STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465078	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	4285 South Highland Drive Holladay, UT 84124

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on interview and record review, the facility did not electronically transmit encoded, accurate, and complete Minimum Data Set (MDS) data to the Centers for Medicare and Medicaid Services (CMS) system within 14 days of completing a resident's assessment. Specifically, for 1 out of 58 sampled residents, the facility did not transmit a resident's completed discharge MDS assessment to CMS. Resident identifier: 57. Findings included: Resident 57 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses of polyosteoarthritis, pain in left hip, carpal tunnel syndrome bilateral upper limbs, cerebral infarction due to embolism of left middle cerebral artery, essential hypertension, noninfective gastroenteritis and colitis, major depressive disorder, insomnia, ischemic optic neuropathy right eye, and ischemic optic neuropathy left eye. Resident 57's medical record was reviewed from 6/3/24 through 6/11/24. A discharge MDS assessment was completed on 1/31/24. Question A0140 of the assessment had the response, Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State, The assessment submission information stated, Do not submit to CMS. On 6/5/24 at 2:11 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that the discharge MDS assessment for resident 57 had been completed, but it had not been transmitted to CMS because she had marked that the facility did not have Medicare or Medicaid certified beds on question A0410 of the assessment.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Specifically, for 1 out of 58 sampled residents, a resident's antihypertensive medication was not held when the diastolic blood pressure (DBP) was below the physician's ordered parameters. Resident identifier: 8. Findings included: Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, Parkinson's disease without dyskinesia without mention of fluctuations, major depressive disorder, generalized anxiety disorder, dementia, chronic pain, and essential hypertension. Resident 8's medical record was reviewed on 6/6/24. On 4/28/23, a physician's order documented dilTIAZem HCl [hydrochloride] ER [extended release] Oral Tablet Extended Release 24 Hour (Diltiazem HCl) Give 240 mg [milligrams] by mouth one time a day for Hold for SPB [sic] [systolic blood pressure] < [less than] 120, DBP < 80, or P [pulse] < 60 related to ESSENTIAL (PRIMARY) HYPERTENSION. A review of the May and June 2024 Medication Administration Record documented when the DBP was less than 80 and the diltiazem was administered to resident 8 when it should have been held according to the physician's order. a. On 5/2/24, 162/77 b. On 5/10/24, 151/78 c. On 5/14/24, 130/77 d. On 5/15/24, 135/79 e. On 5/16/24, 134/66 f. On 5/20/24, 128/74 g. On 5/23/24, 134/76 h. On 5/25/24, 131/77 i. On 5/27/24, 153/76 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. On 5/28/24, 160/64 k. On 5/31/24,142/78 l. On 6/1/24, 136/76 m. On 6/3/24, 130/76 n. On 6/4/24, 132/76 o. On 6/5/24, 130/77 p. On 6/6/24, 116/74 On 6/10/24 at 10:50 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 reviewed the diltiazem physician's order and stated that she was unsure how the physician's order was wrote and she would need to get clarification. On 6/10/24 at 12:28 PM, an interview was conducted with RN 2. RN 2 reviewed the diltiazem physician's order and stated that yes if any of the parameters were below what was specified then the medication should be held. RN 2 stated that the floor nurses would input the physician's orders or sometimes the Director of Nursing (DON) or the Assistant Director of Nursing would help. On 6/10/24 at 12:39 PM, an interview was conducted with the DON. The DON reviewed the diltiazem physician's order and stated that yes it should be held when any of those parameters were outside of what the physician had ordered. The DON stated it was usually to hold with the systolic blood pressure was below the physician's ordered parameters. The DON stated that she would check with the doctor. On 6/10/24 at 12:53 PM, a follow up interview was conducted with the DON. The DON stated the doctor had changed the physician's order because resident 8 usually ran in the 70's anyway's. The DON stated that the doctor changed the physician's order to hold if the DBP was below 90.

