

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  MT Ogden Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 East 5350 South Washington Terrace, UT 84405	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</b></p> <p>Based on interview and record review, the facility did not ensure that residents were free from abuse, neglect, misappropriation of resident property, and exploitation. Specifically, there were no interventions developed to prevent sexual abuse when 2 residents were in a relationship and one was cognitively impaired. This deficiency was found to have occurred at a past non-compliance. Resident Identifiers: 174 and 175.</p> <p>Findings included:</p> <p>1. Resident 174 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included hemiplegia and hemiparesis, abnormalities of gait and mobility, essential hypertension, migraine, epilepsy, and gastro-esophageal reflux disease.</p> <p>Resident 174's medical record was reviewed on 12/2/24 through 12/5/24.</p> <p>An admission Minimum Data Set (MDS) assessment revealed resident 174 had a Brief Interview for Mental Status (BIMS) score of 15, indicating this resident's cognitive status was mildly impaired.</p> <p>Progress notes for resident 174 revealed the following:</p> <p>a. On 5/2/24 at 1:25 PM, This nurse and a CNA [Certified Nursing Assistant] witnessed this resident asking another resident to help cut up her food, and to bring her items saying that she needs extra help. This was witnessed in the dining room on more than one occasion and also in her bedroom.</p> <p>b. On 5/2/24 at 8:20 PM, . A CNA reported to this nurse that the same male resident was found in this resident's bed of a different night. This resident has been told by staff, administration and social services that this behavior is inappropriate.</p> <p>c. On 5/7/24 at 7:57 PM, This nurse was notified by another resident that I should check on resident in her room. Upon entering the room resident was in her bed and another resident appeared to be 'tucking' her into bed. This nurse informed both residents that this is not acceptable behavior and that they are not allowed to enter each other's rooms. Resident was disgruntled and asked the other resident to 'give her a kiss before leaving'. This nurse reiterated that this was inappropriate behavior and that he needed to come with me. Residents' roommate was also upset that a male had entered the room. Resident was left safely in her bed with call light and hydration within reach.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>It was documented that both resident's rooms were down the same hallway in the facility. There was no documentation found or provided that either resident was relocated during the allegation period.</p> <p>The care plan for resident 174 was not updated during the allegation period.</p> <p>No capacity to consent for a relationship was located in the medical record.</p> <p>2. Resident 175 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included athrosclerotic heart disease of native coronary artery without angina pectoris, anemia, unspecified dementia, cognitive communication deficit, reduced mobility, need for assistance with personal care, muscle weakness, and abnormalities of gait and mobility.</p> <p>On 12/18/23, a Montreal Cognitive Assessment (MOCA) was completed for resident 175. The resident was assessed as having a score of 10/30 indicating moderate cognitive impairment.</p> <p>On 4/25/24, a MOCA was completed for resident 175. The resident was assessed as having a score of 11/30 indicating moderate cognitive impairment.</p> <p>On 3/20/24, a BIMS score was completed for resident 175. The resident was assessed as having a score of 9 indicating moderate cognitive impairment.</p> <p>Progress notes for resident 175 revealed the following:</p> <p>a. On 3/22/24, a social service summary note revealed, . [Resident 175] has a diagnoses of dementia and needs staff to help anticipate needs. Resident can communicate with others but does have confusion.</p> <p>b. On 4/10/24, a provider note revealed, .Given his underlying dementia and need for assistance with ADLs [Activities of Daily Living] and ADLs [sic] I certify he is appropriate for skilled nursing facility level of care.</p> <p>c. On 5/2/24 at 9:54 AM, . This resident was seen in another resident's room early in the morning. This other resident is a female and she was asking this resident to do things for her and fetch things for her, like her remote or move her water closer to her. The CNA put a stop to this again reminding the female resident that she needs to do as much for herself, but also told this resident that he needs to focus on himself and the female resident needs to focus on herself.</p> <p>d. On 5/2/24 at 8:19 PM, Resident was asked by another female resident to borrow his phone. When this resident's son came to visit, they were looking for the phone. The resident's phone was found in the female resident's bed. Administration and social services were notified and both residents were told that this is inappropriate behavior. This nurse was also told by a CNA that they found this resident in the bed of the female resident the other night.