ENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465064	A. BUILDING _____ B. WING _____	02/15/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GEORGE CARE AND REHAB CTR	1032 EAST 100 SOUTH ST GEORGE, UT 84770

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252 SS=B	483.15(h)(1) ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation of the facility environment it was determined that facility staff did not provide a safe, comfortable and homelike environment in all areas of the facility. Findings include: 1. It was observed during the survey that the dining area in the special needs unit had exposed wiring from a light fixture and an outlet fixture. The electrical outlet above the nurses' station window had exposed capped wires within the electrical box without a safety plate. The light fixture below the nurses' station window had exposed wires connecting to a light socket containing a light bulb. 2. Resident room 207 in the special needs unit had exposed wires coming out of the wall near the window. These wires appeared to be telephone wires and protruded out about six inches from the wall. 3. Resident room 208 had the wall panel at the head of the window bed peeling off of the wall. This was a 4 by 8 feet wall panel attached to the permanent wall. 4. The Janitor's closet door in the special needs unit did not self lock after staff left the closet. On	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 252 **Corrective Action for Identified Residents:** No residents were identified. **Identification of Residents Potentially Affected:** All residents in the special care unit had the potential to be identified. **Measures to Prevent Recurrence:** The Executive Director will in-service all staff on locking all janitors' closets at all times throughout the facility and will point out the special needs unit specifically. The janitors closet door was repaired to self close when opened on by 3-1-06. The exposed wiring in the light fixture and outlet fixture in the special needs unit was repaired by 3-1-06. The light fixture below the nurses station window was repaired by 3-1-06. The exposed wires in room 207 were repaired and covered appropriately. The paneling in room 208 will be repaired by 3-28-06. **Monitoring/Quality Assurance:** The maintenance supervisor will conduct weekly audits on all janitor closet doors as well as audits on exposed wires and missing outlet covers throughout the facility. Once 100% compliance is achieved for a three-week period, the monthly Performance Improvement committee will decide upon a frequency for future audits.	4-16-2006.

3/6/06 POC acceptable completion date 4/16/06 Brandenburg for

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

Executive Director 3-6-06

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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F 252	Continued From page 1 2/14/06 at 10:45 AM, it was observed that the janitor's door was not locked. Inside of the closet was the cleaner chemical "Neutral Cleaner" On the label of this cleaner it cautioned to seek medical attention if swallowed and do not get on skin or in eyes. At 12:50 PM, the door was again observed to be closed but unlocked.	F 252		
F 272 SS=B	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and	F 272	***F 272*** ***Corrective Action for Identified Residents*** Resident #8 was identified. Resident #8's quarterly Minimum Data Set (MDS) due on 2/5/06 was completed on 2/15/06 and put into resident #8's active clinical medical record ***Identification of Residents Potentially Affected.*** All residents have the potential to be affected. ***Measures to prevent Recurrence*** MDS's and their due dates will be compiled by a Medical Records Designee and this information will be shared with the Utilization Coordinator and the MDS Coordinator monthly on LTC MDS's. ***Monitoring / Quality Assurance*** The Utilization Coordinator and the MDS Coordinator will be monitoring the MDS's for the next 6 weeks for their timeliness of completion. After the 6 week monitoring period the Utilization Coordinator will report to the Performance Improvement Committee regarding these audits. The Performance Improvement Committee will then determine the need for further MDS audits.	**March 31, 2006**

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F 272	Continued From page 2 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility did not conduct periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity, for one of 18 sample residents. Resident identifier 8. Findings included: Resident 8 was admitted to the facility on 4/27/00 with diagnoses including: rheumatoid arthritis and respiratory system disease. Review of resident 8's medical record was done on 2/13/06. The record included a quarterly assessment Minimum Data Set (MDS) completed on 11/5/05. The current quarterly assessment MDS was due to be done on 2/5/06. The current MDS was not on the chart. The facility MDS coordinator was interviewed on 2/14/06 at approximately 9:00 AM. She said that the current MDS had not been completed.	F 272	***Continued Compliance will be the responsibility of the Utilization Coordinator.***	
F 286 SS=B	483.20(d) RESIDENT ASSESSMENT - USE A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced	F 286	F 286 **Corrective action for Identified Resident** **Resident # 10 was identified. Minimum Data Set (MDS) assessments completed for the previous 15 months for Resident # 10 were pulled from her inactive records to her current active medical record**	March 31 , 2006

