STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465074	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Holladay	1205 East 4725 South Salt Lake City, UT 84117

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation and interview, it was determined that the facility did not provide a safe, clean, comfortable, and homelike environment. Specifically, soiled ceiling tiles and dusty air vents were observed throughout the facility, the west hall was found to have a urine-like odor, and the facility environment was in disrepair. Findings include: 1. On 4/1/24 at 9:49 AM and 4/2/24 at 10:56 AM, a strong smell of urine was observed throughout the west hall. The odor could not be pinpointed to a specific room or resident. On 4/2/24 at 12:03 PM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated she did notice a smell in the west hall and that the whole west hall had a smell. 2. On 4/3/24 at 12:35 PM, a strong smell of urine was observed throughout the west hall. The odor could not be pinpointed to a specific room or resident. 3. On 4/4/24 at 10:39 AM, a strong smell of urine was observed in the west hall, starting near room [ROOM NUMBER] down to the end of the hall near the nursing manager's office and exit corridor. 47432 4. On 4/2/24 at 12:22 PM, an observation was made of the west hallway of the building. There was noted to be a foul odor near room [ROOM NUMBER]. 5. On 4/3/24 at 9:17 AM, an observation was made of the hallway outside of the east nursing station. The drop ceiling tiles were noted to be covered in a black, dusty substance. The ceiling vent was also covered in black dust. 6. On 4/3/24 at 9:23 AM an observation was made of a cobweb hanging from the ceiling outside of room [ROOM NUMBER]. An observation was made of stains on the drop ceiling tiles outside of room [ROOM NUMBER]. (continued on next page)

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 4/3/24 at 9:24 AM, an observation was made of multiple dirty fingerprints above the doors leading from the east hallway to the main lobby. The bottoms of the doors were covered in scuff marks and were dirty. 8. On 4/3/24 at 9:33 AM, an observation was made of the west hallway. There were two ceiling vents covered in black dust and the surrounding drop ceiling tiles were also covered in black dust. 9. On 4/3/24 at 9:34 AM, an observation was made of multiple dirty drop ceiling tiles in the main lobby. 10. On 4/3/24 at 10:53 AM, an observation was made of the west hallway of the building. There was again noted to be a foul odor near room [ROOM NUMBER]. 11. On 4/3/24 at 10:53 AM, an observation was made of an orange, sticky substance on the wall between rooms [ROOM NUMBERS]. 12. On 4/3/24 at 10:54 AM, an observation was made of writing written in permanent marker on the wall between room [ROOM NUMBER] and the soiled linens closet. On 4/3/24 at 11:06 AM an interview was conducted with the Housekeeper (HK). The HK stated that she was responsible for cleaning resident rooms, showers, the nurses' stations, and the dining room. The HK stated that she was not responsible for cleaning the hallway. The HK stated that she did not know if the facility had any maintenance staff. 45470 On 4/4/24 at 1:37 PM an interview with the Administrator (ADMIN) was conducted. The ADMIN stated that he was currently filling in for maintenance staff. The ADMIN stated that the vents should have been cleaned about once a month. The ADMIN stated that the vents looked like they had not been cleaned in a while. The ADMIN stated that typically the facility was free of any offensive odors.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interviews and record review, it was determined for 2 out of 26 sampled residents, the facility did not ensure that each resident was free from abuse. Specifically, a staff located a female resident standing in front of a male resident, in the male resident's room. The male resident was seated in a wheelchair and had a hand up the shirt of the female resident, touching the female resident's breast. Both residents have significant cognitive impairment. Due to the facility's identification of abuse, subsequent corrective measures, and the facility's current compliance in this regulatory area, the deficiency was determined to be past noncompliance and the facility achieved compliance on 3/25/2024. Resident identifiers: 21 and 51 Corrective Action Action taken to ensure residents are free from abuse following incident involving sexual contact between two residents with significant cognitive impairment on 3/18/24; resident 51 and resident 21: Residents were immediately separated and redirected. Resident [21] on close observation status; 2:1 oversight, labs ordered-UTI diagnosed . Antibiotics ordered to treat UTI Skin assessed for resident [51] - skin intact, no sign of trauma noted Notifications to physicians, legal guardians and appropriate State Agencies were completed timely The resident [21] was referred to BHS [behavior health services] for potential medication adjustments as appropriate to manage aggression and sexual behaviors Admin and SS [social services] addressed with resident [21]'s legal guardian alternative placement Resident transferred 3/20/24, per resident family Psychosocial monitoring initiated for resident [51] IDT updated both resident care plans as applicable Provider to assess/evaluate residents including medication review SW [Social Work]/IDT wellness visits completed to ensure resident [51] remained at baseline Identification of Like Residents & Action Taken: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An audit was completed by DON [Director of Nursing]/designee to ensure there were no other residents who exhibit sexually inappropriate behaviors towards other residents. The audit was performed 3/18/24, and no other residents were identified as having inappropriate sexual behaviors towards other residents. Progress notes from [DATE]-March 2024 were reviewed for reach resident residing in the facility Facility staff were educated by Administrator and DON on abuse/neglect, (including sexual abuse), reporting requirements, close observation monitoring assignments. IDT was educated on the same, including focus on roll of IDT in care of residents with dementia, residents with sexual behaviors, and interventions and care planning. The education was initiated on 3/20/24. To ensure all staff received training, additional training sessions were provided on 3/25/24 and 3/26/2. The DON/designee will complete random audits of at least 5 resident charts weekly x4 weeks then monthly x2 months to ensure when incidents of sexually inappropriate behavior occurs, appropriate interventions are implemented and no trends are noted, and all allegations of abuse are reported to administrator and state agency timely. After the initial audit on 3/18/2-24, a follow-up audit was conducted 3/25/24 and no inappropriate behaviors were identified. System Changes: Administrator and DON reviewed Abuse & Neglect policies and deemed appropriate. Admin, DON, and RNC [Regional Nurse Consultant] reviewed the event to ensure thorough and timely investigation completed. Any resident exhibiting sexual behavior towards other residents will be evaluated by the IDT. Findings of all audits will be presented to the QAA committee for review and consideration of further corrective actions. Findings include: 1. On 3/18/24 at 4:28 PM, the facility Administrator submitted a form DLBC - 358 Facility Reported Incidents (Form 358) for an allegation of sexual abuse involving resident resident 21 and resident 51 that was alleged to have occurred on 3/18/24 at 1:05 PM. The Form 358 is used by Medicare and/or Medicaid certified nursing homes, in the State of Utah, to make an initial report of allegations abuse, neglect, misappropriation of resident property, and injuries of unknown origin to the State Survey Agency (SSA). On the Form 358, the Administrator documented on 03/18/2024 at 1:05 pm, a nurse reported finding Memory Care resident 21 sitting in his wheelchair, in his room, with his hand up Memory Care resident 51' shirt. The Administrator also documented the nurse reported that resident 51 had been standing in front of resident 21 and was not moving. The Administrator documented resident 21 and resident 51 were separated, with resident 51 being assisted back to her room. The Administrator documented neither resident 21 or resident 51 showed any sign of distress and that the residents were placed on opposite sides of the facility and were being monitored. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/24 at 1:59 PM, an interview with Licensed Practical Nurse (LPN) 1. LPN 1 stated she had been working at the facility since November 2023, and resident 21 had been her patient since she started. LPN 1 stated resident 21 had always been so pleasant, but he was placed on close observation at the end of February. LPN 1 stated resident 21 had started to exhibit some behaviors and nursing staff were tracking them. LPN 1 stated resident 21's behaviors included verbal aggression and that he touched a staff member inappropriatly. LPN 1 stated resident 21 tried to touch other residents. LPN 1 stated staff were able to stop resident 21 and redirect him when he tried touching other residents. LPN 1 resident 21 had been evaluated medically to determine if there were medical reasons to explainhis increased behaviors. LPN 1 stated resident 1 did have a urinary tract infection (UTI) and was started on an antibiotic. LPN 1 stated resident 21 was placed on medication to address his behaviors and when the incident where resident 21 had his hand up resident 51's shirt occurred, resident 21 was discharged to another facility. On 4/2/24 at 2:45 PM, a follow-up interview was conducted with LPN 1. LPN 1 was asked to clarify what she meant when she stated in her previous interview that resident 21 was placed on close observation. LPN 1 stated close observation was implemented when a resident began to exhibit increased behaviors, or had past behaviors. LPN 1 stated when the close observations were necessary, the implementation was a specific assignment for a certified nurse aide (CNA). LPN 1 stated the assigned CNA performed the close observations as well as redirecting the involved residents and ensuring additional observations of the residents were made. LPN 1 stated close observations were not specifically prescribed or ordered, but behavior monitoring was ordered and nurses charted behaviors each shift. LPN 1 stated nursing staff charted close observations in progress notes when implemented. On 4/4/24 at 2:38 PM an interview was conducted with the DON. The DON stated resident 21 and resident 51 were observed going into resident 21's room together. The DON stated that a nurse had found resident 51 in resident 21's room and resident 21 had his right hand under resident 51's shirt. The DON stated that the residents were separated immediately. The DON stated at the time resident 51 was entering resident 21's room, another resident was experiencing a medical emergency. The DON stated since resident 21 had not exhibited any sexual behaviors before this incident, staff were more focused on attending to the resident experiencing a medical emergency than redirecting resident 51. The DON stated resident 21 was placed on close observations immediately, and resident 21 was transferred the next day, per his family's request. Resident 51 was admitted to the facility on [DATE]. Resident 51's diagnoses included: aphasia following nontraumatic subarachnoid hemorrhage; Alzheimer's Disease; unspecified dementia, which was identified to be moderate and included behavioral disturbance; mood disorder, due to known physiological condition; and other signs and symptoms involving cognitive functions and awareness. A review of Resident 51's medical records was completed between 4/1/24 and 4/4/24. Facility staff completed an annual Minimum Data Set (MDS) assessment for resident 51. The assessment reference date (ARD) was 1/28/24. Facility staff assessed that a Brief Interview for Mental Status (BIMS) questionnaire was unable to be performed for resident 51 as the resident was rarely or never understood. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/23, facility staff initiated a care plan for the focus area of elopement and wander risk, related to Alzheimer's dementia for resident 51. The care plan included documentation that resident 51 may be disoriented to place, had impaired safety awareness, and that she wandered throughout the facility. The goal for this care plan, as initiated on 1/27/23 and last revised on 3/4/24, was that resident 51's safety would be maintained. To achieve the identified goal, the facility developed the following interventions on 1/27/23: distract resident from wandering by offering pleasant diversions; provide structured activities; offer food; engage in conversation; television; and books. In addition to the structured activities, interventions included, toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. On 3/18/2024 at 3:40 PM, a facility nurse documented in a nursing note that the nurse called resident 51's daughter to inform her staff had found her mother in the room of a male resident and that the male resident was touching her mother. The nurse documented the daughter asked if her mother was all right. The nurse documented that she informed the daughter staff were not able to determine if her mother was able to even remember the incident and that her mother appeared to be acting normally. The nurse documented the daughter responded by stating, As long as she is ok. The nurse further documented the daughter requested to be updated if her mother's condition changed. On 3/18/2024 at 5:27 PM, a facility nurse documented an alert nursing note for resident 51. The nurse documented, Skin check per DON [Director of Nursing] orders. Nothing notable found. Resident at baseline from a res to res [resident to resident] interaction. No psychosocial distress noted. On 3/18/2024 at 11:26 PM, a facility nurse documented an alert nursing note for resident 51. The nurse documented, Resident observed wandering hallways during the evening per usual behavior. No signs of psychosocial distress noted. Resident calm, pleasant and compliant with cares and medications. Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE]. with diagnoses which included cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebellar artery, vascular dementia, moderate, with agitation, urinary tract infection, site not specified, anxiety disorder, unspecified. Resident 21's medical records were reviewed between 4/1/24 and 4/4/24. Facility staff completed a Quarterly MDS assessment for resident 21, with an ARD of 12/20/23. Facility staff assessed that resident 21's cognitive status was moderately impaired. On 9/8/23 facility staff initiated a care plan for a potential for resident 21 to be verbally aggressive related to dementia and poor impulse control. The goal for this care plan, as initiated on 9/8/23 and revised on 12/12/23, was that the resident will not be harmed and will remain safe. To achieve the identified goal, the facility developed the following interventions on 9/8/23: analyze key times, places, circumstances, triggers, and what de-escalated behavior and document. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/28/2024 at 12:44 PM, a facility nurse documented the following nursing note entry for resident 21: Behaviors: Resident was in hall and asked female resident to 'go to bed and take a nap with him'. Staff present and redirected resident. Shortly after, a female resident was wandering and this resident attempted to touch her buttocks. Staff intervenedand [sic] prevented contact, again redirecting this resident. This resident then positioned himself next to another female resident in a w/c (wheelchair) and attempted to touch her upper legs. Staff again intervened prior to contact being made and redirected. Female resident removed from area. NP (Nurse Practitioner) in house and notified. DON notified. On 2/29/2024 at 5:43 PM, a facility nurse documented the following alert nursing note for resident 21: Upon entering to give room mate medication, Resident was observed in bathroom doorway with no pants, pleasuring self. Resident redirected that he needs to conduct this behavior in privacy. During afternoon shift, staff observed resident trying to touch a female resident. Staff redirected prior to contact being made. UM (Unit Manager) and Administrator aware, NP notified, new orders obtained. On 3/3/2024 a 5:22 PM, a facility nurse documented the following alert nursing note for resident 21: Female CNA [Certified Nursing Assistant] stated to this nurse, while she was helping to transfer resident from toilet to chair resident had his hand under her chest. She informed the resident that, 'that action was not welcome and he needed to be appropriate.' He asked, 'why?' and theCNA [sic] stated, 'it is because we are here to take care of you and I am not okay with you touching my body.' The resident agreed and stopped his attempt to pursue that action. Male staff is assigned to this resident for the rest of the shift. On 3/6/2024 at 12:55 PM, a Social Services note was documented for resident 21. The note included the following: SS (social services) : Follow up with [resident 21] regarding boundary issues with other residents. [Resident 21] was in better mood this date. He is being treated for a UTI (urinary tract infection) and appears less agitated. He was able to communicate