STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	This Plan of Correction constitutes Coral Deserts written evidence of its achievement of substantial compliance of the deficiencies shown on this Statement of Deficiencies (CMS-2567 dated 1/15/22), and its ability to maintain substantial compliance through the monitoring of its quality assurance programs. Preparation and or execution of this Plan of Correction does not constitute admission and/or agreement by Coral Desert of the facts alleged and/or conclusion set forth on this Statement of Deficiencies. This Plan of Correction is prepared and/or executed because the provisions of Health and Safety Code, Section 1250 and 42 Code of Federal Regulations 405.1907 require it. F 656 IMMEDIATE CORRECTIVE ACTION: Resident 91, issue resolved, resident discharged Resident 103, issue resolved, resident discharged Resident 143, issue resolved, Resident care plan updated to reflect the impaired ability to feed self and interventions instituted to provide assistance with ADLs including eating.	1/31/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	1/4/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 656	Continued From page 1	F 656		

plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident consistent with the resident's rights that includes measurable objectives and timeframe's to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Specifically, for 3 out of 19 sampled residents, a resident who required one on one feeding assistance was not receiving that assistance, and two residents who required oxygen did not have the use of oxygen included in the comprehensive care plan. Resident identifiers: 91, 103, and 143.

Findings included:

1. Resident 91 was admitted to the facility on 12/8/22 with diagnoses which included displaced intertrochanteric fracture of left femur, other intraarticular fracture of lower end of left radius, history of falling, chronic obstructive pulmonary disease, dehydration, nutritional anemia, hypertension, and hyperlipidemia.

On 12/13/22 at 11:49 AM, an interview was conducted with Resident 91. Resident 91 was using oxygen via a nasal cannula. No label was observed on the oxygen tubing indicating when it

IDENTIFICATION OF OTHERS:

All residents reviewed for the same or similar concerns and care plans are updated to reflect current needs with measurable interventions and appropriate timeframes to assure highest practicable function.

PROCESS TO PREVENT RECURRENCE:

All new admission orders and comprehensive assessments will be reviewed and double checked by nursing to ensure all orders and care plans are in place to reflect person centered interventions consistent with the resident's rights and have measurable objectives and timeframes to meet needs

MONITORING:

MDS/ designee will monitor 3 new admission charts per week x 4 weeks to ensure all orders and care plans are in place to reflect person centered interventions consistent with the resident's rights and have measurable objectives and timeframes to meet needs.

Findings will be brought to QA committee for further review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 656	Continued From page 2	F 656		

had been changed. Resident 91 stated she did not know when the oxygen tubing was changed.

On 12/13/22, Resident 91's medical record was reviewed.

No oxygen orders were found in the physician's orders.

No oxygen treatment instructions were found on the Treatment Administration records (TAR).

Resident 91's care plan was reviewed, a respiratory focus area and intervention were not included.

A Daily Skilled Note dated 12/10/22, documented, "12/10/2022 07:39 [AM] O2 [Oxygen] 94% [percent] - 12/10/2022 09:33 [AM] Method: Oxygen via Nasal Cannula."

A Daily Skilled Note dated 12/11/22, documented, "12/11/2022 21:52 [9:52 PM] O2 90% - 12/11/2022 21:52 Method: Oxygen via Nasal Cannula."

2. Resident 103 was admitted to the facility on 12/6/22 with diagnoses which included displaced intertrochanteric fracture of left femur, history of falling, moderate protein-calorie malnutrition, type 2 diabetes, chronic obstructive pulmonary disease, left bundle-branch block, hypertension, anemia, major depressive disorder, retention of urine, and urinary tract infection.

On 12/13/22, resident 103's medical record was reviewed.

No oxygen orders were found in the physician's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 656	Continued From page 3	F 656		

orders.

No oxygen treatment instructions were found on the TAR.

Resident 103's care plan was reviewed, a respiratory care focus area or intervention were not included.

A review of resident 103's admission Minimum Data Set assessment dated 12/10/22, revealed that resident 103 used oxygen before her admission and had used oxygen during her current admission.

The hospital discharge summary dated 12/6/22, revealed in the discharge orders "Unchanged DME [Durable Medical Equipment] RESP [Respiratory] Oxygen therapy."

A progress note dated 12/7/22, revealed that resident 103 received respiratory treatment "Oxygen therapy. Oxygen administered while a resident. Use is continuous oxygen. Set at 2L [liters] per NC [Nasal Cannula]."

3. Resident 143 was admitted to the facility on 12/8/22 with diagnoses which included traumatic subdural hemorrhage with loss of consciousness, hemiplegia and hemipareses affecting right dominant side, displaced supracondylar fracture of right humerus, and history of falling.

On 12/12/22 at 3:30 PM, an interview was conducted with resident 143's family member. The family member stated the staff did not cut up resident 143's food. The family member stated resident 143 could only use her left arm, which was her non-dominant arm, since her stroke and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 656	Continued From page 4	F 656		

broken right arm. The family member stated if he was not at the facility to help resident 143, she would not eat because she could not cut up the food by herself. The family member stated, "They expect me to always be here so they just don't do it. They should take care of her whether I am here or not."

On 12/13/22 at 12:24 PM, an observation was made of resident 143's meal ticket that was on the tray. The ticket documented, "CUT UP ALL FOOD" in bold capital letters.

On 12/13/22 at 7:25 AM, an observation was made of Certified Nurses Assistant (CNA) 1. CNA 1 entered resident 143's room, resident 143 was reclined in bed. CNA 1 placed the breakfast tray on the bedside table in front of resident 143. CNA 1 cut up the food on resident 143's plate, then exited the room. CNA 1 did not assist resident 143 with eating.

On 12/14/22 at 7:35 AM, an observation was made of resident 143 lying in bed leaning on her left side, the bedside table was across the bed in front of resident 143. Resident 143's breakfast was on the bedside table. No staff or family were in the room with the resident. Resident 143 was observed not eating.

On 12/14/22 at 12:33 PM, an observation was made of resident 143 lying in bed, with the head of the bed elevated. Resident 143's lunch tray was on the bedside table in front of her. Resident 143's lunch tray had breaded chicken that was cut up, steamed vegetables that were not cut up, a buttered roll that was not cut up, and a dessert that was not cut up. No staff or family were in the room assisting Resident 143. Resident 143 could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 656	Continued From page 5	F 656		

only reach the roll with her fork. Resident 143 held the fork in her left hand and tried to pick up the roll with her fork. Resident 143 tried to cut the roll with her fork. This surveyor observed resident 143 drop her fork after many failed attempts and stopped eating.

On 12/15/22 at 7:15 AM, an observation was made of resident 143 sitting in bed, the bedside table was in front of the resident. Resident 143's breakfast tray was on the bedside table. Scrambled eggs, grapes, and cut up toast were on the plate in front of resident 143. No staff or family were in the room assisting resident 143 with eating. Resident 143 attempted to eat with her left hand but was unable to bring the fork to her mouth.

On 12/15/22, resident 143's medical record was reviewed.

An Initial Admission Record dated 12/8/22, revealed resident 143 had right arm weakness and paralysis.