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F 286	Continued From page 3 by: Based on record review and interview it was determined that the facility did not maintain Minimum Data Set (MDS) assessments completed on residents active record for the previous 15 months for 1 of 18 sample residents. Resident identifier 10. Findings included: Resident 10 was admitted on 1/19/06 and readmitted to the facility on 2/9/06 with diagnoses that included dementia with depressive features, Parkinson's disease, atrial fibrillation, renal insufficiency, hypertension, gastric reflux disease, congestive heart failure, chronic obstructive pulmonary disease, and abdominal aortic aneurysm. Resident 10's medical record was reviewed on 2/13/06. Resident 10 was discharged on 2/1/06 and readmitted on 2/9/06. There was no MDS on resident 10's medical record. In an interview with the MDS coordinator, on 2/13/06 at 2:50 PM, she said that resident 10's, "MDS is probably still on my desk". The MDS coordinator placed the MDS in resident 10's medical record on 2/13/06. The admission MDS was completed on 2/1/06.	F 286	**Identification of Residents Potentially Affected** All residents have the potential to be affected. **Measures to Prevent Recurrence** Utilization Coordinator or designee will inservice the Medical Records Supervisor by 3-14-06. This inservice will explain the necessity of maintaining in residents' active medical records MDS assessments completed for the pervious 15 months **Monitoring/Quality Assurance** Residents returning to the facility from a hospital stay or other break in their facility stay will have their active medical records audited for the presence of MDS assessments completed for the previous 15 months. The Medical Records Supervisor or designee will do weekly audits for 6 weeks. At the completion of the audits, the Medical Records Supervisor will report audit results to the Performance Improvement Committee (Quality Assurance). The Committee will then determine the need for further audits and reports. The Medical Records Supervisor will be responsible for continued compliance.	
F 328 SS=D	483.25(k) SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services:	F 328		

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F 328	Continued From page 4 Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility did not ensure that a resident received proper treatment and care for the following special service: respiratory care. This occurred for one of 18 residents in the survey sample. Resident identifier 5. Findings included: Resident 5 was admitted to the facility on 12/21/05 and re-admitted from a hospital on 2/8/06. Diagnoses included: chronic respiratory failure, chronic obstructive sleep apnea, morbid obesity with depressive features, and congestive heart failure. On 2/14/06 at 3:30 PM, observation of resident 5 and his respiratory care equipment revealed that his Bi-pap machine was not providing oxygen, nor was it set up to provide oxygen. On 2/14/06 at 3:40 PM, LPN 1 was interviewed. In an interview on 2/14/06, LPN 1 said that resident 5 arrived at the facility with this Bi-pap machine. When asked who checked the	F 328	F 328 **Corrective Action for Identified Residents:** Resident #5 was identified. Obtained clarification orders from Dr. Thompson on 3-3-06 discontinuing admission BiPAP orders of "BiPAP 18/13 50 % Fi O2" New order to "start BiPAP 18/13 with 4 liters of O2 per minute via BiPAP circuit. Overnight oximetry study to evaluate effectiveness. "Praxair contacted 3-3-06 and set-up BiPAP machine to correspond with physician's new order. Overnight oximetry coordinated with Praxair for week ending 3-10-06. **Identification of Residents Potentially Affected:** All residents with special respiratory care orders have the potential to be affected. **Measures to Prevent Recurrence:** Director of Nursing (DNS) or designee will in-service licensed nursing staff regarding interpretation of BiPAP orders and subsequent set-up and administration of BiPAP machines. Licensed nurses will also be in-serviced on necessity of obtaining clarification of BiPAP orders that are unclear. The DNS or designee will require licensed nursing staff to demonstrate proper set-up and administration of BiPAP machine use.	March 31, 2006.

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F 328	Continued From page 5 resident's oxygen saturation levels, LPN 1 replied that a nurse should do that. LPN 1 reviewed resident 5's chart and said, "I don't see an order for oxygen sats." LPN 1 and the surveyor looked at the physicians' medication and treatment orders dated 2/8/06 that came with the resident from the hospital. There was an order for "BiPAP 18/13 w/ 50% Fi O2" (BiPAP 18/13 cm H2O {centimeters of water pressure} with 50 percent Fraction of inspired oxygen). LPN 1 did not know what the order meant. She explained that the facility used to have a respiratory therapist but did not currently have a respiratory therapist. When asked about O2 being attached to the Bi-pap machine, LPN 1 called for assistance. LPN 2 came from another hall at 3:50 PM and checked the Bi-pap machine. LPN 2 reported that the Bi-pap machine had no inlet for O2 attachment. The Bi-pap was running with room air. LPN 1 was asked to take resident 5's oxygen saturation level. She took the level at 4:00 PM. The O2 saturation level of resident 5 was 86%. On 2/14/06 at 7:30 PM, LPN 3 was interviewed. LPN 3 had worked the night shift for several years. When asked if she helped the resident to apply the mask and to start the Bi-pap machine, LPN 3 stated that she offered but the resident preferred to hook it up himself. LPN 3 was asked if resident 5 had an order for oxygen and she said, "To my knowledge, he has not used oxygen." LPN 3 looked up the current orders in the medical chart and saw the 2/8/06 order for "BiPAP 18/13 w/ 50% FiO2." LPN 3 did not know what the order meant. She indicated that the order needed clarification.	F 328	**Monitoring/Quality Assurance:** **DNS or designee will conduct weekly audits regarding orders received for BiPAP machine use and subsequent proper resident administration by licensed nursing staff. Audits will be completed for a 2- month period. At the end of designated time period, the DNS or designee will report results of the audits to the Performance Improvement Committee (Quality Assurance). Further need for audits and reporting will then be determined and will continue if directed by the Performance Improvement Committee. DNS will be responsible for continued compliance. Completion date will be March 31, 2006.**	

