STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465006	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mt. Olympus Rehabilitation Center	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)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that, for 1 out of 23 sampled residents, the facility failed to ensure each resident was informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred. Specifically, one resident was on Olanzapine and there was no documentation that she was informed of the risks and benefits or treatment or treatment alternatives or options. Resident identifier: 6Resident 6 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, recurrent, severe with psychotic symptoms; unspecified psychosis; delusional disorders; anxiety disorder; and post-traumatic stress disorder.Resident 6's medical record was reviewed 6/22/26 through 6/29/26.A physician's order dated 5/1/26 at 3:41 PM indicated, OLANZapine Oral Tablet 10 MG [milligrams] (Olanzapine) Give 1 tablet by mouth at bedtime for Schizoaffective disorder. No consent form was in the medical record for Olanzapine.On 6/24/26 at 10:48 AM, an interview was conducted with the Director of Nursing (DON) who stated there was no documentation that resident 6 was informed in advance of the risks and benefits of Olanzapine or treatment alternatives.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that, for 3 out of 23 sampled residents, the facility failed to ensure each resident had the right to choose activities, schedules, health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part; and to make choices about aspects of his or her life in the facility that were significant to the resident. Specifically, three residents were restricted to supervised smoking and designated smoking times when they were assessed to have the functional capacity to smoke independently and one resident's request to be taken off of an antipsychotic medication was not completed as ordered. Resident identifiers: 6, 32, and 66. 1. Resident 66 was admitted [DATE] with diagnoses included major depressive disorder recurrent severe without psychotic features, other specified diabetes mellitus without complications, and nicotine dependence.Resident 66's medical record was reviewed from 6/22/26 through 6/29/26.On 6/4/26, a Safe Smoking Evaluation - V 2 was completed for Resident 66. The assessment stated that Resident 66 smoked traditional cigarettes. The assessment stated that Resident 66 was able to light her cigarettes independently, used ashtrays appropriately, held cigarettes safely at all times, was alert and attentive, was able to safely extinguish cigarettes, and required reminders to adhere to smoking area rules. Despite the level of safety indicators demonstrated by resident 66, the resident was determined to meet criteria for assisted supervised smoking. On 6/22/26 at 11:05 AM, an interview was conducted with Resident 66. Resident 66 stated that she did not like the smoking times at the facility. Resident 66 stated that whoever made the facility smoking schedule clearly did not smoke. Resident 66 stated that she liked to eat her breakfast in the morning and then have a relaxing cigarette, not the other way around like the schedule currently was. Resident 66 stated that she was told she was not allowed to smoke independently because she tried to cross the street at the facility. It should be noted that exit seeking behavior or wandering was not mentioned on the resident's Safe Smoking Evaluation - V 2 completed on 6/4/26.On 6/22/26 at 1:09 PM, an observation was made of the 1:00 PM supervised smoking session. Resident 66 was observed smoking in her wheelchair and lit and smoked her own cigarettes without assistance. 2. Resident 32 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, history of falling, muscle weakness, adult failure to thrive, chronic pain syndrome, and acquired absence of left foot.On 6/22/26 at 1:30 PM, an interview was conducted with resident 32 who stated he had no concerns about the facility except this smoking s-. Resident 32 stated he liked to smoke every 20 minutes but was no longer allowed to because the facility told him he could not have his smokes anymore because of the State. Resident 32 stated he used to be able to smoke on his own up until about three months ago.On 6/23/26 at 1:05 PM, a follow up interview and observation of resident 32 was conducted. Resident 32 was smoking a cigarette with 14 other residents in the smoking area and was being observed and assisted by the Dietary Manager (DM) and the Business Office Manager (BOM). Resident 32 stated he was going to smoke three cigarettes during this break because of the smoking time restrictions. Resident 32 was observed to be holding his cigarette and ashing away from his body; his hold on his cigarette was stable. Resident 32 finished one cigarette and asked the BOM for another one. The BOM got another cigarette and lit it for resident 32. Resident 32 stated he would be able