A Late Loss ADL (Activities of Daily Living) Form dated 12/11/22, revealed resident 143 required one person physical assistance and extensive assistance with eating.

A care plan dated 12/9/22 with a revision on 12/11/22, revealed, "[Resident 143] has a potential nutritional problem r/t [related to] hx [history] of CVA [cardiovascular accident] in adulthood with hemipareses/plegia, under weight, bone fx [fracture]." The goal revealed "[Resident 143] will maintain adequate nutritional status as evidenced by maintaining weight with no s/sx [sign/symptoms] of malnutrition through review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 656	Continued From page 6	F 656		

date." The interventions included, "provide, serve diet as ordered. Monitor and record q [every] meal." [Note: The care plan did not include the feeding assistance that resident 143 required.]

A physician's order dated 12/8/22, revealed a regular diet with regular texture and thin liquids consistency for a one on one feed was ordered.

On 12/14/22 at 7:30 AM, an interview was conducted with CNA 1. CNA 1 stated that a one on one feed meant that the resident needed someone in the room with them to help them eat or to feed them. CNA 1 stated if she were the only CNA working the floor then she would serve all the residents, then return to the resident who needed the one on one feeding, and would provide them with assistance. CNA 1 stated the information on whether a resident needed to be a one on one feed would be passed on in report, it would be documented on the report shift report sheet, and in the resident's medical record. CNA 1 stated she was unaware of any residents on the 100 hall who needed one on one feeding assistance.

On 12/14/22 at 7:38 AM, an observation was made of CNA 1's report sheet. The report sheet did not reveal that resident 143 was a one on one feed.

On 12/15/22 at 8:50 AM, a telephone interview was conducted with the Director of Nursing (DON). The DON stated the CNA's were expected to assist the residents with eating if it was needed. The CNA's and nurses had monthly inservices to go over areas of concern or that may need more education. The DON stated the expectation was the nurses and the CNA's would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 656 Continued From page 7

follow what was on the residents meal ticket and ordered by the physician. The DON stated the care that each resident needed was found on their care plan in their medical record.

F 656

F 677 SS=D ADL Care Provided for Dependent Residents
CFR(s): 483.24(a)(2)

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility did not provide a resident who was unable to carry out activities of daily living the necessary services to maintain good grooming and personal hygiene. Specifically, for 1 out of 19 sampled residents, a resident was not provided one on one feeding assistance. Resident identifier: 143.

Findings included:

Resident 143 was admitted to the facility on 12/8/22 with diagnoses which included traumatic subdural hemorrhage with loss of consciousness, hemiplegia and hemipareses affecting right dominant side, displaced supracondylar fracture of right humerus, and history of falling.

On 12/12/22 at 3:30 PM, an interview was conducted with resident 143's family member. The family member stated the staff did not cut up resident 143's food. The family member stated resident 143 could only use her left arm, which was her non-dominant arm, since her stroke and broken right arm. The family member stated if he

F 677

F 677

IMMEDIATE CORRECTIVE ACTION:

Resident 143 issue resolved. Resident receives assistance with eating. Care plan reviewed and updated as appropriate.

1/31/23

IDENTIFICATION OF OTHERS:

All care plans reviewed for residents with ADL deficits to assure they are receiving necessary services to maintain good nutrition, grooming, personal and oral hygiene.

PROCESS TO PREVENT RECURRANCE:

All new admissions will be reviewed and double checked by nursing to ensure resident ADL needs are identified and resident will be provided with necessary services to maintain good nutrition, grooming, personal and oral hygiene.

MONITORING:

MDS nurse or designee will review 3 comprehensive assessments per week x 4 weeks, to ensure residents with extensive ADL needs are care planned to alert staff of their needs.

findings will be brought to QA for further review,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 677	Continued From page 8	F 677		

was not at the facility to help resident 143, she would not eat because she could not cut up the food by herself. The family member stated, "They expect me to always be here so they just don't do it. They should take care of her whether I am here or not."

On 12/13/22 at 12:24 PM, an observation was made of resident 143's meal ticket that was on the tray. The ticket stated, "CUT UP ALL FOOD" in bold capital letters.

On 12/14/22 at 7:25 AM, an observation was made of Certified Nurses Assistant (CNA) 1. CNA 1 entered resident 143's room, and placed the breakfast tray on the bedside table in front of resident 143. CNA 1 cut up the food on the plate, then left the room. CNA 1 did not assist resident 143 with eating.

On 12/14/22 at 7:45 AM, an observation was made of resident 143 lying in bed leaning on her left side, the bedside table was in front of the resident. Resident 143's breakfast was on the bedside table. Waffles were on the plate that had been cut into squares. No staff or family were in the room with the resident. Resident 143 was observed not eating.

On 12/14/22 at 12:33 PM, an observation was made of resident 143 lying in bed, the head of the bed was elevated. Resident 143's lunch tray was on the bedside table in front of her. Resident 143's lunch tray had breaded chicken that was cut up, steamed vegetables that were not cut up, a buttered roll that was not cut up, and a dessert that was not cut up. No staff or family were in the room assisting resident 143. Resident 143 could only reach the roll with her fork. Resident 143

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 677	Continued From page 9	F 677		

held the fork in her left hand and tried to pick up the roll with her fork. Resident 143 tried to cut the roll with her fork. This surveyor observed resident 143 drop her fork after many failed attempts and stopped eating.

On 12/15/22 at 7:15 AM, an observation was made of resident 143 sitting in bed, the bedside table was in front of the resident. Resident 143's breakfast tray was on the bedside table. Scrambled eggs, grapes, and cut up toast were on the plate in front of resident 143. No staff or family were in the room assisting resident 143 with eating. Resident 143 tried to eat with her left hand but was unable to bring the fork to her mouth.

On 12/15/22, resident 143's medical record was reviewed.

An Initial Admission Record dated 12/8/22, revealed resident 143 had right arm weakness and paralysis.

A Functional Performance Evaluation dated 12/8/22, revealed resident 143 required partial/moderate assistance with eating. Partial/moderate assistance was defined as, "Helper does less than half the effort. Helper lifts or holds trunk or limbs and provides less than half the effort."

A Late Loss ADL (Activities of Daily Living) Form dated 12/11/22, revealed resident 143 required a one person physical assist and extensive assistance with eating.

A care plan dated 12/9/22 with a revision on 12/11/22, revealed, "[Resident 143] has potential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 677	Continued From page 10	F 677		

nutritional problem r/t [related to] hx [history] of CVA [cardiovascular accident] in adulthood with hemipareses/plegia, under weight, bone fx [fracture]." The goal revealed "[Resident 143] will maintain adequate nutritional status as evidenced by maintaining weight with no s/sx [sign/symptoms] of malnutrition through review date." The interventions included, "provide, serve diet as ordered. Monitor and record q [every] meal." [Note: The care plan did not include the feeding assistance that resident 143 required.]

A physician's order dated 12/8/22, revealed a regular diet with regular texture and thin liquids consistency for a one on one feed was ordered.