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>e. On 5/7/24, Nurse was notified by another resident that this resident was in a female resident's room. Upon entering the room this nurse witnessed resident attempting to 'tuck' female resident in bed. This nurse explained to resident that he cannot be in another resident's room. Resident appeared irritable and stated that he did not understand and that he was only trying to help her. Female resident asked this resident to give her a kiss before leaving. This nurse explained to both resident's that this is not appropriate behavior and that he needed to come with me. Resident did exit the room. This nurse educated resident on common areas, and that he is not allowed to enter anyone else's room. Resident expressed understanding.</p> <p>f. On 5/21/24 a provider note revealed, . Dementia with behavioral problem.</p> <p>It was documented that both resident's rooms were down the same hallway in the facility. There was no documentation found or provided that either resident was relocated during the allegation period.</p> <p>The care plan for resident 175 was not updated during the allegation period.</p> <p>No capacity to consent for a relationship was located in the medical record.</p> <p>On 12/4/24 at 1:17 PM, an interview was conducted with resident 37 who was resident 174's roommate at the time of the incident. Resident 37 stated she remembered resident 175 coming into their room, a lot. Resident 37 stated I guess he liked her. Resident 37 stated that resident 174 would ask him to do things for her and he would do them. Resident 37 stated she did not see anything because she stayed on her side of the room.</p> <p>On 12/5/24 at 9:43 AM, and interview was conducted with CNA 1. CNA 1 stated resident 174 had a tendency to be manipulative and would ask others to do things for her that she could do for herself. CNA 1 stated resident 174 had the poor me act going most of the time. CNA 1 stated resident 174 was a little alert and oriented but sometimes confused. CNA 1 stated that she was aware of resident 174 and resident 175 being together a lot, they would go into each other's rooms and hold hands. CNA 1 stated resident 175 was pleasantly confused, he needed to be directed and shown where his room was because he would get disoriented. CNA 1 stated they were supposed to report any signs that residents may have been in a relationship to administration. CNA 1 stated she did not report anything to administration.</p> <p>On 12/5/24 at 9:45 AM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated she was working nights at the time resident 174 and 175 were residents. NA 1 stated resident 174 would ask resident 175 to do things for her most of the time and encourage him to go into her room with her. NA 1 stated resident 175 had sundowners really bad and when night time would come he would get really confused as to where he was or what you were talking about. NA 1 stated per policy we were supposed to see, stop, and report if we saw something. NA 1 stated administration was already aware of resident 174 and 175 being close so she did not bring it up again.</p> <p>On 12/5/24 at 10:04 AM, an interview was conducted with CNA 2. CNA 2 stated she did remember resident 174 and 175. CNA 2 stated that resident 174 would go into 175's room a lot. CNA 2 stated that she did see resident 174 and 175 being friendly with each other while they were in the facility. CNA 2 stated the staff were to see, stop, and report if they see something like that and CNA 2 stated that she told the administrator the resident 174 was seen going into resident 175's room. CNA 2 stated she did not remember any changes being made or any education being done when that happened.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 10:38 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated she did remember resident 174 and 175. RN 1 stated that resident 174 was alert and oriented and liked to manipulate another resident into doing things for her. RN 1 stated that resident was resident 175. RN 1 stated resident 175 was cognitively impaired and would get disoriented and need redirecting at times. RN 1 stated resident 175 would not usually go into other resident's rooms but he did go into resident 174's room. RN 1 stated she found resident 175 in resident 174's room a couple of times and asked him to leave.</p> <p>On 12/5/24 at 10:45 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated resident 175 was alert and oriented but resident 174 would get confused and needed guidance to find his room. The ADON stated resident 175 did go into resident 174's room. The ADON stated there was one incident where resident 175 was tucking resident 174 into bed as you would a child. The ADON stated she asked resident 175 to leave, he became upset and resident 174 then asked him to give her a kiss before he left the room. The ADON stated she told them that was inappropriate and resident 175 left the room unhappy. The ADON stated if they saw any residents that appeared to be in a relationship they were to notify Social Services or the Administrator. The ADON stated she did not report the relationship to anyone.