to light his own cigarette safely if staff let him.Resident 32's medical record was reviewed 6/22/26 through 6/29/26.A Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15, which indicated an intact cognition.A Safe Smoking Evaluation dated 5/12/26 at 11:52 AM indicated, Chart Review Diagnosis.High Risk Diagnosis Review (1 Point Each) . It indicated he received 1 point for, Stroke with any residual weakness. It further indicated he had no, High Risk (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safety Behaviors. It indicated, Physical Evaluation 1. Grip Strength Strong (0 Points) .2. Tremor Present.None (0 Points) .3. Upper extremity coordination.Mild impairment (1 Point) .4. Vision.Adequate (with or without glasses)(0 Points) .5. Mobility considerations.Wheelchair but stable (1 Point) .6. Cognitive status.Alert and Oriented x 4 (0 Points) .7. Physical Evaluation Score: 2. It further indicated, Smoking Observation.Lighting cigarette .Independent and safe (0 Points) .Ash Management.Uses ashtray appropriately (0 Points) .Handling Cigarette.Holds safely at all times (0 Points) .Attention and alertness.Alert and Attentive (0 Points) .Ability to extinguish cigarette.Safely extinguishes (0 Points) .Adherence to smoking are rules.Follows rules (0 Points) .Smoking Observation Score: 0. It indicated, Smoking Safety Determination Total Score from all assessment areas: 1. Remember to count scores from Chart Review, Physical Evaluation, and Smoking Observation Section [Total score was 3] Scoring Criteria: Any score >2 represents a High Risk for Unsafe Smoking Conditions and requires smoking assistance and/or observation to maintain safety.Smoking Safety Determination .Based on the Evaluation, the resident meets criteria for Assisted Smoking. In summary, resident 32 received 2 points for having a history of a stroke with mild impairment and 1 point for being in a wheelchair which totaled 3 points and triggered a determination of, High Risk for Unsafe Smoking Conditions and requires smoking assistance and/or observation to maintain safety, despite being observed to smoke safely.On 6/23/26 at 1:09 PM, an interview was conducted with the DM who stated when she assisted with smoking she had to watch everyone for safety and that there were a couple residents who had to use safety devices. The DM stated resident 32 had no safety issues that she was aware of.On 6/24/26 at 11:08 AM, an interview was conducted with Certified Nurse Assistant (CNA) 2 who stated when she first started working at the facility there were residents who could go out and smoke on their own. CNA 2 stated that starting in March 2026, nobody was an unsupervised smoker anymore, that it became a supervised smoking facility, and that the new smoking policy enforced smoking times. CNA 2 stated she would watch smoking but resident 36 had no safety issues she had to watch for. CNA 2 stated that resident 32 required assistance to get out of bed but was independent with bed mobility and demonstrated the ability to roll side-to-side on his own. CNA 2 stated resident 32 had left-sided weakness, but remained independent with oral hygiene tasks, such as brushing his teeth. CNA 2 further stated that the resident was alert, exhibited no forgetfulness, and was not known to display any behavioral issues or rule-breaking tendencies. CNA 2 stated resident 32 was independent with community access, possessing the cognitive ability to safely leave the facility and sign himself out.On 6/24/26 at 11:15 AM, an interview was conducted with Registered Nurse (RN) 1 who stated the facility had a supervised smoking policy and everybody had to be supervised. RN 1 stated there were no unsupervised smokers at the facility. RN 1 stated resident 32 was alert and oriented to person, place, time, and situation. RN 1 stated resident 32 could definitely smoke safely on his own. RN 1 stated resident 32 signed himself out every time he left the facility and adhered to facility rules. RN 1 stated resident 32 was able to smoke on his own before the changes and that he had no significant changes that would have made that change.On 6/25/26 at 1:21 PM, an interview was conducted with the Director of Nursing (DON) who stated resident 32 was a supervised smoker based on the evaluation because he was in a wheelchair and he had left-sided impairment. The DON stated that resident 32 maneuvered his wheelchair safely and left the faciity on his own safely. The DON stated resident 32 smoked fine on his own.3. Resident 6 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, recurrent, severe with psychotic symptoms; unspecified psychosis; delusional disorders; anxiety disorder; post-traumatic stress disorder; and rheumatoid arthritis.a. On 6/22/26 at 10:14 AM, an interview was conducted with resident 6 who stated she was allowed to go out four times a day to vape and that she had to obtain her vaping materials from staff. Resident 6 stated she was a supervised smoker because she was told she was not