appropriately. No yelling or cursing as he was doing over the past 2 weeks. SS to continue to monitor [Resident 21] for behaviors and boundary issues with other residents. On 3/7/2024 at 11:17 AM, a Social Services note was documented for resident 21. The note included the following: SS follow up with [Resident 21] regarding mood and behaviors. Prior boundary issues with peers. [Resident 21] was calm and foucsed (sic) on working with a Rubics (sic) Cube puzzle. His mood was stable and interactions were without incident this morning. On 3/11/2024 at 4:54 PM, a Physician/Practitioner note was documented for resident 21. The note included the following: Facility staff report that [Resident 21] has had some inappropriate behaviors towards female staff and residents over the past couple of weeks. He has not been aggressive but has attempted to grope females. UA [urinalysis] was ordered and he did have a UTI, which was treated with antibiotics. His inappropriate behavior has improved somewhat, but still continues. On 3/12/2024 at 6:31 PM, a facility nurse documented the following nursing note for resident 21: Resident had one episode of verbal aggression towards a female resident during activity this shift. Redirected per staff and seating rearranged to separate female resident from this resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/2024 at 4:18 PM, a facility nurse documented the following nursing note for resident 21: Phone conversation with resident's daughter concerning an incident today where her father was observed touching a female resident. She was also informed that the facility was exploring new placement for the resident. She replied that she understood but did not understand where the behavior was coming from. On 4/4/24 at 1:56 PM an interview was conducted with the Administrator. The Administrator stated when an instance of a resident-to-resident altercation occurs, he evaluates the willfulness of the act and the resulting harm as factors when determining whether to report or not the incident to the SSA and Adult Protective Services. The Administrator stated if two residents were to hit each other, he would look for physical injury and/or any difference in either residents' behavior to determine whether abuse had occurred. The Administrator stated if two residents swatted at each other, it may or may not need to be reported to the SSA and investigated as abuse. The Administrator stated that a resident punching another resident may be more serious than a resident striking another resident with an open hand slap or a pat.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on observation, interview, and record review, it was determined that for 6 of 26 sampled residents, that the facility did not ensure that all allegations of abuse or neglect were reported to the State Survey Agency (SSA). In addition, the facility did not ensure the results of all investigations of alleged abuse and neglect were reported to the necessary officials, including the SSA, within 5 working days. Due to the facility's identification of missed reporting of reportable allegations and their subsequent implementation of corrective measures, as well as the facility's current compliance in this regulatory area, this deficiency was determined to be past noncompliance. The facility achieved compliance on 3/15/2024. Resident identifiers: 23, 28, 35, 49, 51, 56 Corrective Action On 3/15/2024, the Administrator and DON (Director of Nursing) received training and education on company wide risk management processes to ensure Trigger Events are reported to the Administrator and/or DON. Per the education, a Trigger Event is an unusual situation or adverse event that meets criteria for reporting to State Agencies or Law Enforcement and/or results in: harm; has the potential for serious harm; and/or has the potential for civil, criminal or regulatory action. The education provided instruction that each Trigger Event is to be reported to the Administrator and/or DON, who will review the event with the Regional Nurse Consultant (RNC), who will facilitate a Trigger Call, if applicable, to ensure the event is addressed according to federal regulations, as well as facility and company policy. Action Taken: Facility staff were educated by Administrator and DON on abuse/neglect policy and procedures. In-Service dates for Abuse, Neglect, Reporting requirements, and Close Monitoring Assisgnments were completed on 3/20/24 and 3/26/24. The RNC will audit all abuse allegations to ensure they were immediately reported to the facility Administrator and reported to the appropriate State Agencies. These audits will occur monthly for three months to ensure compliance has been maintained. Audits were completed on 3/22/24 and 3/28/24. Two allegations were found to be reported to the State Survey Agency within 2 hours of the allegation. System Changes: Administrator and DON reviewed and approved Abuse and Neglect policies. Findings of audits will be presented to the Quality Assessment and Assurance (QA&A)committee for review and consideration. Trigger Events (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Trigger Events are unusual incidents/situations or adverse events which require thorough investigation and follow up by facility leadership. These events can be challenging to manage and often require additional guidance in the handling, documenting and/or resolution of such situations or events. In order to provide a forum for supportive team discussions and decision making in managing incidents, Sandstone Healthcare has implemented a Risk Management Process, including the use of trigger event calls. 1. Trigger events should be reported immediately to the Administrator or the Director of Nursing (DON) by facility department managers and staff. 2. The Administrator and/or DON should then notify the Regional Nurse Consultant (RNC) via phone for the purpose of discussing the trigger event. 3. The RNC may proceed to set up a trigger event call, (if deemed necessary), with the Administrator, DON, Regional Director of Operations (RDO). (The Chief Operating Officer and [NAME] President of Clinical Services may also be added to the call as optional attendees). This notification process should be completed as quickly as possible in order to comply with regulatory standards for reporting, should the event be deemed reportable by the team. Following the Call: 4. The Administrator, DON or RNC will send a confirmation email to the Management Group named above, with a short summary including: type of event, facility, date, time, and residents/staff involved. Trigger events are tracked, trended for QA&A Process Improvement Plans, and handled in a confidential manner. The Management Team will assist and support the facility to handle the issues in an appropriate manner to achieve the best possible outcome related to the situation or event. 5. The Administrator or Director of Nursing/Nursing Manager will complete the Risk Management Report in Point Click Care. Subsequent to the education provided on 3/15/24, the facility has met the requirements of this regulation. Findings Include: 1. Resident 51 was admitted [DATE] with diagnoses including unspecified dementia moderate with other behavioral disturbance, Alzheimer's disease unspecified, mood disorder due to known physiological condition unspecified, personal history of other diseases of the circulatory system, and other symptoms and signs involving cognitive functions and awareness. Resident 23 was originally admitted [DATE], readmitted [DATE] with diagnoses including diffuse traumatic brain injury with loss of consciousness of unspecified duration sequela, unspecified dementia mild with agitation, unspecified dementia mild with mood disturbance, type 2 diabetes mellitus without complications, bipolar disorder unspecified, obsessive-compulsive behavior, personal history of traumatic brain injury, wernicke's encephalopathy, anxiety disorder due to known physiological condition, long qt syndrome, and pseudobulbar affect. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 51's medical record was reviewed from 4/1/24 through 4/4/24. Resident 51's most recent annual Minimum Data Set (MDS) assessment did not have a Brief Interview for Mental Status (BIMS) Score. Resident 51 was marked as rarely/never understood and the assessment was not completed. Resident 23's medical record was reviewed from 4/1/24 through 4/4/24 Resident 23's most recent annual MDS assessment dated [DATE] gave Resident 23 a BIMS score of 9. In accordance with the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Manual (RAI) Version 3.0 Manual, a score of 9 represents moderate cognitive impairment. An incident report for Resident 51 dated 2/22/24 at 11:45 AM revealed, pt [patient] was in in dining room past [sic] by another female resident, and slapped at female resident. Other female reciprocated slap, residents separated by staff. Nurse assessed for any injury. No injuries noted, no S/S [signs and sypmtoms] of distress noted. emotional and cognitive status at baseline. MD [doctor of medicine] and DON [director of nursing] and Admin notified. Family notified. A progress note for resident 23 dated 2/22/24 at 11:54 AM revealed, This Resident was in dining room. Another female resident approached this resident and slapped at her. This Resident reciprocated and slapped at other female resident. Staff responded and separated and redirected residents. Resident assessed. No injuryfound [sic]. Resident denies injury or distress. She is laughing and shows no s/s of distress or agitation. Family, MD and DON notified. Administrator notified and aware. Currently resident does not recall occurrence. Resident 51's care plan was reviewed. The following focus, goals, and interventions were revealed: [Resident 51] needs supervision during activities in regard to personal boundaries. This focus was initiated on 2/23/24. [Resident 51] will have no inappropriate contact with others. This goal was initiated on 2/23/24. Meet and anticipate residents [sic] needs. This intervention was initiated on 2/23/24 and was revised on 2/23/24. Redirect resident away from others in crowded situations. This intervention was initiated on 2/23/24 Speak in a positive/upbeat tone. This intervention was initiated on 2/23/24. Resident 23's care plan was reviewed. The following focus, goals, and interventions were revealed: [Resident 23] has potential to be physically aggressive r/t Dementia, Poor impulse control. This focus was initiated 8/2/22 and was revised 3/1/24. [Resident 23] will seek out staff/caregiver when agitation occurs through the review date. This goal was initiated on 8/2/22, revised on 3/4/24, and had a target date of 5/11/24. (continued on next page)

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Sandstone Holladay	1205 East 4725 South Salt Lake City, UT 84117

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Resident 23] will demonstrate effective coping skills through the review date. This goal was initiated on 8/2/22, was revised on 3/4/24, and had a target date of 5/11/24. [Resident 23] will not harm self or others through the review date. This goal was initiated on 8/2/22, was revised on 3/4/24, and had a target date of 5/11/24. The resident's triggers for physical aggression are by residents going into her room. The resident's behaviors [sic] is de-escalated by distraction and staff redirection. This intervention was initiated on 8/2/22 and was revised on 8/2/22. Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. This intervention was initiated on 8/2/22. Coach [Resident 23] about physically reacting to others. This intervention was initiated on 2/23/24. Redirect other residents out of [Resident 23's] room and personal space. This intervention was initiated on 9/20.22. When the resident becomes agitated: Intervene before agitation escalates; Guide away from/remove source of distress; Engage calmly in conversation. This intervention was initiated on12/18/23 and was revised on 12/28/23. On 4/3/24, an interview was conducted with the Certified Nursing Assistant Coordinator (CNAC). The CNAC stated that she had heard about the incident between resident 52 and resident 23, but that she was not present for the incident. The CNAC stated that the incident happened in the main dining room, and she had been in the smaller dining room. (Note: the incident report for Resident 51 listed the CNAC as a witness.) On 4/3/24, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that he was not present when the incident happened. RN 2 stated that the incident occurred in the dining room. RN 2 stated that he only knew what he was told by other staff members and that he was only responsible for filing the incident report. RN 2 stated that anybody on shift that day would remember what happened because it was talked about amongst staff members. (Note: the incident report for Resident 52 was submitted by RN 2.) On 4/4/24 at 2:47 PM, an interview was conducted with the DON. The DON stated that Resident 23 was very impulsive. The DON stated that she did not know why Resident 51 would have started the altercation. The DON stated that Resident 51 is usually mild mannered. The DON stated that Resident 51 does not speak to staff, so they were unable to determine what had upset Resident 51. The DON stated that if Resident 23 is asked, she does not remember the incident. The DON stated that the incident occurred during an activity, and that the activities director had her back turned to both residents and did not see what had happened. The DON stated that there were no injuries and that it was a gentle fight. 48709 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 28 was admitted to the facility on [DATE] with diagnoses which included congestive heart failure, chronic obstructive pulmonary disease, dementia, hypertension, chronic kidney disease, polyosteoarthritis, major depressive disorder, and anxiety disorder. Resident 28's medical record was reviewed from 4/1/24 through 4/4/24. The MDS for Cognitive Patterns dated 1/18/24 indicated that resident 28 had a memory problem and his, Cognitive Skills for Daily Decision Making Made decisions regarding tasks of daily life .[was] Severely Impaired. An Alert Note progress note dated 2/14/24 at 4:32 PM indicated, Resident came out of room and stood at nurses station. Nurse observed open abrasion to L [left] cheek just below eye. Blood in eye, Nasal bridge swelling and bleeding from nose. Resident could not recall what happened. UM notified and responded. Administrator responded. Resident has s/s [signs/symptoms] of pain to cheek bone and nose. No other injury noted. Able to move all extremities. Grasps equal, PERRLA. NP [nurse practitioner] notified and requests resident transported to ER [emergency room] for evaluation. Son notified. EMS [emergency medical services] contacted and initiated for transport. Ice applied to bridge of nose, pressure to abrasion to control bleeding. Upon investigation, blood found in room next to bed and on sheets. Blood drops in front of night stand. Drawers to night stand all open. Injury and blood consistentwith [sic] fall in room due to environmental factors, poor balance, and impulse control. Resident attempting to transfer and ambulate with no foot wear. EMS arrived and report given to EMTP. Copy of POLST [Physician Orders for Life-Sustaining Treatment], Face sheet and meds given to EMS. Resident transferred to St. [NAME] ER for eval. A Physician/Practitioner Note dated 2/16/24 at 5:28 PM indicated, [Resident 28] is an 82 yo [year old] male who resides at [facility name redacted]. The evening of 2/14 he came to the nurse's desk with blood on his face. Facility staff report that he had a small laceration just below the left eye, bleeding from lac and nose, and swelling of the nose and area around left eye. He was unable to say what happened, but staff found blood on his sheets and on the floor next to his bed. He c/o [complained of] pain to the nose and left cheek. LOC [level of consciousness] at baseline of alert, oriented to self only. VS [vital signs] WNL [within normal limits]. He was sent to the ER for eval of facial injuries. He RTF [returned to facility] about 3 hours later. No facial fractures found. ER staff had closed the laceration with medical skin glue. Today he continues to be at cognitive baseline. He has some swelling to left cheek but not enough to impair vision. He is sitting in the hall near the desk and seems irritable when spoken to. Facility staff will continue neuro checks. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan indicated a focus of, [Resident 28] has been recipient of mild physical aggression due to wandering secondary to dementia Date Initiated: 01/05/2024 Revision on: 01/05/2024; which included the goal of, [Resident 28] will remain safe around others through next review date Date Initiated: 01/05/2024 Revision on: 03/06/2024 Target Date: 06/24/2024; and the interventions included, Administer meds as ordered Date Initiated: 01/05/2024 Monitor resident while wandering to avoid going into private spaces. Date Initiated: 01/05/2024 Redirect resident away from other residents while wandering Date Initiated: 01/05/2024. A focus of, [Resident 28] has potential to be physically aggressive (shoving staff with cares and hitting) r/t [related to] Dementia, Poor impulse control. Date Initiated: 07/20/2023 Revision on: 07/20/2023; which included the goal of, [Resident 28] will not harm self or others through the review date. Date Initiated: 07/20/2023 Revision on: 03/26/2024 Target Date: 06/24/2024. A focus of, [Resident 28] is at risk for falls related to deconditioning, gait/balance problems, dementia with confusion and decreased safety awareness. Date Initiated: 05/23/2023 Revision on: 05/23/2023; which included the goal of, [Resident 28] will be free of falls through the review date. Date Initiated: 05/23/2023 Revision on: 03/26/2024 Target Date: 06/24/2024. On 4/3/24 at 10:19 AM, an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated resident 28 had a steady gait and walked all over the facility. CNA 4 further stated that resident 28 would not know if he had a fall. On 4/3/24 at 12:26 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated she saw resident 28 standing in the hallway near his room with a bloody face and was unable to tell her what happened. LPN 1 stated the facility was not sure if he fell because she did not see resident 28 come out of his room, but it was ascertained that he fell because of the blood pattern found in his room. LPN 1 stated resident 28 had poor impulse control, safety awareness, and judgement and that he would become aggressive out of the blue. On 4/4/24 at 11:59 AM, an interview was conducted with the DON. The DON stated the nurse facility did not know what happened, but the nurse found resident 28 with injuries. The DON stated that the facility did not conclude that he had a fall. On 4/4/24 at 2:42 PM, an interview was conducted with the Unit Manager (UM). The UM stated she saw resident 28 slobbering and noticed he had blood coming out of his nose. The UM stated that the resident could not articulate what happened. The UM stated she called the Administrator and that he came to the resident's room and investigated the incident. 45470 3. Resident 49 was admitted to the facility on [DATE] with diagnosis which included Alzheimer's Disease, neurocognitive disorder with Lewy bodies, dementia, cognitive communication, mild protein-calorie malnutrition, psychotic disorder with delusions, depression, hyperlipidemia, arthritis, hallucinations, and insomnia. Resident 35 was admitted to the facility on [DATE] with diagnoses which included dementia, abnormalities of gait and mobility, type 2 Diabetes Mellitus, mild protein-calorie malnutrition, cognitive communication deficit, dysphagia, nondisplaced fracture of lateral malleolus of right fibula, mood disorder, major depressive disorder, and hypothyroidism. Resident 35's medical records were reviewed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nursing Note from 8/12/23 at 4:32 AM documented, Resident [49] sleeping in chair when waking up walked over to other resident sitting in chair ([resident 35]) and slapped her on the shoulder. Resident ([35]) pushed her back and resident ([49]) fell down on her buttocksThis (sic) nurse and cna's intervened, and separated residents, resident assessed([resident 49]) no injurys (sic) noted, denies pain. ROM [range of motion] wnl [within normal limits] for patient, walked patient to her room and help her transfer to her chair, other patient ([resident 35]) assessed, no injurys (sic) noted, ROM wnl for patient help patient ambulate to her room and transferred to bed, On call nurse manager notified . MD [medical director] notified. On 4/4/24 at 1:56 PM an interview was conducted with the Administrator. The Administrator stated when an instance of a resident-to-resident altercation occured, he evaluated the willfulness of the act and the resulting harm as factors when determining whether to report or not the incident to the State Survey Agency (SSA) 4. Resident 56 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction due to thrombosis, type 2 diabetes mellitus, squamous cell carcinoma, protein-calorie malnutrition, atrial fibrillation, need for assistance with personal care, history of falling, mood disorder, pressure ulcer of sacral region, dementia, generalized edema, anemia, hypertension, hyperlipidemia, and renal osteodystrophy. An incident report from 11/26/23 documented, During rounds @ 0120 [at 1:20 AM], CNA observed resident on the floor in her room next to the bed, resident bleeding from the forehead, . resident assessed for injury and assisted onto the bed, resident stated her head hurt when assessed for pain, no other pain noted. The resident states she doesn't know what happened but states that it has not been a great day for her. An Emergency Department (ER) documented dated 11/26/23 documented that resident 56 was seen at theER on [DATE] at 5:25 AM and was given 6 sutures on her forehead. On 2/15/24 an incident report from 2/15/24 documented, Nurse heard noise coming from the residents room approx [approximately] at 3:20 [AM]. Responded to noise. Observed resident laying face down between beds with head towards wall. Bed in low position and call light within reach. Assessed resident noted large laceration to forehead. Called the west nurse over for assistance. Pressure applied to laceration. Head to toe assessment completed. Swelling to R [right] ring finger. Laceration to bridge of nose. Bilateral knee discoloration . Resident c/o [complained of] pain to right ring finger, bilateral knees and head. Neuro checks initiated resident A&O [alert and oriented] x1 . Received orders to send resident out to hospital. 911 called. EMS arrived. Resident sent out to [name redacted] hospital. Resident unable to give a description. An ER documented dated 2/15/24 documented that resident 56 was seen at theER on [DATE] at 4:12 AM for a 10 centimeter (cm) head laceration and was give 20 sutures and 2 staples. An x-ray was preformed on the residents finger and the ER document reported, no acute abnormality of the right hand. The falls on 11/26/23 and 2/15/24 were not reported to the State Survey Agency or investigated by the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident 35 was admitted to the facility on [DATE] with diagnoses which included dementia, abnormalities of gait and mobility, type 2 Diabetes Mellitus, mild protein-calorie malnutrition, cognitive communication deficit, dysphagia, nondisplaced fracture of lateral malleolus of right fibula, mood disorder, major depressive disorder, and hypothyroidism. A Nurses Note from 9/23/23 at 7:28 AM documented, Resident was found on the floor in front of the bathroom door by the CNA. The floor was clear of clutter and debris. Residents right ankle was perpendicular to her leg. Notified provider and sent to [hospital name redacted]. Notified on-call . notified family [name redacted] who requested [name redacted] hospital. EMS administered Morphine, sent facesheet, POLST, medication list with EMS. A Nurses Note from 9/23/23 at 11:50 PM documented, .Res [resident] received morphine just before leaving hospital. Res with medial/lateral Malleolor fracture. Reduction was performed in the ER. NWB [non-weight bearing] and will need surgery. 1150 [11:50PM] resident returned from hospital. Resident has splint on right foot . Resident responds when the foot is touched by being startled . Resident with facial grimace and frowning, tense musclesand [sic] moaning . Resident is restless, crying, attempting to get out of bed. Stayed with resident until a 1 to 1 staff arrived. Neuro checks in place. Will continue to monitor. A Progress Note from 9/28/23 at 5:37 PM documented, Resident arrived from orthopedic surgery appointment at approx. 1600 [4:00 PM] . Orders from [Doctors name redacted] X-ray show non-displaced fibula Malleolus fx [fracture]; surgery not needed. No weight bearing for 2-3 weeks. Keep splint for now, [Doctors name redacted] will change in two weeks. Return to clinic 10/12 or 10/16 to get x rays . Resident currently resting in bed eating dinner. The fall on 9/23/23 and 2/15/24 was not reported to the State Survey Agency or investigated by the facility. On 4/4/24 at 2:21 an interview with the Corporate Resource Nurse (CRN) was conducted. The CRN stated that the facility had recently adapted a new process for investigating and reporting. The CRN stated that the new process what put in place approximately five weeks ago. The CRN stated that the new process involved a conversation with the Administrator, the Regional Nurse Consultant, the DON, and other members of the team immediately after an incident of possible abuse or neglect to determine if the incident required a full investigation and reporting to the State Agency. On 4/4/24 at 4:02 PM an interview with the DON was conducted. The DON stated that to determine the cause of unwitnessed falls, staff interviews were conducted. The DON stated that she did not have staff interviews written down for resident 56's falls or resident 35's falls. The DON stated that interviews were conducted to determine how often staff checked on the resident, if the residents' briefs were wet, among other things to determine if the resident was neglected. The DON stated that if the falls happened at night, then the interviews were conducted the following day. The DON stated that it was her understanding that the facility was to report abuse, and that she didn't think that the falls were due to neglect by the staff because she knew how hard it was to take care of resident 56. 47431