</p> <p>On 12/5/24 at 1:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she did remember resident 174 and 175. The DON stated residents were assessed to determine consent for a consensual relationship by having a conversation with them. The DON stated resident 174 was alert and oriented and able to make decisions for herself and the DON stated she felt resident 175 was able to make the decision because his cognitive level improved while he was in the facility and after he left. The DON stated a specific conversation to determine whether the residents were in a relationship or if they were able to consent did not happen.</p> <p>On 12/5/24 at 1:00 PM, an interview was conducted with the Corporate Resource Nurse (CRN). The CRN stated there were no residents in relationships in the facility currently and there were no staff in relationships with residents. The CRN stated she was unsure if the facility had a consensual consent policy.</p> <p>On 12/5/24 at 1:05 PM, an interview was conducted with the Administrator (ADM). The ADM stated he was made aware of the alleged abuse allegation when another facility called and informed him. The ADM stated he was under the impression the residents were in a consensual relationship. The ADM stated while the residents were at the facility he was aware of the them being close but had no knowledge of any sexual abuse. The ADM stated he had a discussion with them about a relationship. The ADM stated the outcome from the discussion was that both of the residents were able to make the decision for themselves. The ADM stated to determine if a resident was able to consent to a consensual relationship a conversation was had with each resident to determine what a relationship means to them and determine what each resident wanted. The ADM stated if a resident was unable to make the decision due to cognitive ability the family was then involved. The ADM stated the family for either resident was not involved in this case because both residents seemed to be able to make the decision for themselves. The ADM stated after the allegation was brought to their attention a Quality Assurance and Performance Improvement (QAPI) plan was put into place and education with the staff was completed.</p> <p>Corrective action</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The exhibit 358 revealed that staff became aware of the incident on 10/18/24 at 11:00 AM. The exhibit revealed that resident 174 alleged, [resident 174] was involved in an alleged incident that is sexual in nature during her stay .</p> <p>On 11/6/24, the DON and the ADM were unable to get in touch with resident 174 and 175 by telephone, so the DON and the ADM went to the residence of resident 174 and 175, two separate residences to interview the residents.</p> <p>Exhibit 359 revealed that the Administrator and Director of Nursing of the facility visited [resident 174] in her home with her family present. During interview DON asked [resident 174] about her relationship with [resident 175]. [Resident 174] relayed that she and [resident 175] were friends but at least on one other occasion they exchanged mutual affections including kissing. [Resident 174] stated that one night during bed time [resident 175] came to visit her in her room which he had done on other occasions that while she was in her bed he lifted her shirt up, touched her breast and put his hand down her pants. [Resident 174] said she yelled for him to stop and told him to leave her room which he did. Resident stated that this was an isolated incident. [Resident 174] states she did not report this to any staff. Further, [resident 174's] daughter said she was unaware of this alleged incident until the investigation. However, [resident 174] said that she told her friend [name omitted] and that her roommate [name omitted] was in the room at the time of the alleged incident and aware of the situation. [Resident 174] stated that she felt safe at the facility and would like to come back. A summary on interviews revealed, During our investigation, there were no known witnesses. [Resident 37] was [resident 174's] roommate at the time and [resident 174] stated that she was in the room during the time of alleged incident. Upon interview with [resident 37], she stated that she had no memory of [resident 174] yelling at or asking alleged perpetrator [resident 175] to leave their room. She just remembered both of them frequently enjoying the company of one another. A summary of the information from the investigation revealed, Inconclusive. After our investigation we were not able to verify or refute whether or not the allegation had occurred. After review of the charts of each resident, and also reviewing all interviews it was determined that former residents [175] and [174] did have some form of consensual relationship, where they spent time with each other and were affectionate. The two people that [resident 174] stated were aware of the alleged incident denied having knowledge of the incident.</p> <p>On 12/5/24, the facility provided the QAPI plan dated 11/8/24 which identified the issue as Resident and Relationships where All residents were identified as being at risk. The system correction that was put into place was, All staff to be educated on importance of identifying and reporting to Administrator relationships between residents. Social services educated on appropriate follow-up to determine appropriateness of relationship and updating care plan per IDT [Interdisciplinary Team] discussion. Monitoring was done by, Administrator to do a review of the 24 hour report in the morning before morning meeting or potential documentation of resident relationship. With a resolution date of 12/8/24. The QAPI plan was observed to be signed by the QAPI committee members.