safe. Resident 6 stated that she had asked for some liberties last week because she was an introvert and having to smoke with a group of people was difficult and uncomfortable for her because it made her feel anxious and all of that stuff made vaping not worth it to her.On 6/24/26 at 11:33 AM, (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a follow-up interview was conducted with resident 6 who stated she had bought a special vape that enables her to safely use her vape on her own because she did not have to push a button to use it. Resident 6 stated she was able to follow rules and that she was forgetful but she set up a routine for herself to help remind her of what she needed to do. Resident 6 stated she felt safe when she was alone and would like to vape on her own. Resident 6 stated she was pretty independent and could walk on her own with her walker, had not had any falls at the facility, and was able to shower on her own. Resident 6 stated the times for vaping did not align with her schedule because she was a slow eater and would have to miss the smoking times that were scheduled after breakfast and lunch often or else she would not be able to finish her meals.Resident 6's medical record was reviewed 6/22/26 through 6/29/26.An admission Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 15, which indicated an intact cognition.A Care Plan Report dated 5/2/26 indicated resident 6 used a vape and the Interventions were updated on 5/4/26 to include requiring supervision while vaping.A Hot Beverage Safety Evaluation dated 5/2/26 at 12:28 AM indicated she was assessed to have a total score of 0 which indicated she did not: Demonstrate an impaired orientation to person, place, or time; Have a diagnosis of Neuropathy or other neurological impairment; Demonstrate one or more of the following cognitive impairments: Poor safety awareness, impaired short-term memory, impulsiveness; or demonstrate. It indicated this assessment resulted with the determination to be able to consume hot beverages without assistance.A Safe Smoking Evaluation dated 5/4/26 at 8:33 AM indicated, Chart Review Diagnosis.High Risk Diagnosis Review (1 Point Each) . It indicated she received 1 point for, Diagnosis of Cognitive Impairment and 1 point for, Any other (active) diagnosis that may cause tremors, cognitive deficits, or impaired judgement. It further indicated she had no, High Risk Safety Behaviors. It indicated, Physical Evaluation 1. Grip Strength Strong (0 Points) .2. Tremor Present.Mild (1 Point) .3. Upper extremity coordination.Normal (0 Points) .4. Vision.Adequate (with or without glasses)(0 Points) .5. Mobility considerations.Ambulatory (0 Points) .6. Cognitive status.Mild impairment (1 Point) .7. Physical Evaluation Score: 2. It further indicated, Smoking Observation was not completed. It indicated, Smoking Safety Determination Total Score from all assessment areas: 1. Remember to count scores from Chart Review, Physical Evaluation, and Smoking Observation Section [no score was documented] Scoring Criteria: Any score >2 represents a High Risk for Unsafe Smoking Conditions and requires smoking assistance and/or observation to maintain safety.Smoking Safety Determination: .Based on the Evaluation, the resident meets criteria for Assisted Smoking. In summary: Resident 6 was designated as an assisted smoker by an evaluation based on an incomplete assessment; and according to the form, her mild cognitive impairment and tremors were counted twice and her diagnoses alone triggered a determination of, High Risk for Unsafe Smoking Conditions and requires smoking assistance and/or observation to maintain safety.On 6/24/26 at 11:15 AM, an interview was conducted with Registered Nurse (RN) 1 who stated the facility had a supervised smoking policy and everybody had to be supervised. RN 1 stated there were no unsupervised smokers at the facility. RN 1 stated resident 6 had to be supervised to vape. RN 1 stated resident 6 was alert and oriented times 3 or 4, had okay dexterity, and was able to follow the rules and stick to the smoking areas. RN 1 stated the resident left her room now and then but that she was not very social. RN 1 stated a lot of residents had been upset about the smoking policy changes.On 6/25/26 at 1:11 PM, an interview was conducted with the Administrator (ADM) who stated the corporate team had developed the new Safe Smoking Evaluation and policy around March of 2026. The ADM stated the Safe Smoking Evaluation was more detailed and if a resident triggered 2 or more points they had to be supervised. The ADM stated that anyone who was triggered as a supervised smoker by the evaluation had to be watched when they smoked so that they would be safe for smoking. The ADM stated there had been a history at the facility for residents to share smoking paraphernalia with others and that they could not hold other residents accountable for that so all smoking, vapes, tobacco, and lighters were kept by staff in a tool box. The ADM stated