STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A072	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield County Nursing Home	200 North 450 East Panguitch, UT 84759

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 3 sampled residents, that the facility in response to an allegation of neglect did not have evidence that the allegation was thoroughly investigated and did not prevent further abuse while the investigation was in progress. Specifically, the facility did not have evidence of a thorough investigation and allowed the alleged perpetrator to continue to provide resident care while the investigation was being conducted. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses which included anxiety, arthritis, chest pain, decubitus ulcer of coccyx, degenerative joint disease, dementia, depression, history of malignant neoplasm of cervix, hypertension, morbid obesity, osteoporosis, pain, and Schizophrenia. On 5/1/24 resident 1's medical record was reviewed. On 7/21/23, resident 1's Quarterly Minimum Data Set (MDS) Assessment documented that resident 1 was always incontinent of urine with no episodes of continent voiding. The assessment further documented that resident 1 was dependent on staff for all of her toileting hygiene. On 9/25/23 at 9:46 PM, the progress note documented that resident 1 was alert and oriented to self only and was disoriented to time, situation, and place. The note documented that resident 1 only gets up to the toilet for bowel movements. The note documented that resident 1 had redness noted to her coccyx. On 9/25/23, resident 1's intake and output documented that the resident was incontinent of bladder and was changed at midnight, 4:00 AM and 7:00 AM. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/23, the facility reported to the State Survey Agency (SSA) on form 358 an allegation of resident neglect. The report documented that Licensed Practical Nurse (LPN) 1 documented, All night I had a feeling that [Certified Nurse Assistant (CNA) 1] wasn't actually checking briefs and peri-pads when she said she was because she would come out of rooms way quicker than me and the trashes were never filled up or taken out. I couldn't prove she was lying until our 0400 rounds, where we change most of the resident's briefs before day shift. I knew that a specific resident [resident 1] would be incontinent, as she is every night at midnight and at 0400. So, when me and [CNA 1] went into rooms at the same time and when I came out after changing a brief and she had already 'changed' 2 people in the time that I changed one, I grew more suspicious. I asked her, '[CNA1], did you change [resident 1] and reposition her?' [CNA 1] replied, 'No, I didn't reposition her and yes, she was wet.' I volunteered to rotate her. When I went to rotate her, I instead checked her brief and sure enough, she was soaked. Her pads were so heavy with urine it most definitely did not happen in the two minutes or so since [CNA 1] said she had checked her brief. The form documented that resident 1 had redness, macerated peri area, and coccyx redness. Review of the facility form 359 final facility investigation documented that resident 1 was not able to provide much information due to dementia. Resident 1 was unable to recall who had provided her incontinence care. The summary of interview(s) with witness(es) documented that the facility was in the process of scheduling an interview with LPN 1. The summary of interview(s) with the alleged perpetrator(s) documented, Caregiver only works PRN [as needed] and nights. I have not had the opportunity to catch her. She is not willing to come in and sign verbal warnings in the past. The form documented that interviews with other residents were not conducted. The form documented, resident only had redness in the perineal areas from sitting in urine for a long period of time. No other signs of abuse/neglect. The corrective actions taken documented, The caregiver may be suspended for a period of time or not able to care for this resident. The facility conclusion of the investigation documented that the allegation was verified and documented, The interview with the resident did not provide sufficient evidence that she was not cared for. The resident had some skin redness and breakdown in her private areas from sitting in her urine for a long period of time. Review of the facility abuse investigation revealed no other documentation other than what was submitted in form 358 and form 359 to the SSA. CNA 1's September and October 2023 timecard revealed the following: a. On 9/24/23, CNA 1 punched in at 5:26 PM, and punched out at 5:57 AM. b. On 9/27/23, CNA 1 punched in at 5:49 PM, and punched out at 4:31 AM. c. On 9/28/23, CNA 1 punched in at 5:57 PM, and punched out at 8:22 PM. d. On 9/30/23, CNA 1 punched in at 5:55 PM, and punched out at 8:45 PM. e. On 10/1/23, CNA 1 punched in at 5:53 PM, and punched out at 8:38 PM. f. On 10/2/23, CNA 1 punched in at 5:54 PM, and punched out at 10:01 PM. g. On 10/12/23, CNA 1 punched in at 3:47 PM, and punched out at 11:44 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	h. On 10/14/23, CNA 1 punched in at 5:47 PM, and punched out at 9:05 PM. i. On 10/16/23, CNA 1 punched in at 5:51 PM, and punched out at 8:16 PM. j. On 10/17/23, CNA 1 punched in at 5:39 PM, and punched out at 8:42 PM. k. On 10/18/23, CNA 1 punched in at 5:44 PM, and punched out at 8:51 PM. l. On 10/27/23, CNA 1 punched in at 3:40 PM, and punched out at 4:34 AM. m. On 10/29/23, CNA 1 punched in at 5:54 PM, and punched out at 8:41 PM. n. On 10/31/23, CNA 1 punched in at 5:23 AM, and punched out at 6:03 PM. It should be noted that CNA 1's timecard documented her last day worked at the facility was 12/9/23. The facility Abuse Long Term Care Policy documented that in response to allegations of abuse and neglect the facility would protect the resident from further potential abuse while the investigation was in progress. The policy further documented that if the alleged violation was verified that appropriate corrective action was taken, and that the facility would have evidence that all alleged violations were thoroughly investigated. On 5/1/24 at 1:04 PM, an