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24, the facility provided the QAPI plan dated 11/8/24 which identified the issue as Recognizing Abuse where All Residents were identified as being at risk. The system correction that was put into place was, All staff to be educated on importance of identifying abuse and addressing it immediately and appropriately (stopping it, and notifying the administrator). In addition, staff will review specific abuse examples and go through the proper procedures when abuse is identified. Monitoring was done by, Administrator to do a review of the 24 hour report in the morning before morning meeting. LMS training assigned to all staff in the building on abuse. With a resolution date of 12/8/24. The QAPI plan was observed to be signed by the QAPI committee members.</p> <p>On 12/5/24, the education slide show was provided to and reviewed by this surveyor. The education topics reviewed were Residents, Intimacy, and Sexual Contact and abuse scenarios with educational slides provided for each topic.</p> <p>On 12/5/24 an Assessment of Resident Capacity to Consent to Intimacy was provided by the facility and was part of the education given to the facility staff on 11/8/24.</p> <p>Inservices on abuse and reporting were documented as being given to the staff on the following dates:</p> <ul style="list-style-type: none"> <li>a. 6/20/24</li> <li>b. 7/25/24</li> <li>c. 8/30/24</li> <li>d. 9/20/24</li> <li>e. 10/17/24</li> <li>f. 11/8/24</li> <li>g. 11/14/24</li> <li>h. 11/22/24</li> </ul> <p>On 11/11/24 the Residents, Intimacy, and Sexual Contact slide education and abuse scenarios was reviewed again with the staff.</p> <p>On 12/5/24, the 24 Hour Report audits on abuse and relationships were reviewed by the administration from 11/11/24 through 12/5/24 with no concerns being documented.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</b></p> <p>Based on interview and record review, the facility did not implement their written policies and procedures for investigation of abuse allegations. Specifically, an incident of potential sexual abuse was not investigated timely. Resident identifiers: 174 and 175.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident 174 was admitted to 4/28/24 with diagnoses which included hemiplegia and hemiparesis, abnormalities of gait and mobility, essential hypertension, migraine, epilepsy and gastro-esophageal reflux disease.</li> <li>2. Resident 175 was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease of native coronary artery without angina pectoris, anemia, unspecified dementia, cognitive communication deficit, reduced mobility, need for assistance with personal care, muscle weakness and abnormalities of gait and mobility.</li> </ol> <p>The medical records for resident 174 and 175 were reviewed 12/2/24 through 12/5/24.</p> <p>The State Survey Agency (SSA) received a 358 report dated 11/6/24 indicating that another facility where resident 174 resided called on 10/18/24 and informed the previous facility that resident 174 had reported being in a sexual incident with resident 175 while a resident at the facility.</p> <p>On 12/4/24, an Incident Witness Interview Report dated 10/18/24 was conducted with four residents in the facility. No other investigation reports were located or provided.</p> <p>On 12/5/24, an interview was conducted with the Administrator (ADM) and the Director of Nursing (DON). The ADM and DON were asked about the 358 report. The ADM stated he was made aware of the situation after being called by the other facility but did not do a full investigation at that time. The DON stated she did ask a few resident the questions on the Incident Witness Interview Report when she found out about the call but a complete investigation was not done. When asked why the incident was not reported to the SSA until 11/6/24 the ADM and DON stated they were unsure if it needed to be reported since the residents were not longer residents at the facility. The ADM stated he had talked with the long term care manager and was told they should report it. The ADM stated that is when it was reported to the SSA.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Abuse: Prevention of and Prohibition Against under the section labeled Policy revealed, It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Facility staff are prohibited from taking, keeping, using or distributing photographs or video recordings of Facility residents in any manner that would demean or humiliate a resident, regardless of whether the resident provided consent and regardless of the resident's cognitive status. This includes using any type of equipment (e.g., cameras, smart phones, or other electronic devices) to take, keep, or distribute inappropriate photographs or recordings on social media. The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation.</p> <p>Corrective action</p> <p>On 12/5/24 the facility provided the QAPI plan dated 11/8/24 which identified the issue as Recognizing Abuse where All Residents were identified as being at risk. The system correction that was put into place was, All staff to be educated on importance of identifying abuse and addressing it immediately and appropriately (stopping it , and notifying the administrator). In addition, staff will review specific abuse examples and go through the proper procedures when abuse is identified. Monitoring was done by, Administrator to do a review of the 24 hour report in the morning before morning meeting. LMS training assigned to all staff in the building on abuse. With a resolution date of 12/8/24. The QAPI plan was observed to be signed by the QAPI committee members.</p> <p>Inservices on abuse and reporting were documented as being given to the staff on the following dates:</p> <ol style="list-style-type: none"> <li>1. 6/20/24</li> <li>2. 7/25/24</li> <li>3. 8/30/24</li> <li>4. 9/20/24</li> <li>5. 10/17/24</li> <li>6. 11/8/24</li> <li>7. 11/14/24</li> <li>8. 11/22/24</li> </ol> <p>On 12/5/24 the 24 Hour Report audits on abuse and relationships were reviewed by the administration from 11/11/24 through 12/5/24 with no concerns being documented.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</b></p> <p>Based on interview and record review it was determined, for 2 out of 26 sampled residents, that the facility did not ensure that allegations of abuse, neglect, exploitation, or mistreatment were reported immediately, but not later than 2 hours after the allegation was made, if the allegation involved abuse or resulted in serious bodily injury, to the Administrator of the facility, the State Survey Agency (SSA), and adult protective services (APS), and the results of all investigations were reported to the Administrator and the SSA within 5 working days of the incident. Specifically, allegations of abuse were not reported at the time of the allegation to the SSA or APS. Resident identifiers: 174 and 175.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident 174 was admitted to 4/28/24 with diagnoses which included hemiplegia and hemiparesis, abnormalities of gait and mobility, essential hypertension, migraine, epilepsy and gastro-esophageal reflux disease.</li> <li>2. Resident 175 was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease of native coronary artery without angina pectoris, anemia, unspecified dementia, cognitive communication deficit, reduced mobility, need for assistance with personal care, muscle weakness and abnormalities of gait and mobility.</li> </ol> <p>The medical records for resident 174 and 175 were reviewed from 12/2/24 through 12/5/24.</p> <p>On 5/2/24 at 1:25 PM, a nurses note indicated that this nurse and a CNA (Certified Nursing Assistant) witnessed this resident [resident 174] asking another resident to help cut up her food, and to bring her items saying that she needs extra help. This was witnessed in the dining room on more than one occasion and also in her bedroom. This resident [resident 174] was already told that she needs to ask staff for help with these things.</p> <p>On 5/2/24 at 8:20 PM, a nurses note indicated that this resident [resident 174] asked a make (sic) resident [resident 175] to use his phone. When the other resident's son visited today, A search was conducted for his father's phone. It was found in this resident's bed. A CNA reported to this nurse that the same male resident [resident 175] was found in this resident's bed of a different night. This resident has been told by staff, administration and social services that this behavior is inappropriate.</p> <p>Review of the facility's form 358 for this incident indicated that although the facility was made aware of the incident on 10/18/24 at 11:00 AM, the facility did not report it to the SSA until 11/6/24 at 1:10 PM, approximately 19 days after the incident was reported to the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  MT Ogden Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 East 5350 South Washington Terrace, UT 84405	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy titled Abuse: Prevention of and Prohibition Against under the section labeled Identification revealed, . Facility staff with knowledge of an actual or potential violation of this policy must report the violation to his or her supervisor or the Facility administrator immediately. The Facility will assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property. This includes identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This also includes taking, keeping, using or distributing photographs or video recordings of Facility residents in any manner that would demean or humiliate a resident, regardless of whether the resident provided consent and regardless of the resident's cognitive status with any type of device.</p> <p>Corrective action</p> <p>On 12/5/24 the facility provided the QAPI plan dated 11/8/24 which identified the issue as Recognizing Abuse where All Residents were identified as being at risk. The system correction that was put into place was, All staff to be educated on importance of identifying abuse and addressing it immediately and appropriately (stopping it , and notifying the administrator). In addition, staff will review specific abuse examples and go through the proper procedures when abuse is identified. Monitoring was done by, Administrator to do a review of the 24 hour report in the morning before morning meeting. LMS training assigned to all staff in the building on abuse. With a resolution date of 12/8/24. The QAPI plan was observed to be signed by the QAPI committee members.