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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** 33215 Based on interview and record review, the facility did not ensure that residents who used psychotropic drugs received gradual dose reductions (GDR) unless clinically contraindicated, in an effort to discontinue these drugs. A GDR must be attempted in two separate quarters, with at least one month between attempts, within the first year in which an individual was admitted on a psychotropic medication or after the facility had initiated such medication, and then annually. Specifically, for 1 out of 58 sampled residents, a resident taking an antidepressant medication for insomnia had not received a GDR on that medication since 2022, and the medication was not clinically contraindicated. Resident identifier: 23. Findings included: Resident 23 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, cerebral infarction due to embolism, nontraumatic subarachnoid hemorrhage, spastic hemiplegia affecting left nondominant side, pseudobulbar affect, dysphagia, aphasia, major depressive disorder, insomnia, hypotension, and cognitive communication deficit. Resident 23's medical record was reviewed on 6/6/24. On 5/20/22, a physician's order documented traZODone HCl [hydrochloride] Tablet Give 50 mg [milligrams] by mouth at bedtime for insomia [sic]. The physician's order was discontinued on 7/13/22. On 7/14/22, a physician's order documented traZODone HCl Tablet 50 MG Give 1 tablet by mouth at bedtime related to INSOMNIA, UNSPECIFIED. A physician documented clinical contraindication was unable to be located. On 3/28/24, a Nurses Note documented Note Text : IDT [Interdisciplinary Team] psychotropic review. Reviewing abilify, bupropion and trazodone. Tracking in place. Consent in place. Defer to [behavioral health name redacted.] [Note: The progress notes were reviewed from June 2023 to current. This Nurses Note was the only psychotropic review note able to be located.] On 6/11/24 at 10:24 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the psychotropic meetings were held monthly and a note was made. The DON stated that the Pharmacist consultant attended the psychotropic meetings. The DON stated she would do a piece of the alphabet and new admissions so residents did not get missed. The DON stated she would look at the residents who were in the window for a GDR, look at the alert charting to see if the resident had failed a GDR, and looked at where the residents were at with their medications. The DON stated they had tracking in place for behaviors, we make sure the medications had the right diagnosis, and look at the resident's Preadmission Screening and Resident Review level 2. The DON stated that not having a GDR of the trazodone probably had something to do with resident 23's spouse.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not obtain laboratory (lab) services only when ordered by a physician; physician assistant; nurse practitioner, or clinical nurse specialist. Specifically, for 1 out of 58 sampled residents, a resident had a basic metabolic panel (BMP) collected on two occasions without a physician's order. Resident identifier: 12. Findings included: Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affection right dominant side, type 2 diabetes mellitus, dementia, altered mental status, atrial fibrillation, cognitive communication deficit, protein-calorie malnutrition, dysphagia, major depressive disorder, anxiety disorder, and essential hypertension. Resident 12's medical record was reviewed on 6/10/24. A physician's order with a start date of 5/15/24, documented BMP to be drawn three times weekly on Monday Wednesday and Friday, Noc [night] shift to print order and put it in the lab book. one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday]. The physician's order was discontinued on 6/2/24. On 6/3/24, a Lab Results Report documented that a BMP was collected and completed. No documentation could be located or provided to indicate a physician's order was written for the lab collected on 6/3/24. On 6/4/24 at 1:00 AM, an encounter documented by the Medical Director (MD) documented . Chief Complaint / Nature of Presenting Problem: Lab results review Hypernatremia Hypokalemia Hyperchloremia History Of Present Illness: . We will recheck pt [patient] BMP again in 2 days. Follow-up Plan: . We will recheck pt BMP again in 2 days. On 6/4/24 at 5:30 PM, a Nurses Note documented Note Text: New orders to increase tube feed freewater by 20mL/hr [milliliters per hour] to treat hypernatremia, recheck BMP in 3 days on 6/7/24, and to increase AM Lantus dose to 13 units r/t [related to] high blood sugars. Orders placed in PCC [electronic medical record system], copy of order placed in lab book, and amount of water flush changed on feeding machine. On 6/4/24 at 8:15 PM, an Alert Charting Note documented Reason for alert charting : med [medication] changes Interventions: AM Lantus increased to 13U [units]; increase water flush with his enteral feeding to 80ml/hr r/t DX [diagnosis] of hypernatremia; BMP to be drawn in 3 days (6/7/24) . On 6/5/24, a Lab Results Report documented that a BMP was collected and completed. No documentation could be located or provided to indicate a physician's order was written for the lab collected on 6/5/24. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order with a start date of 6/7/24, documented Check BMP on 6/7/24 one time only for 1 Day. A physician's order with a start date of 6/10/24, documented BMP to be drawn weekly on mondays. one time a day every Mon for labs. The physician's order was created on 6/3/24. On 6/10/24 at 3:09 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that when she got a lab order she would put it into the computer, print the face sheet and lab order, and put the face sheet and lab order in the lab book on the date to be drawn. RN 1 stated if the lab was not an urgent lab the lab came every Monday, Wednesday, and Friday. RN 1 stated that urgent labs were drawn in house and the lab would come pick them up. RN 1 stated there was a lab tracking sheet in the front of the lab book and the nurse communication book. RN 1 stated that she would update the resident's family with everything. RN 1 stated that she would inform the resident's family before the lab was drawn, why the lab was being drawn, and the results of the lab. On 6/10/24 at 3:15 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that first thing in the morning should would check the labs. The ADON stated the outside lab company had an on-line service that she was able to review. The ADON stated that when the lab was ordered she would write it down and make sure it got done. The ADON stated if the lab was an ongoing lab she would track the lab. The ADON stated she would pull and print the lab orders for the lab book. The ADON stated she would check the results screen, any unmatched labs were matched to the residents, and she would make sure the MD signed the labs. The ADON stated that urgent labs were draw by the staff and the labs would be sent with the courier. The ADON stated that the courier was usually at the facility within an hour. The ADON stated that results with urgent labs were fairly quickly, same day, and the lab would fax the results to the facility. The ADON stated that sometimes the MD would give verbal orders and those were hard to track.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47432 Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, several surfaces that came into contact with food or food preparation utensils were found to be dirty, staff were observed to not practice hand hygiene, food was exposed to open air, and there were several instances of potential physical food contaminants. Findings included: On 6/5/24, an inspection of the facility kitchen was conducted. On 6/5/24 at 11:26 AM, an observation was made of a metal rack used to store clean meal trays after they were sent through the dishwasher. There was metal plating surrounding the metal rack. The metal plating was noted to be rusty. There was a meal tray touching the rusty surface. There was also a small red bug crawling on the metal rack. On 6/5/24 at 11:29 AM, an observation was made of a vent blowing air from the ceiling. The vent was noted to be covered in a thick layer of dust. On 6/5/24 at 11:34 AM, an observation was made of a metal storage cart used to store clean baking sheets. The racks of the cart were noted to be dirty and covered in food crumbs. The dirty racks were in contact with the baking sheets. On 6/5/24 at 11:52 AM, an observation was made of a container of coffee grounds. The container of coffee grounds did not have a lid on it and was open to the air. The coffee grounds were not actively in use. On 6/5/24 at 12:14 PM, an observation was made of the lunch tray line. Dietary Aide (DA) 1 was observed grabbing their cell phone out of their pocket and looked at the phone screen. DA 1 put the phone back in their pocket. DA 1 then wrote in permanent marker on the saran wrap covering a hotel pan full of chicken noodle soup. DA 1 then opened the walk-in fridge and placed the soup in the fridge. DA 1 then wiped their right arm across their forehead. DA 1 then touched a cup of hot chocolate. DA 1 dumped out the hot chocolate and opened a new packet of hot chocolate powder and poured it into the cup. DA 1 then took a cart full of meal trays from the kitchen to the hallway. DA 1 was not observed to wash their hands during the series of events. On 6/5/24 at 12:17 PM, an observation was made of a stack of clean plates on a drying rack. The plate on top of the stack of dishes was noted to still have food debris on it. On 6/5/24 at 12:18 PM, an observation was made of the ceiling above food preparation areas. The ceiling was noted to have food debris and stains. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 1:48 PM, an interview was conducted with the Assistant Dietary Manager (ADM). The ADM stated that there is a cleaning schedule for the kitchen. The ADM stated that the kitchen should be cleaned daily. On 6/6/24 at 3:02 PM, an additional interview was conducted with the ADM. The ADM stated that the kitchen staff were actually responsible for cleaning the vents in the kitchen, not maintenance. The ADM stated that the vents were not on the kitchen cleaning list, but they had been added and that she had stayed late the previous night to clean the vents.