11 walked into the kitchen area and did not don a hairnet. She walked past a food preparation area, dishwasher, and the three-compartment sink area. During an interview on 07/15/2024 at 9:28 AM, CNA #11 stated she just came to drop off a diet slip and did not know that she had to wear a hairnet. She said she thought she could enter the kitchen without a hairnet if she did not get close to the stoves. During an interview on 07/15/2024 at 9:34 AM, the DS stated she thought staff could enter the kitchen without a hairnet if they did not come close to the stove. During an interview on 07/17/2024 at 2:10 PM, the Administrator stated he expected staff to wear hairnets when in the food preparation area and when serving food.