On 12/13/22 at 1:03 PM, an interview was conducted with CNA 2. CNA 2 stated resident 143 could eat by herself, she just needed to be sat up. CNA 2 stated resident 143's husband would cut up her food and if he was not here then resident 143 could do it by herself. CNA 2 stated the staff would go in and check on resident 143. CNA 2 stated that resident 143 was a slow eater but she could do it all by herself. CNA 2 stated the staff did help resident 143 if she wanted to get up, get dressed, or shower since resident 143 could only use one side from having a stroke.

On 12/14/22 at 7:30 AM, an interview was conducted with CNA 1. CNA 1 stated that a one on one feed meant that the resident needed someone in the room with them to help them eat or to feed them. CNA 1 stated if she were the only CNA working the floor then she would serve all the residents, then return to the resident who needed the one on one feeding, and would provide them with assistance. CNA 1 stated the information on whether a resident needed to be a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 677	Continued From page 11 one on one feed would be passed on in report, it would be documented on the report shift report sheet, and in the resident's medical record. CNA 1 stated she was unaware of any residents on the 100 hall who needed one on one feeding assistance. On 12/14/22 at 7:38 AM, an observation was made of CNA 1's report sheet. The report sheet did not reveal that resident 143 was a one on one feed. On 12/15/22 at 8:50 AM, a telephone interview was conducted with the Director of Nursing (DON). The DON stated the CNA's were expected to assist the residents with eating if it was needed. The CNA's and nurses had monthly inservices to go over areas of concern or that may need more education. The DON stated the expectation was the nurses and the CNA's would follow what was on the residents meal ticket and ordered by the physician. The DON stated the care that each resident needed was found on their care plan in their medical record.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692	F 692 IMMEDIATE CORRECTIVE ACTION: Resident 18, issue resolved. feeding tube has been placed and care plan updated as appropriate. IDENTIFICATION OF OTHERS: All residents reviewed to identify significant weight loss to ensure appropriate interventions are implemented timely.	1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 692	Continued From page 12	F 692		

balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility did not ensure that residents maintained acceptable parameters of nutritional status. Specifically, for 1 out of 19 sampled residents, a resident with weight loss did not receive timely and appropriate interventions. Resident identifier: 18.

Findings included:

Resident 18 was initially admitted to the facility on 7/26/22 and readmitted to the facility on 8/29/22 with diagnoses which included dependence on ventilator, unspecified intracranial injury, epilepsy, type II diabetes hemiplegia and hemipareses on left non-dominant side, dysphagia, and anxiety.

On 12/15/22, resident 18's medical record was reviewed.

On 9/29/22, the Weight Summary revealed a weight of 181 pounds.

On 12/14/22, the Weight Summary revealed a weight of 143.5 pounds.

[Note: This was a 37.5 pound weight loss, 20.72

PROCESS TO PREVENT RECURRENCE:

Residents weight and nutritional status will be reviewed by RD and ADON in weekly nutrition at risk meeting (NAR) to monitor for unplanned weight loss and determine appropriate interventions to recommend to MD/ APN timely.

MONITORING:

ADON/ designee will review 3 random residents for significant weight loss to ensure follow up and notification and implementation of recommendations are completed. review will be completed weekly x 4 weeks.

Findings will be brought to QA committee for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 692	Continued From page 13	F 692		

percent weight loss in 76 days.]

A care plan dated 8/11/22 revealed, "At risk for potential nutrition problem per inadequate oral intake, fluid deficit." A goal developed on 8/11/22 and revised on 11/11/22, revealed, "[Resident 18] will maintain adequate nutritional status as evidenced by maintaining weight with no sign/symptom of malnutrition through review date of 1/24/23." An intervention to monitor and document intake and output as per facility policy was created on 12/2/22.

No entries were made to the care plan that indicated resident 18's weight had decreased.

A physician's order dated 8/29/22, revealed resident 18 was on a Consistent Carbohydrate (CCHO)mechanical soft diet with chopped texture and thin liquids.

A Nutrition Note dated 10/6/22, revealed, "No new weight recorded this week. Pt [Patient] continues to receive PO [by mouth] feedings, of which he is taking 65%. This intake is not adequate to meet his nutrition goals, and wt [weight] loss is expected...Provider notified."

A Provider Visit Note dated 10/10/22, revealed, "[Resident 18] states he is still eating and drinking really well with no issues. Weight at 175 lbs [pounds]. No changes to plan."

On 10/12/22, the Weight Summary revealed a weight of 168.2 pounds.

A Nutrition Note dated 10/15/22, revealed, "Pt experienced a recent wt loss of 13# [pounds] (in 2 weeks). His PO intake is recorded at 67 %, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 692	Continued From page 14	F 692		

is shy of pt's nutrition goals. Pt expresses concern that he was previously gaining wt and wanted to return to his weight from a month ago. Also suspect fluid shift per diuretics. If wt loss continues, will suggest supplementation...Provider notified."

It should be noted, the physician's order revealed resident 18 had been on Furosemide 20 milligrams one tablet every morning since admission to the facility on 8/29/22. No new diuretics had been added to Resident 18's medication regimen. Resident 18's weight one month prior to the Nutrition Note dated 10/15/22, was 175 pounds.

The care plan was not updated and no new interventions were put into place with resident 18's weight decrease.

A Provider Visit Note dated 10/17/22, revealed, "...[Resident 18] stated he is still eating and drinking better. He is tolerating more food than before. Weight 175 lbs. No changes to plan."

On 11/2/22, the Weight Summary revealed a weight of 157 pounds.

The care plan was not updated and no new interventions put into place with resident 18's weight decrease.

On 11/9/22, the Weight Summary revealed a weight of 155.6 pounds.

A Nutrition Note dated 11/11/22, revealed, "Pt lost 2# this week (13# in one month). Provider notified...PO intake of CCHO averages 65%. Continue to monitor. Add supplement if wt loss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 692	Continued From page 15	F 692		

continues."

The care plan was not updated and no new interventions put into place with resident 18's weight decrease.

On 11/16/22, the Weight Summary revealed a weight of 154 pounds.

A Nutrition Note dated 11/19/22, revealed, "Pt continues to lose wt...Provider notified...Add Boost Very High Calorie twice a day. Continue to monitor."

A physician's order dated 11/19/22, revealed resident 18 was started on Boost Very High Calorie two times a day for inadequate intake to meet needs, weight loss.

A Provider Note dated 11/21/22, had a weight noted of 154 lbs and revealed to, "continue current treatment, no changes to current plan."

On 11/23/22, the Weight Summary revealed a weight of 151.6 pounds.

On 11/29/22, the Weight Summary revealed a weight of 146.6 pounds.

A Nutrition Noted dated 12/2/22, revealed, "Pt lost 5 # this week...PO intake not meeting nutritional goals...increase Boost to three times a day. If wt continues to trend downward, suggest considering replacing Percutaneous Endoscopic Gastrostomy for enteral nutrition support."

A physician's order dated 12/2/22, revealed resident 18 was started on Boost Very High Calorie three times a day for inadequate intake to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 692	Continued From page 16	F 692		

meet needs, weight loss.

On 12/14/22, the Weight Summary revealed a weight of 143.5 pounds.