that once a resident got admitted , the DON (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed the Safe Smoking Evaluation and was responsible for keeping it updated. The ADM stated there were currently no unsupervised residents at the facility.On 6/25/26 at 1:21 PM, an interview was conducted with the DON who stated that the nurse does the Safe Smoking Evaluation on admission and then she checked all of them with her chart checks. The DON stated that the new Safe Smoking Evaluation and policy were recently updated by facility management and that the same tool and policy was utilized for residents who used vapes. The decision of whether a resident was supervised or not was based on the evaluation tool and that if residents had certain diagnoses, the decision could definitely be based on their diagnoses only. The DON stated the decision was also based on their cognition, mobility, and physical symptoms like tremors. The DON stated she usually did the smoking observation with the resident on their first time out to smoke and would observe to see if the resident could light the cigarette safely, hold it safely and not drop it, ash it safely, and ensure the resident could get to and from the smoking area safely. The DON stated that upon admission, resident 6 did get weak and had chronic back pain but that she was getting better. The DON stated resident 6 was supervised for using her vape because of her mobility and her tremor. The DON stated she had been talking to facility management about the resident complaints about the new smoking policy and that they had been trying to compromise with residents but also wanted to ensure their safety.On 6/25/26 at 1:34 PM, an interview was conducted with the Administrator who stated when the new smoking policy rolled out they wanted to make sure that if a resident did not want to follow it that they wanted to help them find other places to go to.b. On 6/22/26 at 10:14 AM, an interview was conducted with resident 6 who stated she felt the Nurse Practitioner (NP) was not listening to her because it had been weeks since she asked to be taken off Olanzapine, but all that had happened was that the dose was lowered. Resident 6 stated she also spoke to the Medical Doctor because she was not taken off of the medication and still nothing changed. Resident 6 stated she talked to Registered Nurse (RN) 1 the night before last about changing her Olanzapine and three other medications, and nothing had happened yet. Resident 6 stated she even got a copy of her medications and went through every one of them to look at the side effects of each so she could talk to the NP. Resident 6 stated she wanted to be taken off of the Olanzapine because it made her gain weight and that she had gained 10-15 pounds. Resident 6 stated that the weight gain was not just for looks but that she had scoliosis and two neck surgeries and the added weight made the pain worse. Resident 6 stated she had bariatric surgery and that was very painful to go through and these medications made her feel insatiable and that there was nothing to do around here so she had nothing else to look forward to but meals. Resident 6 stated she could go to the gym but she was an introvert and had other issues that made it hard for her to go to the gym with other people.Resident 6 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, recurrent, severe with psychotic symptoms; unspecified psychosis; delusional disorders; anxiety disorder; and post-traumatic stress disorder.A physician's order dated 5/1/26 at 3:41 PM indicated, OLANZapine Oral Tablet 10 MG [milligrams] (Olanzapine) Give 1 tablet by mouth at bedtime for Schizoaffective disorder. A physician's order dated 5/14/26 at 1:05 PM indicated, OLANZapine Oral Tablet 7.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime for MDD [Major Depressive Disorder]. It should be noted that there was no documentation of the provider signing this order.A Psychotropic Note dated 5/20/26 at 3:36 PM indicated, .- Schizoaffective disorder- OLANZapine Oral Tablet 10 MG [milligram] (Olanzapine)- D/C [discontinue] OLANZapine Oral Tablet 10 MG (Olanzapine) 10 mg PO [by mouth] Give 1 tablet by mouth at bedtime for 1 week for Schizoaffective OLANZapine Oral Tablet 10 MG (Olanzapine) 7.5 mg PO Give 1 tablet by mouth at bedtime for 1 week for Schizoaffective OLANZapine Oral Tablet 5 MG (Olanzapine) 5 mg PO Give 1 tablet by mouth at bedtime for 1 week for Schizoaffective OLANZapine Oral Tablet 2.5 MG (Olanzapine) 2.5 mg PO Give 1 tablet by mouth at bedtime for 1 week for Schizoaffective.A Medication Administration Record (MAR) dated 5/1/26 to 5/31/26 indicated resident 6 received 10 mg of Olanzapine from 5/1/26 through 5/13/26 and 7.5 mg of Olanzapine from 5/14/26 through 5/31/26.A MAR dated 6/1/26 to 6/31/26 indicated resident 6 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received 7.5 mg of Olanzapine from 6/1/26 through 6/22/26.A Physician Progress Note dated 6/23/26 at 9:10 AM indicated, Patient