

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465006	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2025
NAME OF PROVIDER OR SUPPLIER Mt. Olympus Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 East 3300 South Salt Lake City, UT 84109	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined for 1 out of 10 sampled residents, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident was dropped from a hoier lift and died; the facility used a transfer sheet and not an approved Hoyer sling while transferring the resident. Resident identifier: 3. NOTICE:Notice of Immediate Jeopardy (IJ) was given verbally to the Administrator on [DATE] at 11:00 AM. The Administrator was asked to develop an immediate plan to ensure resident safety related to Hoyer lifts and Hoyer slings. PLAN:On [DATE] at 6:26 PM, the facility Administrator provided the following abatement plan for the removal of the IJ effective at [DATE] at 10:00 PM. IJ Abatement Plan [facility name redacted] F689 Free of accidents, hazards, and supervision & [and] F726 Competent Nursing StaffImmediate ActionHoyer Inspections were conducted on all facility Hoyer lifts [DATE]. Transfer sheets were disposed of [DATE]. Hoyer slings clearly labeled, others slings removed from facility to more easily distinguish from other materials on [DATE]. Facility policy for Use of Facility Equipment for Resident Care updated [DATE]. Competency checklist with return demonstration conducted for Nursing personnel currently on shift [DATE]. Abatement Plan Regional Nurse Consultant (RNC) provided education to Nursing administrative personnel on [DATE] regarding proper use of Hoyer slings and lifts with return demonstration. This training includes the Director of Nursing (DON) and Assistant Director of Nursing (ADON) The Regional Nurse Consultant (RNC) and Director of Nursing (DON) initiated training with skill competency checklists with return demonstration for Nursing Assistants (NAs) and Licensed Nurses (LN s) on current shift ([DATE] day shift) for proper use of Hoyer slings when transferring a resident using a mechanical (Hoyer) lift. A demonstration video, retrieved from the manufacturer instructions, is included in the skills training competency. Nursing Home Administrator (NHA)/designee has clearly labelled the manufacturer tags on the Hoyer slings with the date they arrived at the facility. Housekeeping educated on 10.17.2025 on proper laundering of Hoyer slings per manufacturer instructions and when slings will be discarded per manufacturer instructions, 'If sling labels are removed or no longer legible, sling must be immediately removed from use' ([Medical supply company name redacted], 2022). Nursing Home Administrator (NHA)/designee updated facility policy for Use of Facility Equipment for Resident Care updated [DATE]. The policy specifies mechanical lift slings that are not owned and approved by Mt. Olympus Rehab are not permitted for use in this facility. The updated policy specifies, 'our staff will use our facility-owned and maintained equipment to ensure compliance, safety, and quality of care. ([Facility name redacted], [DATE]). Director of Nursing (DON) or designee will continue to train and educate Nursing Assistants (NAs) and Licensed Nurses (LNs) prior to permitting nursing personnel to work their next assigned shift. As of [DATE], Licensed Nurses (LNs) and Nursing Assistants (NAs) will be educated by the Director of Nursing or designee prior to being permitted to work direct patient care for next assigned shift. Competency Check- Transferring a Resident using a mechanical liftFull Body Slings: Instructions for use ([Medical supply company name redacted])Application VideoFacility Nursing personnel (LNs, NAs) will be contacted to come to the facility to receive the training by the Regional Nurses Consultant (RNC)/designee and Director of Nursing (DON) or designee [DATE]. The Facility will train as many nursing personnel (LNs, NAs) as possible by 22:00 [10:00 PM] on [DATE]. Nursing personnel (LNs, NAs) who are unable to attend the training will receive education prior to the start of their next shift. Newly hired Nursing personnel will be educated prior to their first direct patient care shift. Regional Nurse Consultant/Designee and Director of Nursing (DON)/designee will provide training to nursing personnel (LNs, NAs) working on night shift [DATE] as they present for their shifts and prior to allowing them to work direct patient care assignments. Training will continue at the beginning of each shift until all nursing personnel (LNs, NAs) have received the training/education. Training verification will be initially measured by return demonstration and then validated by designated leadership via focused direct observation audits. Regional Nurse Consultant (RNC) to round in the facility weekly at random to spot audit facility employee knowledge, competency of utilizing Hoyer slings and lifts. After the facility is determined to be in full compliance with F689 and F726, rounding to be conducted monthly x [times] 3 months. Alleged Date/Time of IJ Abatement: [DATE] @22:00 [10:00 PM].The abatement was verified onsite by the survey team on [DATE] at 1:45 PM.Findings included:Resident 3 was admitted to the facility on [DATE] with diagnoses which included: acute gastric ulcer with hemorrhage, unspecified diastolic (congestive) heart</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>

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