interview was conducted with resident 1. Resident 1 stated that she was not able to ambulate to the toilet by herself and required staff assistance for toileting. Resident 1 stated that staff assisted her to the bathroom so that she could change her soiled brief. Resident 1 stated that she did not have too much experience with staff helping her to the bathroom at night, and that staff did not come to see if her brief was wet during the night. Resident 1 stated that staff had never left her in a wet brief for a long period of time and she reported no issues with skin breakdown in the buttock or groin area. On 5/1/24 at 4:03 PM, an interview was conducted with the Nurse Manager (NM). The NM stated that she was in the process of working with Human Resources (HR) to terminate CNA 1 because she did not meet the performance requirements. The NM stated that CNA 1 worked as needed at the facility and was suspended after the incident in September 2023. The NM stated she was not aware that CNA 1 was allowed to continue to work at the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/24 a 4:24 PM, a follow-up interview was conducted with the NM. The NM stated that she received a report from LPN 1 that CNA 1 was not performing incontinence care. The NM stated that she interviewed LPN 1 about the incident but did not have any documentation of that interview. The NM stated that it was the same information that was submitted in the event report which was documented on form 358. The NM stated that she then went through the process with the Nursing Administrator (NADM) on what to fill out with regards to the SSA notification. The NM stated that she made the report to the SSA and APS. The NM stated that she was informed by HR that they had to go through the proper channel of warnings and that she could not just terminate CNA 1. The NM stated that she does not recall if she interviewed CNA 1 after the incident and stated that she did not have any documentation of an interview. The NM stated that they would ensure the safety of the residents by not allowing CNA 1 to be in the facility. The NM stated that CNA 1 came into the facility to sign a written warning, and she was not sure how long she was suspended for. On 5/1/24 at 4:38 PM, an interview was conducted with the Clinical Operations Manager (COM). The COM stated that CNA 1 should have been suspended during the incident investigation. The COM stated that none of the incidents came through the safety net and therefore she was not aware of them. The COM verified that CNA 1 worked 2 shifts after the incident occurred and that CNA 1 worked up until December 2023. The COM stated that CNA 1 was still not terminated, and they were working with HR with that process. On 5/1/24 at 4:53 PM, an interview was conducted with the NADM. The NADM stated that the COM and NM would conduct any abuse investigations with the support of the risk management team. The NADM stated that the NM was responsible for the abuse investigation primarily with support from the social worker and the management team. The NADM stated that the social worker would ensure that the resident was emotionally supported during the investigation. The NADM stated that she was aware that the NM was working with HR on education. The NADM stated that she knew that there were concerns with CNA 1 related to attendance, sleeping on the job, and concerns about care that was being addressed with HR, but the specifics she was not aware of. The NADM stated that the investigation process was collaborative effort of the management team. On 5/1/24 at approximately 5:00 PM, an interview was conducted with the Licensed Clinical Social Worker (LCSW). The LCSW stated that when there was an allegation of abuse whoever was notified first would do the investigation and they would bring people in as needed. The LCSW stated that the NM was ultimately responsible for the investigation. The LCSW stated that he was made aware of the incident with CNA 1 today. The LCSW stated that the NM completed the form 359 and did not conduct any other resident interviews. The LCSW stated that he would assess the resident for any psychological or emotional damage during the investigation. The LCSW stated that when he was notified of any incident(s) he would open a care management note and document throughout the day the time notifications were made to outside agencies. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/2/24 at 9:07 AM, an interview was conducted with the NM, the NADM, the Administrator (ADM), and the LCSW. The NADM stated that when they had an allegation of abuse or neglect it was reported to any one of the shared leaders and they could initiate a report to Adult Protective Services (APS) and the SSA. The NADM stated that the abuse coordinator was the NM, but the allegations were reviewed by risk management of the nursing home and the attached hospital. The NADM stated that an event report was then generated and that was how they tracked and documented any allegations. The NADM stated that the facility investigation would take place and then they would close the loop with the actions taken for the investigation. The NADM stated that any of the administrative staff could handle this. The NADM stated that they get HR involved to protect the resident and HR would suspend the caregiver if needed. The NADM stated that they conducted coaching sessions with the caregiver and they worked with HR to do what was needed. The NADM stated that they felt that the licensed nurses were providing the care that the resident needed and that they were working with a performance issue with CNA 1. The NADM stated that education and coaching occurred prior to CNA 1 returning to work. It should be noted that no documentation could be found of the education, coaching or performance plan that was implemented after the incident on 9/25/23 and prior to CNA 1 returning to work on 9/27/23. The NADM stated that they needed to look at the coaching and education a little bit closer. The NADM stated that CNA 1 was off the schedule but picked up the extra shifts and returned to work. The NADM stated. I don't know that we knew she picked up that shift after the fact.