was seen in person for follow-up in the facility. Her medication list was reviewed with her, and medication changes were discussed.olanzapine were discontinued.On 6/24/26 at 3:06 PM, an interview was conducted with RN 1 who stated resident 6 requested to speak to the doctor about stopping or tapering her Olanzapine on Saturday, 6/20/26, but she did not tell him why. RN 1 stated he called the NP that day and said the NP stated she would see the resident on Monday.On 6/25/26 at 11:52 AM, an interview was conducted with the Director of Nursing (DON) who stated that RN 1 contacted the NP on Saturday on behalf of resident 6, so the NP came in and did a medication review which resulted in resident 6's Olanzapine order being discontinued. The DON stated the Olanzapine taper documented in the psychotropic note on 5/20/26 at 3:36 PM was not an order. The DON stated the NP gave her a verbal order to decrease her Olanzapine from 10 mg to 7.5 mg on 5/14/26 instead of tapering the resident off of her Olanzapine. The DON stated that NP would send their orders and she or the MDS Coordinator would put the new orders into the medical record. The DON stated the NP put a late note into the medical record because she asked the NP to clarify her notes and orders regarding the Olanzapine taper and order. The DON stated resident 6 was supposed to be discharged on 5/20/25 but then plans changed and she was going to be staying at the facility and when that happened the NP did not want to taper resident 6 off of Olanzapine and gave the DON a verbal order to keep the dose at 7.5 mg but it was not documented anywhere. The DON stated that when the NP put in the late note from 5/20/26 on 6/24/26, that it was actually supposed to have been documented on 5/14/26 instead.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that for 1 of 23 sampled residents, that the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, one resident was not tapered off of Olanzapine as ordered and requested by the resident. Resident identifier: 6.On 6/22/26 at 10:14 AM, an interview was conducted with resident 6 who stated she felt the Nurse Practitioner (NP) was not listening to her because it had been weeks since she asked to be taken off Olanzapine, but all that had happened was that the dose was lowered. Resident 6 stated she also spoke to the Medical Doctor because she was not taken off of the medication and still nothing changed. Resident 6 stated she talked to Registered Nurse (RN) 1 the night before last about changing her Olanzapine and three other medications, and nothing had happened yet. Resident 6 stated she even got a copy of her medications and went through every one of them to look at the side effects of each so she could talk to the NP. Resident 6 stated she wanted to be taken off of the Olanzapine because it made her gain weight and that she had gained 10-15 pounds. Resident 6 stated that the weight gain was not just for looks but that she had scoliosis and two neck surgeries and the added weight made the pain worse. Resident 6 stated she had bariatric surgery and that was very painful to go through and these medications made her feel insatiable and that there was nothing to do around here so she had nothing else to look forward to but meals. Resident 6 stated she could go to the gym but she was an introvert and had other issues that made it hard for her to go to the gym with other people.Resident 6's medical record was reviewed 6/22/26 through 6/29/26.Resident 6 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, recurrent, severe with psychotic symptoms; unspecified psychosis; delusional disorders; anxiety disorder; and post-traumatic stress disorder.A physician's order dated 5/1/26 at 3:41 PM indicated, OLANZapine Oral Tablet 10 MG [milligrams] (Olanzapine) Give 1 tablet by mouth at bedtime for Schizoaffective disorder. A physician's order dated 5/14/26 at 1:05 PM indicated, OLANZapine Oral Tablet 7.5 MG (Olanzapine) Give 1 tablet by mouth at bedtime for MDD [Major Depressive Disorder]. It should be noted that there was no documentation of the provider signing this order.A Psychotropic Note dated 5/20/26 at 3:36 PM indicated, .- Schizoaffective disorder- OLANZapine Oral Tablet 10 MG [milligram] (Olanzapine)- D/C [discontinue] OLANZapine Oral Tablet 10 MG (Olanzapine) 10 mg PO [by mouth] Give 1 tablet by mouth at bedtime for 1 week for Schizoaffective OLANZapine Oral Tablet 10 MG (Olanzapine) 7.5 mg PO Give 1 tablet by mouth at bedtime for 1 week for Schizoaffective OLANZapine Oral Tablet 5 MG (Olanzapine) 5 mg PO Give 1 tablet by mouth at bedtime for 1 week for Schizoaffective OLANZapine Oral Tablet 2.5 MG (Olanzapine) 2.5 mg PO Give 1 tablet by mouth at bedtime for 1 week for Schizoaffective.A Medication Administration Record (MAR) dated 5/1/26 to 5/31/26 indicated resident 6 received 10 mg of Olanzapine from 5/1/26 through 5/13/26 and 7.5 mg of Olanzapine from 5/14/26 through 5/31/26.A MAR dated 6/1/26 to 6/31/26 indicated resident 