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on observation, interview, and record review it was determined, for 1 of 26 sampled residents, that the facility did not ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming. Specifically, a resident with severely impaired cognitive skills had long fingernails with brown substance under the fingernails. Resident identifier: 28. Findings include: 1. Resident 28 was admitted to the facility on [DATE] with diagnoses which included congestive heart failure, chronic obstructive pulmonary disease, dementia, hypertension, chronic kidney disease, polyosteoarthritis, major depressive disorder, and anxiety disorder. On 4/1/24 at 9:51 AM, an observation of resident 28 was made of him standing at the nurse's station in the west hall, his nails were long with a brown substance observed under all of his nails. Resident 28's medical record was reviewed from 4/1/24 through 4/4/24. The MDS (Minimum Data Set) for Cognitive Patterns dated 1/18/24 indicated that resident 28 had a memory problem and his, Cognitive Skills for Daily Decision Making Made decisions regarding tasks of daily life . [was] Severely Impaired. The LN-Functional Abilities-GG document dated 1/18/24 at 5:13 AM indicated resident was dependent for Self-Care Personal Hygiene. On 4/3/24 at 12:26 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated resident 28 refused cares but that they would give him time, space, and approach him later to provide cares. LPN 1 stated he had poor impulse control, safety awareness, and judgement. On 4/4/24 at 10:35 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated staff cut his fingernails when they are noticeably long. CNA 1 stated that resident 28 would allow her to cut his fingernails sometimes. On 4/4/24 at 10:39 AM, an interview was conducted with CNA 2. CNA 2 stated she had to initiate asking resident 28 to provide showers and hygiene because he would not ask for it. CNA 2 stated she did notice that his nails were long and soiled and that sometimes residents had poop under their nails. CNA 2 stated when a resident has long nails they could scratch staff or themselves. CNA 2 stated she did not cut them this morning because he would not answer her and that she planned on returning to ask again later. On 4/4/24 at 11:20 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that a resident who continuously refused cares would eventually come around if you kept trying. In a follow-up interview at 11:20 AM, RN 1 stated she was able to cut resident 28's nails today with no problems. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 12:19 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the CNA's were trained to try again later if a resident refused hygiene that was offered. The DON stated that the CNA should report to the nurse when they were unable to provide hygiene to a resident. The DON stated that staff should look at a resident's fingernails anytime they go and do anything with the resident and were to be cut as needed or as allowed. The DON stated that the CNAs needed to get the nurse involved if a resident had continuously refused getting his fingernails clipped. The DON further stated that resident 28 could not cut his own nails.

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F 0689 Level of Harm - 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** 45470 Based on observation, interview, and record review the facility did not, for 2 of 26 sampled residents, ensure that the environment remained as free of accident hazards as possible, and that each resident received adequate supervision and assistance device to prevent accident. Resident identifiers: 35 and 56. Findings include: 1. Resident 56 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction due to thrombosis, type 2 diabetes mellitus, squamous cell carcinoma, protein-calorie malnutrition, atrial fibrillation, need for assistance with personal care, history of falling, mood disorder, pressure ulcer of sacral region, dementia, generalized edema, anemia, hypertension, hyperlipidemia, and renal osteodystrophy. On 4/1/24 at 9:18 AM an observation of resident 56 was made. Resident 56 was sitting in a wheelchair close to the nurses' station. Resident 56 was observed to have a bandage on her head dated 4/1. Resident 56 was unable to explain why she had a bandage on her head. Resident 56's electronic medical record was reviewed. Resident 56's Minimum Data Set (MDS) from 12/20/23 documented that resident 56 required a two-person extensive assist with bed mobility, transfers, and toilet use. The MDS documented that the resident scored a 5 on the Brief Interview for Mental Status (BIMS). In accordance with the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Manual (RAI) Version 3.0 Manual, a score of 5 represents severe cognitive impairment. Resident 56's care plan was reviewed. Resident 56 had a care plan initiated on 9/20/23 with a focus that stated, [resident 56] is at risk for falls related to dementia with Confusion and decreased safety awareness, deconditioning, weakness. The goal stated, [resident 56] will be free of minor injury through the review date. The interventions stated, Allow resident to sleep in upright position as she prefers. , initiated 12/1/23. Anticipate and meet the resident's needs., initiated 9/20/23. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance., initiated 9/20/23. Bolster mattress to bed., initiated 2/16/24. Ensure commonly used items (ice water, glasses if applicable, call light, phone, remote) are within reach of resident prior to leaving room., initiated 9/20/23. Ensure resident bed remote is clipped near resident on bedsheet., initiated 10/13/23. Ensure that the resident is wearing appropriate footwear (non-skid shoes, non-skid socks, etc.) prior to any transfers or ambulating., initiated 9/20/23. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An incident report from 10/12/23 documented, resident found sitting on the floor, by bathroom door, with lower extremities under the bed. Resident wearing non skid socks when found. Bed found not in low position. Bed was in low position before fall. CNA [Certified Nursing Assistant] states resident plays with a bed remote. The resident's description on the incident report documented, Resident stated, I don't think I fell resident denies hitting head. The immediate action taken on the incident report stated, head to toe assessment done. Redness to R [right] hip noted. Skin intact. No deformities noted. ROM [range of motion] at baseline. Resident assisted back into bed. The care plan was reviewed, and it revealed that an intervention was added to the residents fall care plan. The intervention was added on 10/13/23 and stated, Ensure resident bed remote is clipped near resident on bedsheet. An incident report from 11/26/23 documented, During rounds @ 0120 [at 1:20 AM], CNA observed resident on the floor in her room next to the bed, resident bleeding from the forehead, . resident assessed for injury and assisted onto the bed, resident stated her head hurt when assessed for pain, no other pain noted. The resident states she doesn't know what happened but states that it has not been a great day for her. The incident report did not document any new interventions. An Emergency Department (ER) documented dated 11/26/23 documented that resident 56 was seen at theER on [DATE] at 5:25 AM and was given 6 sutures on her forehead. On 4/4/24 at 11:45 AM an interview with the Director of Nursing (DON) was conducted. The DON stated that that the intervention after the fall on 11/26/23 was to send her out to the hospital, and on 12/1/23 the care place was updated that stated, Allow resident to sleep in upright position as she prefers. An incident report from 1/20/24 documented, When giving res [resident] her morning meds this RN [registered nurse] observed a bruise to resident's L [left] forehead and swelling down to L eye. When asked res stated she fell , but is unable to give any details regarding what happened. The incident report did not document any new interventions. The care plan was reviewed and there were no updated interventions for the residents fall care plan. On 4/4/24 at 11:46 AM an interview with the DON was conducted. The DON stated that the intervention for the call on 1/20/24 was to ensure that pillows were placed between her bed and her dresser. The DON stated that she could not find the intervention in her fall care plan and that the fall care plan should have been longer than what it currently was. The DON stated that she found the intervention regarding the pillow placement in the resident's skin care plan and that it was added on 1/22/23. (continued on next page)