On 12/15/22 at 10:54 AM, an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated resident 18 was losing weight because he wanted to lose weight and refused to have his Percutaneous Endoscopic Gastrostomy (PEG) tube replaced. The ADON stated she was unsure why no other interventions had been put in place to combat the weight loss other than the added Boost. The ADON stated there was a recall on a protein drink that had been used previously but she was unsure as to why no other supplementation or medication had been tried.

On 12/15/22 at 11:33 AM, an interview with the Registered Dietician (RD) was conducted. The RD stated the residents were weighed every Wednesday, and the weights were reviewed by herself and the ADON in the weekly nutrition meeting. The RD stated she evaluated all the residents in the building on Thursdays, and would add supplements or fortification if it was needed based on the weight loss and her evaluation. The RD stated fortifying just means "adding butter" and "more food" to a resident's diet. The RD stated if a resident would not eat all of the food they were being given then there was no reason to fortify it or increase the amount. The RD stated resident 18 just needed to have his PEG tube replaced but resident 18 was resistant to it. The RD stated resident 18 was using Boost but did not drink all of it all of the time. The RD stated it may be worth it to try other supplements or measures to help stop resident 18's weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693	F 693	

§483.25(g)(4)-(5) Enteral Nutrition
(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility did not ensure that a resident who was fed by enteral means received the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications. Specifically, for 1 out of 19 sampled residents, a resident's tube feeding was not infusing at the prescribed infusion rate. Resident identifier: 17.

Findings included:

Resident 17 was admitted to the facility on

F 693

IMMEDIATE CORRECTIVE ACTION:

Resident 17 issue resolved. Tube feeding rate is consistent with current order. Resident family members have been educated again on importance of patient receiving the proper amount of formula in order to maintain weight and nutritional status. Care plan reviewed and updated.

1/31/23

IDENTIFICATION OF OTHERS:

All residents with enteral feeding orders were reviewed to ensure the infusion rate is consistent with physician orders and care plan.

PROCESS FOR PREVENTING RECURRENCE:

Education provided to LN to follow orders for enteral feeding as written. Order for tube feeding rate will be entered into emar and care plan. LN to ensure feeding pump is programed properly.

MONITORING:

DON/ designee will review enteral feeding pump settings to ensure they are consistent with the order as written once a week x 4 weeks.

Findings will be taken to QA committee for review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 693	Continued From page 18	F 693		

7/25/22 with diagnoses which included chronic respiratory failure with hypoxia, tracheostomy, dependence on ventilator, dysphagia, cognitive communication deficit, chronic diastolic congestive heart failure, essential hypertension, rheumatoid arthritis, major depressive disorder, and need for assistance with personal care.

On 12/12/22 at 4:12 PM, an observation was made of resident 17 lying asleep in bed with a family member (FM) in the room. Resident 17's tube feeding (TF) was infusing at 75 milliliters an hour (ml/hr) with 40 ml/hr of water flush. On the TF bag a label revealed a date and time of 12/11/22 at 2000 (8:00 PM) and a run rate of 65 ml/hr.

On 12/15/22, resident 17's medical record was reviewed.

A physician's order dated 11/9/22, revealed, "Enteral Feed Order, 1.5 kcal [kilocalorie]/ml [milliliter] 55 ml/hr with 25 ml of water flush every hour as tolerated. GOAL of 65 ml/hr. Increase appropriately."

A Physician Progress Note dated 11/25/22, revealed, "[Resident 17's] rate is now up to 55/hr [hour] due to family worried about her vomiting. The goal is still at 65ml/hr. Flush is now at 30 ml every hour."

The following observations were made of resident 17's TF infusing at a rate of 75 ml/hr with 40 ml flush every hour:

a. On 12/13/22 at 8:22 AM, no family was present in resident 17's room. No label observed on the TF bag.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 693	Continued From page 19	F 693		

b. On 12/13/22 at 1:00 PM, a family member was present in resident 17's room. No label was observed on the TF bag.

c. On 12/13/22 at 3:56 PM, a family member was present in the room. No label was observed on the TF bag.

d. On 12/14/22 at 9:37 AM, a family member was present at resident 17's bedside. The TF bag was labeled with a date of 12/13/22, and an infusion rate of 75 ml/hr.

e. On 12/14/22 at 2:05 PM, no family was present in resident 17's room. The TF bag was labeled with a date of 12/13/22, and an infusion rate of 75 ml/hr.

f. On 12/14/22 at 4:16 PM, no family was present in resident 17's room. The TF bag was labeled with a date of 12/13/22, and an infusion rate of 75 ml/hr.

g. On 12/15/22 at 7:30 AM, no family was present in resident 17's room. The TF bag label was not dated and had an infusion rate documented of 75 ml/hr.

On 12/15/22 at 7:20 AM, an observation was made of Licensed Practical Nurse (LPN) 1 in the 100 hallway. LPN 1 asked the Respiratory Therapist (RT) to "check that her feeding was going so she didn't have to get all dressed" while the RT was in room 118. It should be noted room 118 was an isolation room and full personal protective equipment was required to enter. An immediate interview was conducted with LPN 1. LPN 1 stated it was just "easier" if the RT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 693	Continued From page 20	F 693		

checked it for her since the resident was in isolation. LPN 1 stated it was not the RT's job to verify feeding rates. LPN 1 stated she did check all other feedings and followed the physician's order as they were written.

On 12/15/22 at 8:42 AM, a telephone interview was conducted with the Director of Nursing (DON). The DON stated the nurses were expected to follow the physician's order as they were wrote. The DON stated the night nurses changed the feeding supplies for those residents on tube feedings and each nurse was suppose to verify the feeding was running as it should.

On 12/15/22 at 10:45 AM, an interview was conducted with LPN 1. LPN 1 stated orders for enteral feedings were found in the order section of the medical record. An observation was made of LPN 1 locating the enteral feeding order in resident 17's medical record. LPN 1 stated the feeding should be infusing at 65 ml/hr. LPN 1 located the order on the Medication Administration Record for resident 17 which revealed the rate to be 65 ml/hr with a 25 ml of flush every hour. LPN 1 stated the provider would come the next day and review resident 17's medical record and make any adjustments at that time. LPN 1 stated the night shift changed the tube feeding and would set the rate but it was every nurses job to verify the tube feeding was infusing as ordered.

Additional information provided after survey exit.

On 12/25/22 at 7:00 PM, a voicemail was received from Resident 17's FM. The FM stated he had caused the facility to get a "bad mark" and had increased resident 17's feeding rate from 70

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 693	Continued From page 21 ml/hr to 75 ml/hr on 12/7/22. The FM stated as a result of this "the facility didn't know the rate had been changed." [Note: The tube feeding rate goal for Resident 17 was set at 65 ml/hr with a 25 ml hourly flush and it ran at 75 ml/hr with a 40 ml hourly flush the entire time the survey team was in the facility.]	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 2 out of 19 sampled residents, residents who required oxygen did not have a physician's order for oxygen. Resident identifiers: 91 and 103. Findings included: 1. Resident 91 was admitted to the facility on 12/8/22 with diagnoses that included displaced intertrochanteric fracture of left femur, other intraarticular fracture of lower end of left radius,	F 695	F 695 IMMEDIATE CORRECTIVE ACTION: Resident 91 issue resolved resident discharged Resident 103 issue resolved, resident discharged. IDENTIFICATION OF OTHERS: All residents reviewed to ensure residents needing oxygen have appropriate orders and care plans. PROCESS TO PREVENT RECURRENCE: Education provided to LN to assess for respiratory care needs and ensure that MD is notified, and appropriate orders obtained, and care plan updated. All new admissions will be reviewed during clinical meeting to ensure those requiring oxygen have physician orders in place. MONITORING: DON/ designee will review 3 random resident's initial admission records x 4 weeks to identify respiratory status and ensure oxygen needs are addressed with proper orders and care plans updated. Findings will be brough to QA for review.	1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 695	Continued From page 22	F 695		

history of falling, chronic obstructive pulmonary disease, dehydration, nutritional anemia, hypertension, and hyperlipidemia.