</p> <p>Inservices on abuse and reporting were documented as being given to the staff on the following dates:</p> <ol style="list-style-type: none"> <li>1. 6/20/24</li> <li>2. 7/25/24</li> <li>3. 8/30/24</li> <li>4. 9/20/24</li> <li>5. 10/17/24</li> <li>6. 11/8/24</li> <li>7. 11/14/24</li> <li>8. 11/22/24</li> </ol> <p>On 12/5/24 the 24 Hour Report audits on abuse and relationships were reviewed by the administration from 11/11/24 through 12/5/24 with no concerns being documented.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</b></p> <p>Based on interview and record review, it was determined, for 2 of 26 sampled residents, that the facility, in response to allegations of abuse, neglect, exploitation, or mistreatment, failed to provide evidence that all alleged violations were thoroughly investigated. Specifically, an allegation of suspected sexual abuse was not thoroughly investigated. Resident identifier: 174 and 175.</p> <p>1. Resident 174 was admitted to 4/28/24 with diagnoses which included hemiplegia and hemiparesis, abnormalities of gait and mobility, essential hypertension, migraine, epilepsy and gastro-esophageal reflux disease.</p> <p>2. Resident 175 was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease of native coronary artery without angina pectoris, anemia, unspecified dementia, cognitive communication deficit, reduced mobility, need for assistance with personal care, muscle weakness and abnormalities of gait and mobility.</p> <p>The medical records for resident 174 and 175 were reviewed 12/2/24 through 12/5/24.</p> <p>The exhibit 358 revealed that staff became aware of the incident on 10/18/24 at 11:00 AM. The exhibit revealed that resident 174 alleged, [resident 174] was involved in an alleged incident that is sexual in nature during her stay .</p> <p>Exhibit 359 revealed that the Administrator and Director of Nursing of the facility visited [resident 174] in her home with her family present. During interview DON asked [resident 174] about her relationship with [resident 175]. [Resident 174] relayed that she and [resident 175] were friends but at least on one other occasion they exchanged mutual affections including kissing. [Resident 174] stated that one night during bed time [resident 175] came to visit her in her room which he had done on other occasions that while she was in her bed he lifted her shirt up, touched her breast and put his hand down her pants. [Resident 174] said she yelled for him to stop and told him to leave her room which he did. Resident stated that this was an isolated incident. [Resident 174]states she did not report this to any staff. Further, [resident 174's] daughter said she was unaware of this alleged incident until the investigation. However, [resident 174] said that she told her friend [name omitted] and that her roommate [name omitted] was in the room at the time of the alleged incident and aware of the situation. [Resident 174] stated that she felt safe at the facility and would like to come back. A summary on interviews revealed, During our investigation, there were no known witnesses. [Resident 37] was [resident 174's]roommate at the time and [resident 174]stated that she was in the room during the time of alleged incident. Upon interview with [resident 37], she stated that she had no memory of [resident 174] yelling at or asking alleged perpetrator [resident 175] to leave their room. She just remembered both of them frequently enjoying the company of one another. A summary of the information from the investigation revealed, Inconclusive. After our investigation we were not able to verify or refute whether or not the allegation had occurred. After review of the charts of each resident, and also reviewing all interviews it was determined that former residents [175] and [174] did have some form of consensual relationship, where they spent time with each other and were affectionate. The two people that [resident 174] stated were aware of the alleged incident denied having knowledge of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 at 1:30 PM, an interview was conducted with the Administrator (ADM) and the Director of Nursing (DON). The DON stated when they were informed of the incident she interviewed 4 residents about feeling safe in the facility but a full investigation was not done until a couple weeks later. The ADM stated the investigation was not completed immediately when the incident was reported to the facility. The ADM stated they were unsure if one needed to be completed since the residents no longer resided at the facility but after a discussion with the long term care manager it was determined an investigation was needed. The ADM stated a QAPI plan was then put into place improving the understanding of the types of abuse, how to report abuse, the investigation process and staff education was completed.</p> <p>The facility policy titled Abuse: Prevention of and Prohibition Against under the section labeled Investigation revealed, . 1. All identified events are reported to the Administrator immediately. 