

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465009	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/24/2024
NAME OF PROVIDER OR SUPPLIER  Harrison Pointe Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  3430 Harrison Boulevard Ogden, UT 84403	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46232</p> <p>Based on observation, interview and record review it was determined, for 2 of 14 sampled residents, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choice. Specifically, two residents received their morning medications late. Resident Identifiers: 12 and 13.</p> <p>Finding Included:</p> <p>1. Resident 12 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, chronic respiratory failure with hypoxia, cognitive communication deficit, mild cognitive impairment of uncertain or uncertain or unknown etiology, chronic pain syndrome, and personal history of pulmonary embolism.</p> <p>On 9/24/24 at 10:32 AM, an observation was made of Registered Nurse (RN) 2 during the morning medication pass. RN 2 was observed to be preparing resident 12's medications which consisted of gabapentin, oxycodone, clopidogrel, vitamin B12, cyclobenzaprine, multivitamin, oxybutynin extended release, vitamin C and D, Tylenol and eye drops. Resident 12 was observed to receive their medication at 10:40 AM.</p> <p>Resident 12's physician orders were reviewed and documented the scheduled morning medications were due to be given from 7:00 AM - 9:00 AM.</p> <p>On 9/24/24 at 10:45 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated they were a little late with medications because they had people stop them and ask for stuff. RN 2 stated medication pass was from 6 am to 10 am. RN 2 stated they did have people they could ask to help them with med pass but had not done so. RN 2 stated during medication pass, the computer system would alert the staff regarding medication timing using a color system. RN 2 stated if a resident's name was in red then it meant the medication was over due; if the residents name was in yellow then it meant the medication was due; if the residents name was in green then it meant the medication was given. RN 2 stated they still had 5 more residents to give medications to. It was observed that all 5 of the residents names were in red.</p> <p>2. Resident 13 was admitted to the facility on [DATE] with the diagnoses of chronic obstructive pulmonary disease, longstanding persistent atrial fibrillation, paroxysmal atrial fibrillation, and other thrombophilia.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/24/24 at 10:51 AM, an observation was made of Licensed Practical Nurse (LPN) 2 during morning medication pass. LPN 2 stated they were finishing up with their current resident and had one more resident left with morning medications. At 11:03 AM, LPN 2 was observed preparing resident 13's medications which consisted of metoprolol, diltiazem, apixaban, allopurinol, senna plus and MiraLAX. Resident 13 was observed receiving their medications at 11:09 AM. A follow up interview was conducted with LPN 2. LPN 2 stated morning medications were scheduled to be given from 7:00 AM - 9:00 AM but they were allowed to administer medication an hour before to an hour after the scheduled times.</p> <p>Resident 13's physician orders were reviewed and documented the scheduled morning medications were due to be given from 7:00 AM - 9:00 AM.</p> <p>On 9/24/24 at 12:43 PM, an interview was conducted with the Director of Nursing (DON). The DON stated they had a flex med pass which allowed flexibility for medications to be given an hour prior to an hour after they were scheduled. The DON stated it was not uncommon for the nurses to ask for help if they were behind on med pass. The DON stated if a resident name appeared red during med pass, then it meant the medications were late. The DON stated they were not aware of any nurses requesting assistance with medication pass today. The DON stated if medications were given outside of the flex times, they expected the nurses to notify the provider and write a progress note about giving the medication late.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>49789</p> <p>Based on observation, interview and record review, it was determined for 1 of 14 sampled residents, that the facility did not ensure that a resident who was assessed to be an elopement risk received adequate supervision to prevent accidents. Specifically, a resident did not have adequate interventions in place to mitigate the risk for elopement for 4 days following an elopement risk assessment that determined the resident was a high elopement risk. Resident identifier 6.</p> <p>Findings included:</p> <p>On 3/16/24, resident 6 was admitted to the facility with the diagnoses of dementia, psychotic disturbance, mood disturbance, anxiety, history of transient ischemic attack and cerebral infarction without residual deficits, and cognitive communication deficit.</p> <p>Resident 6's medical record was reviewed on 9/24/24.</p> <p>On 3/16/24, an elopement assessment was conducted, the document indicated resident 6 was a high wander risk. The assessment stated the resident had dementia and had no history or current behaviors of wandering.</p> <p>[It should be noted that this was an initial assessment, and the facility did not have historical wandering behavior documented for resident 6.]</p> <p>On 3/19/24, a second elopement assessment was conducted and indicated resident 6 continued to be a high wander risk. The assessment stated the resident had dementia, was disoriented, had a 1-2 times elopement history in the past 6 months, made statements of desire to exit the facility, had aimless wandering with the potential to go outside, had active exit seeking behavior, wander behavior was worse in the past 90 days, and was ambulating independently with an assistive device.</p> <p>A review of resident 6's care plan was conducted, wander risk and elopement prevention interventions were not added to the care plan following the elopement assessments conducted on 3/16/24 and 3/19/24.</p> <p>On 3/23/24, form 358 was submitted at 5:20 pm for elopement that stated the Resident was found approximately 10 feet past our property line heading north across [a local street]. [A staff member] immediately went to and redirected her back to the building. She was assessed for any injury, none found. Increased supervision. A referral was made to another facility that has a memory care unit that can better care for her needs. She will be transferred as soon as possible. The resident eloped from the facility at approximately 4:15 pm, the staff was aware of the elopement at 4:20 pm. Administrator was notified at 4:30 pm.</p> <p>(continued on next page)</p>		

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