On 12/13/22 at 11:49 AM, an interview was conducted with resident 91. Resident 91 was observed wearing oxygen with the nasal cannula properly placed. An observation was made that the oxygen tubing had no information as to when it was last changed. Resident 91 stated she did not know how often the staff changed the tubing.

Resident 91's Medical Record was reviewed.

No physician's order for oxygen was found.

No documentation was found on the Treatment Administration Record (TAR) for use of oxygen or oxygen tube changes.

Resident 91's care plan was reviewed and there was no focus area or interventions for oxygen therapy.

On 12/10/22, a Daily Skilled Note revealed, "12/10/2022 07:39 [AM] O2 [oxygen] 94% [percent]-12/10/2022 09:33 [AM] Method: Oxygen via Nasal Cannula."

On 12/11/22, a Daily Skilled Note revealed, "12/11/2022 21:52 [9:52 PM] O2 90% - 12/11/2022 21:52 Method: Oxygen via Nasal Cannula."

2. Resident 103 was admitted to the facility on 12/6/22 with diagnoses that included displaced intertrochanteric fracture of left femur, history of falling, moderate protein-calorie malnutrition, type 2 diabetes, chronic obstructive pulmonary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 695	Continued From page 23	F 695		

disease, left bundle-branch block, hypertension, anemia, major depressive disorder, retention of urine, and urinary tract infection.

Resident 103's Medical Record was reviewed:

No physician's order for oxygen was found.

No documentation was found on the TAR for use of oxygen or oxygen tube changes.

The admission Minimum Data Set assessment dated 12/10/22, revealed that resident 103 was using oxygen before her admission and was using oxygen during her current admission.

The hospital discharge summary dated 12/6/22, revealed in the discharge orders "Unchanged DME [Durable Medical Equipment] RESP [Respiratory] Oxygen therapy."

A progress note dated 12/7/22, revealed that resident 103 was receiving respiratory treatment "oxygen therapy. Oxygen administered while a resident. Use is continuous oxygen. Set at 2L [liters] per NC [Nasal Cannula]."

On 12/11/22, a Daily Skilled Note that included vital signs revealed, "O2 90.0% - 12/11/2022 21:34 [9:34 PM] Method: Oxygen via Nasal Cannula."

On 12/12/22, a Daily Skilled Note that included vital signs revealed, "O2 92.0% - 12/12/2022 6:02 [AM] Method: Oxygen via Nasal Cannula."

On 12/13/22, a Daily Skilled Note that included vital signs revealed,"O2 96% - 12/13/2022 07:50 [AM Method: Room Air." Under the respiratory

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 695	Continued From page 24	F 695		

assessment the note revealed, "Other observations and interventions include Pt [patient] tolerating O2 therapy well."

On 12/14/22 at 9:21 AM, an interview was conducted with the Corporate Resource Nurse (CRN). The CRN stated she was unable to find a physician's order for oxygen in the physician's order and the TAR for resident 103. The CRN stated, "it is what it is."

On 12/15/22 at 9:23 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that a physician's order was required for a resident to receive oxygen. RN 1 stated when the oxygen order was put into the computer it would transfer over to the TAR with instructions. RN 1 stated oxygen tubing should be changed every week and labeled. RN 1 stated if the tubing was observed without a label, the tubing would be changed as soon as it was identified.

A review of the facility Oxygen Administration Policy revealed that "It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained." Under procedures the document "1. Obtain appropriate physician's order, and 2. Identify the resident." A full list of procedures was provided. Included in the Instructions for tubing and humidifier changes were the following:

"1. Label humidifier with the day. Change pre-filled humidifier per manufacturer's recommendations. Other humidifiers must be filled with distilled water replaced every 24 hours and replaced every 30 days.
2. Oxygen tubing is to be replaced every seven

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 695	Continued From page 25 (7) days. Oxygen masks or nasal prongs are to be replaced every seven (7) days. 3. Store cannula/mask in bag when not in use. 4. Humidifiers are not required if flow of oxygen is two (2) liters or less per minute. 5. Re-fill non-disposable humidifiers with distilled water, as needed."	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used in	F 757	F 757 IMMEDIATE CORRECTIVE ACTION: Resident 18 issue resolved. Medication given within parameters set in order. MD performed a medication review and clarified parameters. Care plan updated as appropriate. OTHER RESIDENTS IDENTIFIED: All orders reviewed to assure any resident with parameters set in order are followed as written or clarified to avoid unnecessary drug. PROCESS TO PREVENT RECURRENCE: Education/ inservice provided to LNs about unnecessary drugs including following parameters as ordered. Pharmacy consultant to review resident charts monthly for inconsistencies with medications. MONITORING: DON/ designee will review 3 random residents' eMAR for presence of unnecessary drugs including drugs given outside of parameters. 3 times per week x 4 weeks. Findings will be brought to QA committee for further review.	1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 757	Continued From page 26	F 757		

excessive dose; 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. Specifically, for 1 out of 19 sampled residents, the facility administered a narcotic within two hours of an antianxiety medication which was outside of the physician ordered parameters. Resident identifier: 18.

Findings included:

Resident 18 was initially admitted to the facility on 7/26/22 and readmitted to the facility on 8/29/22 with diagnoses which included dependence on ventilator, unspecified intracranial injury, epilepsy, type II diabetes hemiplegia and hemiparesis on left non-dominant side, dysphagia, and anxiety.

On 12/15/22, resident 18's medical record review was completed.

A physician's order dated 9/24/22, documented an order for "Oxycodone HCl [hydrochloride] 7.5mg [milligrams] tablet, give 1.5 tablet by mouth every 4 hours as needed for pain."

A physician's order dated 11/23/22, documented an order for "Alprazolam 0.5 mg tablet, give 1 tablet by mouth every 6 hours as needed for anxiety. DO NOT GIVE NARCOTICS WITHIN 2 HOURS OF THIS MED [medication]."

A review of the October 2022 Medication Administration Record (MAR) documented the following entries when resident 18 received the Oxycodone within two hours of the Alprazolam.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 757	Continued From page 27	F 757		

a. On 10/5/22, Oxycodone was administered at 5:42 AM, and Alprazolam was administered at 7:34 AM.

b. On 10/6/22, Oxycodone was administered at 9:53 AM, and Alprazolam was administered at 11:39 AM.

c. On 10/9/22, Oxycodone was administered at 7:55 PM, and Alprazolam was administered at 9:50 PM.

d. On 10/25/22, Oxycodone was administered at 7:10 PM, and Alprazolam was administered at 8:57 PM.

e. On 10/29/22, Oxycodone was administered at 8:25 PM, and Alprazolam was administered at 10:01 PM.