2. After receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm (See, Protection, below). 3. A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse. The findings of the examination shall be recorded in the resident's medical record. 4. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee. Upon receiving a report or allegation of a potential violation of this policy involving the taking, keeping, using, or distributing photos or video recordings, the Administrator or his or her designee will analyze the allegations and determine whether the conduct at issue implicates resident privacy or security as protected by the Health Insurance Portability and Accountability Act (HIPAA). Any such actual or potential violation will be managed as per the Facility's HIPAA policies and procedures. 5. The investigation will include the following: An interview with the person(s) reporting the incident; An interview with the resident(s); Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; A review of the resident's medical record;</p> <p>An interview with staff members (on all shifts) who may have information regarding the alleged incident; Interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; An interview with staff members (on all shifts) having contact with the accused employee; and A review of all circumstances surrounding the incident.</p> <p>6. To the extent there is evidence that could be used in a criminal investigation, staff will immediately notify the Administrator or his/her designee. Staff are not to tamper with or destroy any such evidence at any time. 7. At the conclusion of the investigation, the Facility will attempt to determine if abuse, neglect, misappropriation of resident property, or exploitation has occurred. 8. The investigation, and the results of the investigation, will be documented. 9. All phases of the investigation will be kept confidential in accordance with the Facility's policies governing the confidentiality of medical records and privilege of quality assurance/ quality improvement programs.</p> <p>Corrective action</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/5/24 the facility provided the QAPI plan dated 11/8/24 which identified the issue as Recognizing Abuse where All Residents were identified as being at risk. The system correction that was put into place was, All staff to be educated on importance of identifying abuse and addressing it immediately and appropriately (stopping it , and notifying the administrator). In addition, staff will review specific abuse examples and go through the proper procedures when abuse is identified. Monitoring was done by, Administrator to do a review of the 24 hour report in the morning before morning meeting. LMS training assigned to all staff in the building on abuse. With a resolution date of 12/8/24. The QAPI plan was observed to be signed by the QAPI committee members.</p> <p>Inservices on abuse and reporting were documented as being given to the staff on the following dates:</p> <ol style="list-style-type: none"> <li>1. 6/20/24</li> <li>2. 7/25/24</li> <li>3. 8/30/24</li> <li>4. 9/20/24</li> <li>5. 10/17/24</li> <li>6. 11/8/24</li> <li>7. 11/14/24</li> <li>8. 11/22/24</li> </ol> <p>On 12/5/24 the 24 Hour Report audits on abuse and relationships were reviewed by the administration from 11/11/24 through 12/5/24 with no concerns being documented.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431</b></p> <p>Based on observation and interview, the facility did not ensure safe and secure storage of drugs and biologicals in accordance with accepted professional principles; or include the appropriate accessory and cautionary instructions, and the expiration date on the medication. Specifically, one multi-dose vial was not labeled with an opened date, and a medication was taped back into the medication blister pack. Resident identifiers: 162.</p> <p>Findings included:</p> <p>Resident 162 was admitted to the facility on [DATE] with diagnoses which included fracture of lower end of left tibia, type 2 diabetes mellitus with diabetic neuropathy, Bell's palsy, muscle wasting and atrophy.</p> <p>On 12/4/24 at 8:16 AM, an observation was made of the 100-hall medication cart. An opened vial of Humulin 100 ml/units injection solution for resident 162 was located in the top right drawer of the medication cart and it did not have an opened date written on the vial.</p> <p>On 12/4/24, at 8:17 PM, an observation was made of a medication blister pack located in the locked drawer of the 100-hall medication cart. Resident 162's blister pack of Absenting 100 mg was observed to have a pill taped back into the 35 numbered space.</p> <p>On 12/04/24 at 8:17 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she did not see an opened date on the Humulin injection solution vial. LPN 1 stated there should be an open date on the vial. LPN stated that medications should not be taped back in blister packs, they should be disposed of properly.</p> <p>On 12/04/24 at 8:47 AM, an interview with the Director of Nursing (DON) was conducted. DON stated that when insulin vials were opened, they should be marked with an open date. DON stated that medication should not be taped back into the blister pill packs and that refused medications should be disposed of.</p>