6 received 7.5 mg of Olanzapine from 6/1/26 through 6/22/26.A Physician Progress Note dated 6/23/26 at 9:10 AM indicated, Patient was seen in person for follow-up in the facility. Her medication list was reviewed with her, and medication changes were discussed.olanzapine were discontinued.On 6/24/26 at 3:06 PM, an interview was conducted with RN 1 who stated resident 6 requested to speak to the doctor about stopping or tapering her Olanzapine on Saturday, 6/20/26, but she did not tell him why. RN 1 stated he called the NP that day and said the NP stated she would see the resident on Monday.On 6/25/26 at 11:52 AM, an interview was conducted with the Director of Nursing (DON) who stated that RN 1 contacted the NP on Saturday on behalf of resident 6, so the NP came in and did a medication review which resulted in resident 6's Olanzapine order being discontinued. The DON stated the Olanzapine taper documented in the psychotropic note on 5/20/26 at 3:36 PM was not an order. The DON stated the NP gave her a verbal order to decrease her Olanzapine from 10 mg to 7.5 mg on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/14/26 instead of tapering the resident off of her Olanzapine. The DON stated that NP would send their orders and she or the MDS Coordinator would put the new orders into the medical record. The DON stated the NP put a late note into the medical record because she asked the NP to clarify her notes and orders regarding the Olanzapine taper and order. The DON stated resident 6 was supposed to be discharged on 5/20/25 but then plans changed and she was going to be staying at the facility and when that happened the NP did not want to taper resident 6 off of Olanzapine and gave the DON a verbal order to keep the dose at 7.5 mg but it was not documented anywhere. The DON stated that when the NP put in the late note from 5/20/26 on 6/24/26, that it was actually supposed to have been documented on 5/14/26 instead.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mt. Olympus Rehabilitation Center	2200 East 3300 South Salt Lake City, UT 84109

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that for 1 of 23 sampled residents, that the facility did not ensure that the resident environment remained as free of accident hazards as was possible. Specifically, a resident was found to have a nicotine vape in his possession despite being assessed as requiring supervision when smoking. Resident identifier: 3. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included osteomyelitis of vertebra lumbar region, bacteremia, methicillin resistant staphylococcus aureus infection as the cause of diseases classified elsewhere, type 1 diabetes mellitus without complications, and other psychoactive substance abuse with psychoactive substance-induced mood disorder. Resident 3's medical record was reviewed from 6/22/26 through 6/29/26.On 5/8/26, a Safe Smoking Evaluation - V 2 was completed for resident 3 upon his admission to the facility. The assessment stated that resident 3 smokes 1 pack of traditional cigarettes per day and that Resident 3 met the criteria for assisted smoking. On 6/9/26, it was documented in Resident 3's care plan that resident 3 smoked cigarettes, would not smoke without supervision through the next review date, required supervision while smoking, and that resident 3's tobacco supplies were stored in the smoking box. On 6/23/26 at 9:37 AM, an interview was conducted with resident 3 for the initial survey sample pool. During the interview, resident 3 was observed to be in possession of a nicotine vape. The vape was laying on his chest throughout the interview. On 6/24/26 at 2:27 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that residents were not allowed to vape in the building as it was considered smoking. LPN 1 stated that vapes should be stored in the locked box with other smoking supplies.On 6/25/26 at 1:21 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that residents were not allowed to vape inside of the building. The DON was not aware that resident 3 had a vape in his possession.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 1 of 23 sample residents were seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. Resident identifier: 4.Resident 4 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included metabolic encephalopathy, osteomyelitis of vertebra, streptococcus group A, pressure ulcer of the sacral region and right buttock, myocardial infarction and chronic respiratory failure. Resident 4's medical record was reviewed on 6/29/26.Resident 4's progress notes were reviewed. The progress notes indicated that resident 4 had been seen by the facility physician on the following dates after the latest admission: 3/23/265/26/26Documentation for the physician visit from April 2026 was not observed in the medical record. On 6/29/26 at 2:20 PM, an interview was conducted with the Director of Nursing (DON) who stated she was unsure how often the providers were supposed to see