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	465074	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Holladay	1205 East 4725 South Salt Lake City, UT 84117

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/15/24 an incident report from 2/15/24 documented, Nurse heard noise coming from the residents room approx [approximately] at 3:20 [AM]. Responded to noise. Observed resident laying face down between beds with head towards wall. Bed in low position and call light within reach. Assessed resident noted large laceration to forehead. Called the west nurse over for assistance. Pressure applied to laceration. Head to toe assessment completed. Swelling to R [right] ring finger. Laceration to bridge of nose. Bilateral knee discoloration . Resident c/o [complained of] pain to right ring finger, bilateral knees and head. Neuro checks initiated resident A&O [alert and oriented] x 1 . Received orders to send resident out to hospital. 911 called. EMS arrived. Resident sent out to [name redacted] hospital. Resident unable to give a description. An ER documented dated 2/15/24 documented that resident 56 was seen at theER on [DATE] at 4:12 AM for a 10 centimeter (cm) head laceration and was give 20 sutures and 2 staples. An x-ray was preformed on the residents finger and the ER document reported, no acute abnormality of the right hand. A Nurses Note from 2/15/24 at 9:31 AM documented, Resident returned from [name redacted] hospital at approx. 0730 [7:30 AM] with a dx [diagnosis] of laceration without foreign body of scalp. Resident returned with 2 staples and 20 sutures to laceration on forehead. Splint noted to R ring finger . No neurological deficits noted. H-T [head to toe] completed by this nurse. New discoloration/swelling noted to L eye, resident unable to open eye due to swelling. Small laceration also noted above left eyebrow. Site cleansed and steri strip applied. During assessment resident observed picking at both lacerations. Slight bleeding noted to both sites, site cleansed . Staff attempted to ice residents face, but resident refused. NP [Nurse Practitioner] notified . The care plan was reviewed, and it revealed that an intervention to resident 56's care plan on 2/16/24 and it stated, Bolster Mattress to bed. On 4/3/24 at 4:53 PM an interview with RN 3 was conducted. RN 3 stated that she was the nurse for resident 56 when resident 56 fell on [DATE]. RN 3 stated, I was at the nurses' station when I heard a loud noise. I began checking rooms, I opened her door and saw that she wasn't on her bed. I walked in and saw her laying face down and she [resident 56] was saying, oh god it's dripping. [resident 56] wasn't able to tell me what happened. [Resident 56] does often try to get up. I called the doctor right away, and reported it to the family and the on call manager. I believe resident 56 got a bolster mattress after that fall. RN 3 stated that the fall happened during the night shift and there were three CNA's and 2 nurses working at the time. 2. Resident 35 was admitted to the facility on [DATE] with diagnoses which included dementia, abnormalities of gait and mobility, type 2 Diabetes Mellitus, mild protein-calorie malnutrition, cognitive communication deficit, dysphagia, nondisplaced fracture of lateral malleolus of right fibula, mood disorder, major depressive disorder, and hypothyroidism. On 4/4/24 at 1:29 PM an observation of resident 35's room was made. Resident 35 was observed in her bed. A bolster mattress was on resident 35's bed, the bed was in the low position, the room was free of clutter, the call light was within reach, and there was not a fall mat observed next to the bed. Resident 35 was unable to be interviewed due to low cognition. Resident 35's electronic medical record was reviewed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A quarterly MDS from 3/19/24 documented that a BIMS questionnaire could not be conducted do the resident being rarely or never understood. Resident 35's care plan was reviewed. A care plan initiated on 10/13/23 stated, [Resident 35] is at risk for falls related to dementia with decreased safety awareness and poor impulse control, gait imbalance, weakness, psychotropic medication use. The goal stated, [Resident 35] will be free of minor injury through the review date. The interventions stated, Anticipate and meet the resident's needs., initiated 10/13/23. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance., initiated 10/13/23. Bolstered mattress in place while resident is in bed., initiated 10/23/23. Educate staff to allow resident to stay up after meals as she seems to prefer to stay out of bed., initiated 1/12/24. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility., initiated 10/13/23. Ensure commonly used items (ice water, glasses if applicable, call light, phone, remote) are within reach of resident prior to leaving room., initiated 10/13/23. Ensure that the resident is wearing appropriate footwear (non-skid shoes, non-skid socks, etc.) prior to any transfers or ambulating., initiated 10/13/23. [Resident 35] has a custom wheelchair. Ensure that resident is positioned correctly while up in wheelchair., initiated 3/1/24. Offer resident her strips of fabric she enjoys fiddling with., initiated 2/9/24. Offer sensory blanket when awake., initiated 2/19/24. Resident moved to a room closer to the nurses' station., initiated 10/20/23. The resident needs a night light., initiated 12/4/23. The resident needs activities that minimize the potential for restlessness/falls while providing diversion and distraction., initiated 12/4/23. The resident uses fall prevention device: Floor ma. Ensure the device is in place as ordered., initiated 2/2/24. An Alert Note from 8/11/23 at 10:26 AM documented, CNA witnessed the patient fall on her buttocks with no head injury. She reported that she saw the patient get up from the chair, stumbled back and fell on her buttocks. It should be noted that the resident's fall care plan was initiated on 10/13/23. On 4/4/24 at 11:52 AM an interview with the DON was conducted. The DON stated, With her fall on 8/11/23, we were concerned that she wasn't getting enough sleep. The fall happened right after lunch. A staff member saw her stand up and fall down on her bum. I think that's when we put in charting of hours of sleep for her as an intervention. A Nurses Note from 9/23/23 at 7:28 AM documented, Resident was found on the floor in front of the bathroom door by the CNA. The floor was clear of clutter and debris. Residents right ankle was perpendicular to her leg. Notified provider and sent to [hospital name redacted]. Notified on-call . notified family [name redacted] who requested [name redacted] hospital. EMS administered Morphine, sent facesheet, POLST, medication list with EMS. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Nurses Note from 9/23/23 at 11:50 PM documented, .Res [resident] received morphine just before leaving hospital. Res with medial/lateral Malleolor fracture. Reduction was performed in the ER. NWB [non-weight bearing] and will need surgery. 1150 [11:50PM] resident returned from hospital. Resident has splint on right foot . Resident responds when the foot is touched by being startled . Resident with facial grimace and frowning, tense musclesand [sic] moaning . Resident is restless, crying, attempting to get out of bed. Stayed with resident until a 1 to 1 staff arrived. Neuro checks in place. Will continue to monitor. A Progress Note from 9/28/23 at 5:37 PM documented, Resident arrived from orthopedic surgery appointment at approx. 