A review of the December 2022 MAR documented the following entries when resident 18 received the Oxycodone within two hours of the Alprazolam.

a. On 12/2/22, Oxycodone was administered at 9:11 PM, and Alprazolam was administered at 10:50 PM.

b. On 12/8/22, Oxycodone was administered at 7:26 PM, and Alprazolam was administered at 7:24 PM.

On 12/14/22 at 7:20 AM, an interview with a Licensed Practical Nurse (LPN) 1 was conducted. LPN 1 stated parameters for medications were found in the physician's order section and/or the MAR of the medical record. LPN 1 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 757	Continued From page 28 parameters of a medication should be followed for the safety of the residents. On 12/15/22 at 8:30 AM, an interview with the Director of Nursing (DON) was conducted. The DON stated it was the expectation of the facility for all the nurses to administer medications as they were prescribed and if there was a question to talk with the provider. The DON stated the nurses were expected to verify every medication given and give medications within the parameters set by the provider for the safety of the residents.	F 757		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not ensure that medication error rates were not 5 percent or greater. Observations of 30 medication opportunities, on 12/14/22, revealed 2 medication errors which resulted in a 6.67% medication error rate. Specifically, for 1 out of 19 sampled residents, a resident received two expired medications. Resident identifier: 148. Findings included: Resident 148 was admitted to the facility on 12/11/22 with diagnoses which included Alzheimer's disease. On 12/14/22 at 7:34 AM, Licensed Practical	F 759	F 759 IMMEDIATE CORRECTIVE ACTION: Resident 148 issue resolved, resident discharged. Education provided to LNs on rules for safe and effective med pass including ensuring medications are not used after their expiration date. OTHER RESIDENTS IDENTIFIED: All residents could be affected by the same or similar concern. PROCESS TO PREVENT RECURRENCE: Continue to provide education to LNs on preventing medication errors including monitoring for expired medications. LN or designee will check med carts weekly for expired medications. .	1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 759	Continued From page 29 Nurse (LPN) 1 was observed to administer PreserVision AREDS 2 tablets with an expiration date of 3/31/22 and Centrum Adult Multivitamin 1 tablet with an expiration date of 4/30/22 to resident 148. On 12/14/22 at 7:40 AM, an interview was conducted with LPN 1. LPN 1 stated the medications came from the resident's hospice company. LPN 1 stated it was the responsibility of the admitting nurse to verify that the medications were not expired and each nurse should check the expiration date on the medication before giving them to the residents. [Note: Both medications were placed back into the medication cart for future use.] On 12/15/22 at 8:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated medications came from the pharmacy and it was the on duty nurse to verify those medications and place them in the medication cart for use. The DON stated the nurses were expected to verify any medications that came in with the residents, this included the expiration dates, prior to use of the medications.	F 759	MONITORING: LN will review med carts weekly x 4 weeks and as needed for expired medications. Findings will be given to DON, variances will be brought to QA committee for further review	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761	F 761 IMMEDIATE CORRECTIVE ACTION: Resident 9 issue resolved; resident discharged. Resident 17 issue resolved; expired medication discarded. Resident 100 issue resolved; resident discharged.	1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 761	Continued From page 30 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with accepted professional principles, included the accessory and cautionary instructions and the expiration date when applicable, and were stored in locked compartments. Specifically, observations were made of medications left unattended on top of the medication cart, the medication cart was left unlocked when unattended, and expired medications were administered. Resident identifiers: 9, 17, 100, and 148. Findings included: 1. On 12/14/22 at 7:09 AM, Licensed Practical Nurse (LPN) 1 was observed to enter resident 9's room and leave the medication cart for the 100 hallway unlocked with medications unattended on	F 761	Resident 148 issue resolved; resident discharged. Contents of medication carts examined, and all expired or unlabeled medication were discarded, replacement stock obtained from pharmacy and appropriately dated. All medication stored and secured appropriately. IDENTIFICATION OF OTHERS: All residents with potential for same or similar concerns. PROCESS TO PREVENT RECURRENCE: Education provided to LNs on labeling, dating, storing medication in accordance with policy. LN will check med carts weekly for expired or unlabeled meds. MONITORING: LN will review med carts for properly labeled and dated medication and ensure all medication are stored and secured appropriately. LN will report to findings to DON weekly x 4 weeks Variances will be brought to QA committee for further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 761	Continued From page 31	F 761		

top of the medication cart.

2. On 12/14/22 at 7:34 AM, LPN 1 was observed to administer PreserVision AREDS 2 tablets with an expiration date of 3/31/22, and Centrum Adult Multivitamin 1 tablet with an expiration date of 4/30/22, to resident 148. LPN 1 was immediately interviewed and stated the medications came from the resident's hospice company. LPN 1 stated it was the responsibility of the admitting nurse to verify the medications were not expired and each nurse should check the expiration dates while they were passing the medications.

[Note: Both medications were placed back into the medication cart for future use.]

3. On 12/14/22 at 7:43 AM, the medication cart in the 100 hall was observed with LPN 1. The insulin pen for resident 18 had an expiration date of 11/18/22, on the label and nothing written on the cap. LPN 1 stated the insulin pen was expired and that was why there was a second insulin pen in the drawer for resident 18. LPN 1 stated she would discard the expired insulin pen and took the pen out of the medication cart. LPN 1 stated the medications in the cart were the medications used for the residents and the medication room had more medications if needed. LPN 1 stated insulin was good for 30 days after being opened.

4. On 12/14/22 at 7:50 AM, an observation was made of the medication refrigerator in the medication room on the 100 hallway. It was observed to have a bottle of Omeprazole that expired on 12/12/22, for resident 17. LPN 1 was interviewed and stated resident 17's Omeprazole was refrigerated and the bottle in the refrigerator was the supply the staff used for resident 17.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 761	Continued From page 32 5. On 12/14/22 at 8:25 AM, an observation was made of the medication cart on the 200 hallway. It was observed to have two insulin pens for resident 100 with no date written on the cap. Registered Nurse (RN) 1 was interviewed and stated the insulin pens came the night before and she forgot to put the date on the cap. RN 1 stated the insulin pens should have been marked with the date they were pulled out of the refrigerator. RN 1 stated insulin was good for 28 days after being open and 45 days out of the refrigerator if not opened. On 12/15/22 at 8:35 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurse on duty was responsible for verifying the medications when they came from the pharmacy. The staff were expected to write the date on the container when the medication was opened. The DON stated "there may need to be some more education" when told about the medication cart being left unlocked when unattended and medications being left on top of the medication cart when unattended.	F 761		
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not file laboratory reports that were dated and contained the name and address of the testing	F 775	F 775 IMMEDIATE CORRECTIVE ACTION Resident 97 issue resolved, resident discharged. Resident 103 issue resolved, resident discharged. 1/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 775	Continued From page 33	F 775	IDENTIFICATION OF OTHERS:	

laboratory in the residents' clinical record. Specifically, for 2 out of 19 sampled residents, results of laboratory (lab) tests were not in the residents medical record and were not readily accessible. Resident identifiers: 97 and 103.