the residents in the facility. The DON stated the providers were the ones who kept track of who needed to be seen and when. On 6/29/26 at 2:46 PM, a follow up interview was conducted with the DON who stated the Medical Doctor (MD) for the facility told her that the residents were to be seen on admission, then at 30 days and again at 60 days. The DON stated she was told by the MD that the residents could be seen by either the physician or the nurse practitioner. The DON stated she was also told the residents should be seen one day after they were admitted or on the following Monday if the resident was admitted on a weekend. The DON stated she was unsure if resident 4 had been seen by a provider on that day but was told that the MD had the note from the visit in April but she could not provide it and it was not in resident 4's medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 3 out of 23 sampled residents, that the facility did not maintain medical records on each resident that were complete; accurately documented; readily accessible; and systematically organized. Specifically, a physician visit note was not documented in the medical record, a resident's medication administration record was not accurately completed, and a physician's note was entered late in the resident's medical record. Resident identifiers: 6, 10, and 41 1. Resident 6 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, recurrent, severe with psychotic symptoms; unspecified psychosis; delusional disorders; anxiety disorder; and post-traumatic stress disorder.Resident 6's medical record was reviewed 6/22/26 through 6/29/26.A Physician Progress Note dated 5/14/2026 at 8:20 AM was entered as a Late Entry and indicated, Patient was seen in person on 5/14. She requested discontinuation of olanzapine due to weight gain and increased appetite. I discussed with her that olanzapine is being used for schizoaffective disorder, bipolar type, and that it should not be stopped abruptly. Reviewed risks and benefits of discontinuing olanzapine in the setting of schizoaffective disorder, bipolar type, and advised against abrupt cessation. Implemented a gradual taper of olanzapine from 10 mg at bedtime for 1 week, then 7.5 mg at bedtime for 1 week, then 5 mg at bedtime for 1 week, then 2.5 mg at bedtime for 1 week. She verbalized understanding of the taper schedule and agreed to monitor for any worsening mood symptoms, psychosis, sleep disturbance, or other concerns during the dose reduction. Follow-up was recommended to reassess symptoms, tolerability, and consider alternative treatment options if needed.A Physician Progress Note dated 5/20/26 at 9:46 AM was documented on 6/24/26 at 8:47 AM that indicated, Late Entry .Patient was seen in person for follow-up in the facility. Discharge had been planned for 5/20, but this was reviewed with her and she decided to remain for long-term care. The change in disposition was discussed during the visit. Based on this change, themedication [sic] plan was reviewed and olanzapine 7.5 mg will be continued for one month. Ongoing stay and treatment plan were discussed with her in detail.On 6/25/26 at 11:52 AM, an interview was conducted with the Director of Nursing (DON) who stated that RN 1 contacted the NP on Saturday on behalf of resident 6, so the NP came in and did a medication review which resulted in resident 6's Olanzapine order being discontinued. The DON stated the Olanzapine taper documented in the psychotropic note from 5/20/26 at 3:36 PM was not an order. The DON stated the NP gave her a verbal order to decrease her Olanzapine from 10 mg to 7.5 mg on 6/14/26 instead of tapering the resident off of her Olanzapine. The DON stated that NP would send their orders and she or the Minimum Data Set (MDS) Coordinator would put the new orders into the medical record. The DON stated the NP put a late note into the medical record because she asked the NP to clarify her notes and orders regarding the Olanzapine taper and order. The DON stated resident 6 was supposed to be discharged on 5/20/25 but then plans changed and she was going to be staying at the facility and when that happened the NP did not want to taper resident 6 off of Olanzapine and gave the DON a verbal order to keep the dose at 7.5 but it was not documented anywhere. The DON stated that when the NP put in the late note from 5/20/26 that it was actually supposed to have been documented on 5/14/26 instead.2. Resident 10 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and severe dementia with psychotic disturbance.Resident 10's medical record was reviewed 6/22/26 through 6/29/26.A physician's order dated 3/4/26 at 6:00 PM indicated, May have wander guard to Left Wrist: Check for Placement and Function Q shift.A Medication Administration Record dated 6/1/26 to 6/30/26 indicated, May have wander guard to Left Wrist: Check for Placement and Function Q shift every shift for Safety -Start Date- 03/04/2026 1800 [6:00 PM]. It further indicated nurses documented