1600 [4:00 PM] . Orders from [Doctors name redacted] X-ray show non-displaced fibula Malleolus fx [fracture]; surgery not needed. No weight bearing for 2-3 weeks. Keep splint for now, [Doctors name redacted] will change in two weeks. Return to clinic 10/12 or 10/16 to get x rays . Resident currently resting in bed eating dinner. A Nursing Note from 10/19/23 at 10:48 AM documented, Resident observed sitting on the floor next to her bed. Residents [sic] was leaning towards her left side and was using her left hand to support herself. The bed was at the lowest position. Head to toe completed-assessed for injury prior to getting her back in bed. No new skin injury noted . The care plan was updated on 10/20/23 and stated, Resident moved to a room closer to the nurses' station. A Nurses Note from 10/22/23 at 5:47 AM documented, Resident found lying face down on the floor next to the bed. Head to toe assessment completed. No lacerations, skin tears, bruising, or deformities noted. No new injuries noted . The care plan was updated on 10/23/23 and stated, Bolstered mattress in place while resident is in bed. An Alert Note from 12/1/23 at 3:58 AM documented, Resident was found sitting on the floor in front of her w/c [wheelchair] with her feet forward towards her bed in her bedroom doorway. The UWF [unwitnessed fall] happened on 12/1/23 at 1815 [6:15 PM]. Resident unable to tell nurse what happened. Looks like she slipped out of her w/c . Resident has black boot to her R foot for fracture from a previous fall on 9/23. Circulation on R foot is good and boot is in place. She had a sock and shoe on the other foot. She was helped up into w/c and taken to her bed and placed in her bed where she has spent the rest of the evening relaxing . The care plan was updated on 12/4/23 after the residents next fall on 12/3/23. A Nurses Note from 12/3/23 at 5:47 AM documented, Resident was found sitting on floor next to bed. Assessed by nurse. No new injuries or areas of redness or bruising found. Started on neuros . The care plan was updated on 12/4/23 and stated, The resident needs a night light. And The resident needs activities that minimize the potential for restlessness/falls while providing diversion and distraction. An Alert Note from 12/10/23 at 4:00 AM documented, Resident was found by nurse sitting on floor next to bed on opposite side of her bedside mat. Bed in lowest position. Resident had removed boot from RLE [right lower extremity]. Head to toe assessment complete. No new injuries noted. The care plan was not updated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An Alert Note from 1/11/24 at 6:45 PM documented, At approximately 1845 [6:45 PM] nurse was notified that resident had slid of [sic] her bed. Nurse went into room and observed resident sitting on the floor next to her bed. Her back was against the bed and she was sitting upright on her bottom. Bed was at lowest position. Resident had been put into bed 10 min prior. Resident did not hit her head. H-T [head-to-toe] assessment completed. No new injuries upon assessment . The care plan was updated on 1/12/24 and documented, Educate staff to allow resident to stay up after meals as she seems to prefer to stay out of bed. An Alert Note from 2/1/24 at 8:30 PM documented, Resident found on floor beside bed. Bed at lowest setting. Brief was undone, but still on. Head to toe assessment done. No injuries seen, but she did have some fresh BM [bowel movement] on finger tips and a few scratches on bottom. Brief did have BM. Helped back intobed [sic] at lowest setting . The care plan was updated on 2/2/24 and stated, the resident uses fall prevention device: Floor mat. Ensure the device is in place as ordered. An Alert Note from 2/5/24 at 2:35 AM documented, [Resident 35] had a new unwitnessed fall this evening. She was found on the floor next to her bed. Small abrasion to L knee found. Wound cleaned with wound spray and covered with bandaid. No further injuries . She was unable to tell nurse how the fall occurred . The fall care plan was updated on 2/9/24 and documented, Offer resident her strips of fabric she enjoys fiddling with. A Nursing Note from 2/17/24 at 2:32 PM documented, Resident slid herself off the bed onto her buttocks. The bed is on the lowest setting. This nurse was watching from the nursing station. No injuries/deformities noted . The fall care plan was updated on 2/19/24 and documented, Offer sensory blanket when awake. An Alert Note from 2/23/24 at 4:25 PM documented, Resident slipped out of her wheelchair onto the floor in the main dining room during the activity at 1620 [4:20 PM]. Fall was witnessed by CNA. Resident did not hit her head or appear to have any pain. Nurse assessed. No injuries noted. Resident has been very anxious today attempting to stand up several times throughout the shift. Staff redirecting her with sensory activities . The fall care plan was not updated. A Nurses Note from 3/3/24 at 9:45 AM documented, The resident got up from her wheelchair and sat down on the floor. This nurse got up and walked out of the nursing station and around to the left of the hall. The resident fell back while sitting on her buttocks and hit the back of her head. A small bump on her posterior head noted. Resident has full range of motion in all extremities .Will continue to monitor. The fall care plan was not updated. On 4/4/24 at 9:05 AM an interview with CNA 4 was conducted. CNA 4 stated that if a resident had an unwitnessed fall, CNA's were instructed to make sure the resident was safe, and immediately tell a nurse. CNA 4 stated that vitals were started and staff were supposed to try and find out if anyone saw the fall or try to identify the cause of the fall. CNA 4 stated that neuros were filled out and once the neuros were completed the sheet was given to the nurses station. CNA 4 stated that there were general fall preventions for all of the residents. CNA 4 that staff were typically educated on new fall prevention interventions during rounds. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/4/24 at 9:47 AM an interview with Licensed Practical Nurse (LPN) 1 was conducted. LPN 1 stated that if a resident had an unwitnessed fall, the nurses are expected to initiate neurological checks, assess for injuries, check range of motion, ask the resident about pain, assess the residents baseline, complete a skin check, and identify any immediate injuries. LPN 1 stated that staff are expected to inform the DON, complete an incident report, and try to identify the cause of the fall. On 4/4/24 at 11:40 AM an interview with the DON was conducted. The DON stated that the facility conducts a fall committee meeting weekly. The DON stated that the fall committee members included herself, the unit managers, sometimes social services, and the activities members. The DON stated that recent falls, trends and new interventions were discussed in the fall committee meetings. The DON stated that all new interventions were placed in the care plan. The DON stated that new interventions were implemented after each fall. The DON stated that after a resident fell , an incident report was completed, and the fall was discussed in the interdisciplinary team meeting.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review, it was determined, for 1 of 26 sampled residents, that the facility failed to ensure PRN (as needed) orders for psychotropic drugs were limited to 14 days, unless the attending physician or prescribing practitioner believes that it was appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. Specifically, a PRN order for Ativan was ordered for more than 21 days. Resident identifier: 16. Findings include: 1. Resident 16 was admitted to the facility on [DATE] with diagnoses which included encounter for palliative care, dysphagia, major depressive disorder, Alzheimer's disease, chronic kidney disease, anxiety disorder, dementia, hypertension, and type 2 diabetes mellitus. Resident 16's medical record was reviewed from 4/1/24 through 4/4/24. A BIMS (Brief Interview for Mental Status) V3 dated 10/19/23 at 7:08 PM indicated that Cognitive Skills for Daily Decision Making was, Severely Impaired: never/rarely made decisions. A [Company Name Redacted] Hospice Physician Order dated 3/14/24 at 10:33 AM indicated, Start Lorazepam 2 MG/ML [milligram/milliliter] solution. Give 0.25 ML PO/SL [by mouth/sublingual] every 2 hrs [hours] as needed for restlessness or anxiety. No end date was included in the medication order. A physician's order dated 3/14/24 at 6:00 PM indicated, LORazepam Oral Concentrate 2MG/ML (Lorazepam) *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Anxiety. No end date was included in the medication order. A Psychotropic Medication Review dated 3/17/24 at 8:44 PM indicated that Lorazepam Oral Concentrate 2 MG/ML with a dosage of 0.25 ml every 2 hours as needed was reviewed. It further indicated the Committee Recommendation was to maintain current medication dosages. The Medication Administration Record dated 3/1/24-3/31/24 indicated Lorazepam Oral Concentrate 2MG/ML [milligram/milliliter] (Lorazepam) *Controlled Drug* Give 0.25 ml by mouth every 2 hours as needed for Anxiety, was administered on 3/15/24 at 1:07 AM, 8:41 AM, and 1:34 PM; and on 3/21/24 at 12:10 PM. On 4/4/24 at 12:20 PM, a concurrent interview was conducted with the Director of Nursing (DON) and the Corporate Resource Nurse (CRN). The DON stated the hospice company did not want to follow the 14-day rule. The CRN stated that the Ativan medication should have been limited to 14 days for PRN medications and that the medication should have probably been discontinued because the resident was not using it.