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F 328	Continued From page 6 The facility did not have the capacity to administer the order.	F 328		
F 329 SS=D	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, it was determined that facility staff did not ensure that drugs (a hypnotic) were not used for excessive duration. This occurred for one of 18 residents in the survey sample, resident 11. Findings include: 1. Resident 11 was an 87 year old male admitted to the facility on 11/2/05 with the diagnoses of Parkinson's, narcolepsy, seizure disorder, peptic ulcer and an embolism. During a review of resident 11's Physician Recertification orders dated January 2006 and through February 12, 2006, it was documented that resident 11 had a physician's order for "Temazepam [a hypnotic] 15 mg. PO [by mouth] QHS [every night] for insomnia". The original	F 329	F329 **Corrective Action for Identified Residents:** Resident #11 was identified. Physician contacted and orders received to change routine hypnotic orders to prn (as needed) basis. Medication Administration Record (MAR) was corrected to ensure hypnotic will not be administered for greater than 9 continuous days. Hypnotic Tracking sheet was initiated to evaluate sleeping pattern and efficacy of hypnotic medication. **Identification of Residents Potentially Affected:** All residents receiving hypnotic medication have the potential to be affected. **Measures To Prevent Recurrence:** Director of Nursing (DNS) or designee will in-service licensed nursing staff related to regulations pertaining to hypnotics. **Monitoring/Quality Assurance:** The DNS or designee will conduct routine audits on new admissions within 72 hours to identify those residents admitting with orders for hypnotic medications. Audits will also be completed within 72 hours by DNS or designee for hypnotic orders received via physician visits or telephone orders. If hypnotic medication is ordered routinely, physician will be contacted to obtain either	3-31-06

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F 329	Continued From page 7 physician order for the Temazepam was dated 1/3/06. During a review of resident 11's Medication Administration Record (MAR) for January and through February 12, 2006, it was documented that resident 11 received the hypnotic every night during that time frame. During an interview with the Registered Nurse (RN) on 2/14/06 at 7:40 AM, the RN stated that residents taking hypnotics should have "a sleep monitor sheet." It was also stated for resident 11 regarding the sleep monitor sheet, "looks like we don't have one," but it should be tracked in the Nurses Notes. A review of the Nurses Notes for resident 11 from January 12, 2006 until February 13, 2006, determined there was not any documentation regarding resident 11's sleeping pattern or efficacy of the hypnotic medication. On 2/15/06 at 7:25 AM, the Director of Nursing stated that the nurses were not tracking resident 11's hypnotic.	F 329	documentation of necessity for routine administration, or orders to change hypnotic to prn (as needed) basis. DNS or designee will at this time audit Medication Administration Record (MAR) for initiation of Hypnotic Tracking sheet and ensure MAR reflects scheduled drug holiday every 10th day. Audits will be conducted for a 2-month period. At the completion of these audits, the DNS or designee will report to the Performance Improvement Committee (Quality Assurance). Further need for audits and reporting will then be determined and will continue if directed by the Performance Improvement Committee. DNS will be responsible for continued compliance.	
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation of the facility environment it was determined that facility staff did not ensure the nurses' station was equipped to receive	F 463		

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F 463	Continued From page 8 resident calls through a communication system from resident rooms and toilet facilities from the special needs unit. Findings include: On 2/13/06 at 12:30 PM, observation in room 309 revealed that the call light for bed A did not work. When the call light button was pushed, the light in the hall outside room 309 above the door did not light up. On 2/14/06 at 10:20 AM, the resident in bedroom 209 was observed attempting to get out of bed and needed assistance. During an interview with a CNA (Certified Nursing Assistant) at 10:25 AM, the CNA stated that she did not know if the call system worked because she has "never heard them." It was observed on all days during the survey that the following resident bedroom and bathroom areas of the special needs unit did not have a functioning communication system. 1. Bedrooms 205, 206, 207, 208, 209, and 211 had an outlet type plate cover over the call system communication controls. This prevented access to the system. 2. The call system in bedroom 202 did not have pull cords to activate the call system. 3. The call system in bedroom 201 functioned properly for the bed near the window but not for the bed near the hallway door. 4. The resident restrooms for bedrooms 205,	F 463	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 463 **Corrective Action for Identified Residents:** All resident rooms in the special needs unit were identified. **Identification of Residents Potentially Affected:** All residents in the special care unit had the potential to be identified. **Measures to Prevent Recurrence:** The Executive Director is accepting bids and will plan on having a call light system in place for each bed and each bathroom in the special needs unit with a monitor at the nurses station in the special needs unit by 4-16-2006. **Monitoring/Quality Assurance:** The maintenance supervisor will do a monthly audit on the new call light system once it is installed to assure it is functioning properly for two months and then the Performance Improvement (Quality Assurance) Committee will decide how frequently they will be completed.	4-16-2006

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F 463	Continued From page 9 206, 207, 208, 209, and 211 did not have a functioning communication call system. During an interview with the Administrator on 2/15/06, he stated that the system was deactivated some time ago and that he has requested the system to be reactivated.	F 463		