a y for Day and Night on 6/1/26 through the Day on 6/8/26 and a - starting on the Night shift on 6/8/26 through the Day shift on 6/29/26.On 6/29/26 at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:57 AM, an observation was made of resident 10 and he was wearing a wander guard on his left wrist.On 6/29/26 at 11:01 AM, an interview was conducted with Registered Nurse (RN) 2 who stated he believed resident 10 was supposed to be wearing a wander guard and that nurses verified placement by visualizing it and then documenting that on the Treatment Administration Record. RN 2 reviewed the MAR and stated a y would probably mean that he had it on, but he did not know why nurses were documenting a negative sign or dash [-] and did not know what that meant. RN 2 stated he would go assess the resident to see if he was wearing his wander guard. On 6/29/26 at 11:04 AM, an interview was conducted with the Director of Nursing (DON) who stated resident 10 had a history of wandering and that he would try to go to the doors but his wander guard would set off an alarm. The DON reviewed the MAR and stated the negative sign that was documented from 6/8/26 through 6/29/26 was concerning and that she was going to go look into it.3. Resident 41 was admitted to the facility on [DATE] with diagnoses which included other specified disorders of the brain; alcohol dependence; alcoholic polyneuropathy; and epileptic seizures related to external causes, not intractable, without status epilepticus.On 6/22/26 at 1:51 PM, an interview was conducted with resident 41 who stated that he had not received his Lyrica for a couple of weeks and did not know why but the nurses just told him that his order for Lyrica ran out. Resident 41 stated it helped him with his nerve pain.Resident 41's medical record was reviewed 6/22/26 through 6/29/26.A physician's order dated 4/30/26 at 2:29 PM indicated, Lyrica Capsule 100 MG [milligrams] (Pregabalin) .for 30 days.A Medication Administration Record (MAR) dated 5/1/26 to 5/31/26 indicated Lyrica was administered from 5/1/26 though 5/30/26 at 2:00 PM.A Physician Progress Note dated 6/5/26 at 10:23 AM indicated, .- Visit Date: 05/06/2026.Clinical Data.Neuropathy-Pregabalin [Lyrica] Oral Capsule 100 MG.It should be noted that this late note resulted in confusion as to whether resident 41 had Lyrica ordered on 6/5/26 or not.A Nurses Note dated 6/24/26 at 10:25 AM indicated, Late Entry: .New NP order for Lyrica 100mg BID (twice a day). Order placed.It should be noted that when the progress notes were reviewed this note was not in the medical record.A physician's order dated 6/26/26 at 7:00 PM indicated, Lyrica Oral Capsule 100 MG (Pregabalin).A MAR dated 6/1/26 to 6/30/26 indicated Lyrica was administered 6/24/26 through 6/29/26.On 6/29/26 at 11:16 AM, an interview was conducted with the DON who was reviewing the physicians note dated 6/5/26 at 10:23 AM for the visit on 05/06/2026 and stated when the doctor wrote their progress note it was based on what the resident should have been on. The DON stated that there were other medications in that note that the resident was not on either so she needed to call him. It should be noted that resident 41 was prescribed and administered Lyrica on 5/6/26 but not when the note was entered on 6/5/26.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for 1 of 23 sampled residents, the facility failed to ensure that each resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Specifically, one resident opted to receive the pneumococcal immunization but it was not provided. Resident identifier: 10. Resident 10 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and severe dementia with psychotic disturbance.Resident 10's medical record was reviewed 6/22/26 through 6/29/26.An Immunization Consent dated 3/4/26 indicated resident 10 consented to, Pneumococcal Vaccine to be administered on 3/10/26.It should be noted that there was no documentation in the medical record that resident 10 received a Pneumococcal Vaccine.On 6/29/26 at 2:54 PM, an interview was conducted with the Director of Nursing (DON) who stated resident 10 did not receive his immunizations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and interview, it was determined that the facility failed to maintain documentation related to staff COVID-19 vaccination that included that staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and the COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Specifically, 4 staff members had no documentation that they were offered or provided Covid-19 immunizations. Staff identifiers: 1, 2, 3, and 4. On 6/29/26 at 9:00 AM, the employee records were reviewed for Staff 1, 2, 3, and 4. There was no documentation that indicated immunizations had been offered or administered to the staff members.On 6/29/26 at 2:54 PM, an interview was conducted with the Director of Nursing who stated the COVID-19 immunization was offered to all staff during the flu season but it was not documented.