Findings included:

1. Resident 97 was admitted to the facility on 11/28/22 with diagnoses that included fracture of left femur, presence of artificial hip joint, abnormalities of gait, muscle weakness, acute kidney failure, thrombocytopenia, hypertension, rheumatoid arthritis, benign prostatic hyperplasia, and insomnia.

Resident 97 was transferred to the hospital on 12/6/22, for altered mental status. A review of the hospital discharge documents revealed that resident 97 had a urinary tract infection (UTI). The discharge document also revealed that resident 97 had a urinalysis (UA) and urine culture. Resident 97 was given a written prescription for an antibiotic to be given three times each day for seven days. In reviewing resident 97's chart it was noted that there were no laboratory results for the UA and culture that was obtained at the hospital.

On 12/7/22, a progress note revealed "pt [patient] returned to [name of Long Term Care Facility removed] with dx [diagnosis] of UTI."

On 12/8/22, a progress note revealed, "Patient currently receiving Cephalexin for probable UTI (increased WBC [White Blood Cells] in urine). C&S [culture and sensitivity] results are currently pending (no growth at this time). Will monitor patient for efficacy of drug and for adverse

All current patients with lab orders reviewed to ensure results are in the clinical record and readily accessible.

PROCESS TO PREVENT RECURRENCE:

LNs and health information manager will be educated on policy to file lab results in clinical record.

Lab tracking binder will be kept at each nursing station to ensure lab results are received timely.

MONITORING:

DON/ designee will review 3 random residents with lab orders weekly x 4 weeks to ensure results are received and part of the clinical record. Findings will be brought to QA committee for further review.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 775	Continued From page 34	F 775		

reactions."

On 12/14/22 at 11:13 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated when a resident came back from the hospital with a new prescription a nurse put it into the computer and it would be checked by two people. RN 1 stated after the prescription was checked, it would be scanned into the resident's medical record. RN 1 stated medications were entered into the orders tab in the medical record. RN 1 stated the physician would be messaged to let them know there was a new prescription for the resident. RN 1 stated that the resident was re-assessed when the medication was completed.

On 12/14/22 at 11:18 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that once lab results were received the staff would message the physician and complete antibiotic charting. The ADON stated antibiotic charting was in a progress note attached to the medication. The ADON stated the results for resident 97 may be in the medical records system used at the hospital, and they might be in the infection control book. The ADON stated resident 97 did not have a UTI, but had elevated WBC in his urine and she felt he responded well to the antibiotic. The ADON stated there was no growth on the urine culture so the antibiotic that had been prescribed had been continued because of the WBC in the urine. The ADON stated resident 97 had intermittent confusion. The ADON stated resident 97 did not have a diagnosis of dementia and she blamed resident 97's confusion on his post-surgical status. The DON stated if a resident had a change in condition the physician would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 775	Continued From page 35	F 775		

notified and if there were orders for labs the labs would be drawn. The ADON stated the physician came to the facility almost every day, especially for new admissions and quarterly assessments.

2. Resident 103 was admitted to the facility on 12/6/22 with diagnoses that included displaced intertrochanteric fracture of left femur, history of falling, moderate protein-calorie malnutrition, type 2 diabetes, chronic obstructive pulmonary disease, left bundle-branch block, hypertension, anemia, major depressive disorder, retention of urine, and urinary tract infection.

On 12/13/22, resident 103's medical record was reviewed.

On 12/6/22, a physician's order for ciprofloxacin for infection was entered.

Resident 103's Medication Administration Record revealed that ciprofloxacin was administered for the designated seven day period.

On 12/8/22, a progress note revealed, "Patient is receiving ciprofloxacin for UTI which grew Enterococcus Faecalis and Pseudomonas Aeruginosa. Both bacteria are susceptible to this drug, and patient will be monitored for efficacy and adverse reactions."

No laboratory results were found in resident 103's medical record.

On 12/14/22 at 3:00 PM, an interview was conducted with the ADON. The ADON stated laboratory results were kept in the antibiotic stewardship binder. The ADON provided the antibiotic stewardship binder that contained lab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 775	Continued From page 36 ■ ■ results separated by month. A urinalysis result was found for resident 97 in the December section, however, there was no result from the urine culture. A urinalysis result and culture result were found in the December section of the binder for resident 103. The ADON stated the results could be found in the hospital records that were available to the facility. The ADON obtained and printed the urine culture results and emailed the UA and culture results for both resident 97 and resident 103 to the State surveyor.	F 775		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards of food	F 812	F 812 IMMEDIATE CORRECTIVE ACTION: Food item were covered and food past "use by" date were discarded. IDENTIFICATION OF RESIDENTS AFFECTED: All residents have potential to be affected. PROCESS TO PREVENT RECURRENCE: Dietary manager or designee will educate kitchen staff to keep food items covered and stored in accordance with professional standards for food safety and to discard any food item which is past the use by date. Registered dietician to complete monthly kitchen audits to ensure proper sanitation and food safety per professional standards.	1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 812	Continued From page 37	F 812	MONITORING:	

service safety. Specifically, food items in the dry storage room, refrigerator, and freezer were open to air and food items in the refrigerator were past the "use by" date.

Findings included:

On 12/12/22 at 1:40 PM, an initial walk-through of the kitchen was conducted. In the walk-in refrigerator a container of cottage cheese was observed with a use by date of 12/7/22. The date written on the top of the container was 12/10/22. Additionally, in the walk-in freezer, a box of uncooked bacon strips was open to air. In the walk-in freezer, a box of pizza dough with a "use by" date of 12/7/22 was observed. A box with frozen tortillas and a box of sausage links were also observed to be open to air. In the dry food storage room, a package of spaghetti noodles was observed to be unsealed and open to air.

On 12/15/22 at approximately 11:00 AM, a second walk-through of the kitchen was conducted. In the walk-in refrigerator, a container of cottage cheese was observed with a use by date of 12/7/22. The date written on the top of the container was 12/10/22. A box of uncooked bacon strips was also observed to be open to air. In the walk-in freezer, a box of Italian sausage was open to air. In the dry food storage room, a box of corn bread mix was not sealed and open to air.

On 12/15/22 at approximately 11:30 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that the Registered Dietitian did not do kitchen audits for sanitation or food safety. The DM stated she was responsible for ordering and accepting shipments

MONITORING:

Dietary manager or designee will audit kitchen for expired or uncovered food items weekly x 4 weeks. Findings will be brought to department head meeting weekly and QA monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 812	Continued From page 38 of food with the help from her staff. The DM stated staff had been educated about proper food storage and handling. The DM stated she would review proper food storage and handling with her staff. During the interview, the DM spoke to the cook about the bacon that was open to air. The cook immediately went and packaged the bacon in sealed plastic bags and returned to show that it had been completed. The DM stated the cottage cheese with a use by date of 12/7/22, should not be used and should be thrown away.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842	F 842 IMMEDIATE CORRECTIVE ACTION Resident 97 issue resolved. patient discharged. IDENTIFICATION OF OTHERS Residents' records were reviewed for accuracy of documentation and accessibility. PROCESS TO PREVENT RECURRENCE: Medical records will develop a system to sort and organize documents to either be scanned into EHR or be placed in overflow chart for ease of accessibility. MONITOR: Health information Manager or designee (H.I.M) will review 3 charts weekly x 4 weeks to ensure the residents records are complete, accurate, readily accessible and organized. findings will be reviewed by QA committee.	1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 842	Continued From page 39	F 842		

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 842	Continued From page 40	F 842		

services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on Interview and record review, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized. Specifically, for 1 out of 19 sampled residents, neurological checks from a resident's fall were not in the medical record and were not complete. Resident identifier: 97.

Findings included:

Resident 97 was admitted to the facility on 11/28/22 with diagnoses that included fracture of left femur, presence of artificial hip joint, abnormalities of gait, muscle weakness, acute kidney failure, thrombocytopenia, hypertension, rheumatoid arthritis, benign prostatic hyperplasia, and insomnia.

A review of resident 97's medical record revealed that resident 97 was put on alert charting "post fall" and the medical record revealed that resident 97 was monitored for three days.

On 12/3/22 at 17:52 PM, a note text revealed "Pt [Patient] had an unwitnessed fall in his room with non-lip socks. Patient's vitals were 99% [percent] O2 [oxygen] on room air, pulse 94, BP [blood pressure] 120/72, temp [temperature] 99.2 degrees Fahrenheit, and respirations were 20. Pt was oriented to person and time but not place or event. Patient was bleeding from a new skin tear on his right middle finger knuckle. No bruising was found, but his low back/coccyx was red. Pt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 842	Continued From page 41	F 842		

has some shoulder pain. DON [Director of Nursing] [staff member name] and [physician] were notified as well as his [family member]. Skin tear was cleansed with Ns [normal saline] and steri strips and a Band-Aid was put on. Patient education was given on pressing call light when he want's to get out of bed to prevent future falls. Call light and water were put within reach. Vitals and neuro [neurological] checks will be taken every 15 minutes for an hour then every 30 minutes for an hour. [Physician] wants to be contacted if his neurologic status changes." [Note: No neurological checks were found in resident 97's medical record.]

On 12/14/22 at 4:09 PM, the Corporate Registered Nurse (CRN) provided a copy of resident 97's neuro checks from the fall on 12/3/22. The CRN stated the documentation of the neuro checks were located in the medical records office.

On 12/15/22 at 9:23 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated when a resident had a fall, the resident was assessed by the RN. RN 1 stated if a resident hit their head the resident would not be moved until it was deemed safe to do so. RN 1 stated after the resident was assessed they would be assisted back to bed. RN 1 stated after meeting the immediate needs of the resident, the physician would be called, and the resident's family would be called. RN 1 stated staff were required to complete "fall charting" and would complete neuro checks if the resident had hit their head. RN 1 stated neuro checks for an unwitnessed fall included taking vital signs every 15 minutes for the first hour, taking vital signs every 30 minutes for the next two hours, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 842	Continued From page 42 taking vital signs every hour for four hours. RN 1 stated neuro checks should be completed every shift for 3 days.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880	F 880 IMMEDIATE CORRECTIVE ACTION: Resident 9 issue resolved, resident discharged. IDENTIFICATION OF OTHERS: All residents have potential for same or similar concerns. PROCESS FOR PREVENTING RECURRENCE: All LN staff will be educated/ in serviced on facility infection control policies and medication pass process. DON/ designee will be providing ongoing didactic and skills training for all new and existing staff. MONITORING: Human resources or designee will monitor random nurse in service record weekly x 4 weeks to ensure all new and existing nursing staff are educated on facility infection control policies and medication pass process designed to provide safe, sanitary and comfortable environment and to help prevent development of transmission of communicable disease and infection. Findings will be brought to QA committee for review.	1/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 880	Continued From page 43	F 880		

reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 880	Continued From page 44	F 880		

diseases and infections. Specifically, staff did not use hand hygiene (HH) during medication pass, a medication was touched with an ungloved hand and placed back in the medication pack for future use, and medication was touched after no HH was used and administered to a resident. Resident identifier: 9

Findings included:

1. On 12/14/22, an observation was made of Licensed Practical Nurse (LPN) 1. LPN 1 did not use HH prior to beginning medication pass. LPN 1 deposited 2 pills into the medication cup which held previously dispensed medications for resident 9. LPN 1 took her ungloved right hand and placed it into the medication cup to retrieve one of the medications. The medication was then placed back into the medication pack and placed back into the medication cart drawer. The medications were then administered to resident 9. No HH used on exiting the room after touching resident 9's personal belongings.

2. On 12/14/22, LPN 1 was observed to not use HH prior to administering medications to the resident in room 109. The resident refused one of the medications. LPN 1 took her ungloved right hand and placed it into the medication cup to retrieve the medication, other medications remained in the cup. The other medications were then administered to the resident in room 109. No HH was used on exiting room 109.

On 12/14/22 at 7:20 AM, an interview was conducted with LPN 1. LPN 1 stated HH should be done to keep things clean. LPN 1 stated it was okay to return medication to the pill packs if the medications were clean.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 880	Continued From page 45	F 880		

On 12/14/22 at 10:19 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated the staff were expected to use HH before entering a room and after exiting a room.

On 12/15/22 at 9:07 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses should use HH before, in between, and after each resident during medication pass. The DON stated the nurses should not touch the medications with bare hands and should pop the medications out of the card without touching the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING **01** B. WING	**12/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	**1490 EAST FOREMASTER DRIVE, BUILDING B** **ST GEORGE, UT 84790**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
E 000	Initial Comments Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 12/19/2022 in the presence of the administrator and the plant manager are found in 42 Code of Federal Regulations, Section 483.73 The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. No deficiencies cited.	E 000		
K 000	INITIAL COMMENTS Statutory and regulatory authority for this Life Safety Code survey that was conducted on 12/19/2022 in the presence of the plant manager are found in 42 Code of Federal Regulations, Section 483.70, (a) and the 2012 Edition, NFPA 101 Life Safety Code including NFPA publications referenced therein. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) Life Safety from fire.	K 000		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920	Extension cord was removed from from ceiling outlet wiring and the original fixed lighting fixture was reinstalled, terminating the deficiency. Maintenance dept. has done in-service with team regarding extension cords and fixtures. Plant manager will continue to do weekly rounds of facility and rooms to remove any power cords and extension cords and will document routine checks in the TELS building management program.	01/02/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 1/17/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465160	A. BUILDING **01** B. WING _____	**12/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL DESERT REHABILITATION AND CARE	**1490 EAST FOREMASTER DRIVE, BUILDING B ST GEORGE, UT 84790**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 920	Continued From page 1 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based upon observations made in the presence of the plant manager on 12/19/2022, it was determined that the facility did not use power and extension cords in accordance with NFPA 101, 99 and 70. This deficiency affected 1 of 6 smoke compartments. Findings include: During the facility tour an extension cord plug was wired into a light outlet in the lobby. Flexible cords and cables shall not be used as a substitute for the fixed wiring of a structure NFPA 70 400.8.	K 920		