STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Orchard Park	740 North 300 East Orem, UT 84057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on facility policy review, facility document review, and interview, the facility failed to develop written procedures for investigating allegations of abuse, misappropriation, and exploitation. The policy failed to include the procedures of a thorough investigations to include identification of staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation; investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment had occurred; or providing complete and thorough documentation of the investigation. This affected 1 (Resident #190) of 1 abuse investigations reviewed. Findings include: A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 10/2024, revealed, Residents have the right to be from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy indicated, 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements. The policy review revealed it did not include the procedures of a thorough investigation to include identification of staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation; investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment had occurred; or providing complete and thorough documentation of the investigation. Facility document review on 03/05/2025 at 12:45 PM revealed a two-hour state reportable notification, Form 358, was electronically filed with the state survey agency on 10/31/2024 regarding a report of sexual abuse on 10/29/2024. The report indicated Resident #190 reported that a male staff member touched the resident with his hand in an appropriate manner. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Orchard Park	740 North 300 East Orem, UT 84057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed a five-day follow-up report, Form 359, was electronically submitted to the state survey agency on 11/06/2024 that indicated the facility completed its report with sufficient information for the results of the investigation. The facility concluded the allegation could not be verified. A review of the facility's abuse allegation documents indicated the facility did not have documented evidence of a thorough investigation, including the interviews that were conducted during the investigation. During an interview 03/05/2025 at 4:11 PM, the Administrator stated regarding the allegation made by Resident #190 that he interviewed the staff and wrote it down; and interviewed the one male staff member who worked that day. The Administrator stated he summarized the interviews by the resident, doctor, and the male staff member on duty on Form 359 (the five-day follow-up electronic submission investigation form to the state survey agency). When asked for a copy of the interviews, the Administrator then stated he did not write down any interviews for the resident, the doctor, or the staff member interviewed, and the Director of Nursing (DON) filled out some of the information on the form. During an interview regarding the allegation made by Resident #190 on 03/06/2025 at 11:26 AM, the Director of Nursing (DON) stated there were no other discussions with any other persons other than the nurse, the aide, and the resident. The DON stated he did not ask any residents if there were any issues with their care and the social worker during that time would have talked with the residents. The DON stated he just looked at the schedule and tried to figure who the male person was, but identified the persons who would have cared for the resident during that time. During a follow up interview on 03/06/2025 at 12:16 PM, the Administrator stated he discussed the allegation made by Resident #190 with the doctor who reported it, the DON, the aide, the resident, and another person; but could not remember who. The Administrator stated he did remember interviewing a resident but could not remember if there was anyone else. The Administrator stated the facility had a form containing general questions to the residents and they would document that, but this was not done at the time of the incident. The Administrator stated the only documentation he had was what was on Form 359 (five-day follow-up investigation). The Administrator stated he looked at the resident's past and the circumstances, then he interviewed the one male who was on staff during that time. On 03/06/2025 at 10:20 AM, the Administrator stated the facility did not have a policy for abuse investigations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Orchard Park	740 North 300 East Orem, UT 84057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and review of facility policy, the facility failed to maintain a medication error rate of less than 5%. Observations of medication pass administration revealed 3 errors out of 30 opportunities which resulted in a 10% (percent) medication error rate. This affected 2 (Resident #21 and #90) of 2 residents observed during medication pass. Resident #21 was given one drop of artificial tears, instead of two drops. Resident #90 was given one drop of artificial tears, instead of two drops; and was administered magnesium 500 milligrams (mg), instead of magnesium 400 mg. Findings included: A facility policy titled, Administering Medications, revised in 02/2025, indicated, 4. Medications are administered in accordance with prescriber orders, including any required time frame. The policy also indicated, 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 1. An admission Record indicated the facility admitted Resident #21 on 04/29/2024. According to the admission Record, Resident #21 had a medical history that included diagnoses of insomnia and CREST syndrome (an autoimmune disease that causes thickening and hardening of the skin). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/23/2024, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident had intact cognition. Resident #21's March 2025 Order Summary Report contained an order, dated 02/24/2025, for Artificial Tears Ophthalmic Solution 0.5-0.6% (percent), polyvinyl alcohol-povidone, instill 2 drops in both eyes three times a day for dry eyes. During medication pass observation on 03/04/2025 at 7:30 AM, Registered Nurse (RN) #1 administered one drop of Refresh tears (artificial liquid tear solution) into Resident #21's right and left eye. Resident #21's March 2025 Medication Administration Record indicated RN #1 electronically documented in the electronic medical record that Artificial tears ophthalmic solution 0.5-0.6%, instill 2 drop [sic] in both eyes three times a day for dry eyes was administered at 7:30 AM on 03/04/2025. During an interview on 03/04/2025 at 9:30 AM, RN #1 stated she administered one drop of the artificial tears into each of Resident #21's eyes and she should have administered two drops into each eye. 2. An admission Record indicated the facility admitted Resident #90 on 02/25/2025. According to the admission Record, Resident #90 had a medical history that included a diagnosis of type 2 diabetes mellitus without complications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Orchard Park	740 North 300 East Orem, UT 84057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #90's March 2025 Order Summary Report contained an order dated 03/03/2025, for Artificial Tears Ophthalmic Solution (Artificial Tear Solution), Instill 2 drop [sic] in both eyes two times a day for dry eyes, and an order dated 02/25/2025, for Magnesium Oxide Oral Tablet 400 mg (Magnesium Oxide), give 400 mg by mouth every 8 hours for nausea, vomiting, diarrhea. During medication pass observation on 03/04/2025 at 7:50 AM, Registered Nurse (RN) #1 administered one drop of Refresh tears (artificial liquid tear solution) into Resident #90's right and left eye and also gave magnesium 500 mg one tablet to be taken orally. Resident #90's March 2025 Medication Administration Record indicated RN #1 electronically documented in the electronic medical record that Artificial tears ophthalmic solution instill 2 drop in both eyes two times a day for dry eyes and Magnesium Oxide supplement oral tablet 400 mg were administered at 8:00 AM on 03/04/2025. During an interview on 03/04/2025 at 9:30 AM, RN #1 stated she administered one drop of the artificial tears into each of Resident #90's eyes and she should have administered two drops into each eye. RN #1 then stated she realized she administered more magnesium to Resident #90 than the physician order. RN #1 stated she did not believe the facility had a 400 mg tablet. RN #1 stated she had been trained and was expected to administer medications based on the physician orders, and if she noticed that she did not have the medication needed based on the medication administration record, then she should check the medication room to see if the medication was available there. Observation of the medication room on 03/04/2025 at 10:15 AM revealed two magnesium 500 mg tablet bottles located on the medication shelf. During an interview on 03/04/2025 at 10:43 AM, the Director of Nursing (DON) stated the process for ensuring staff were administering the right medications was to ensure the nurses used the five rights of medication administration. The DON stated if a required medication was not in stock, then staff ordered the medication through the electronic medical record from the pharmacy. The DON stated the Supply Manager was responsible for reordering house supplements and vitamins and if a supplement or vitamin was not available, that was communicated to the physician. The DON stated staff had been trained and were expected to administer medication based on the physician's orders. During an interview on 03/04/2025 at 11:52 AM, the Administrator stated his expectation was that all clinical staff administered the correct medications within the acceptable window of time as prescribed by the doctors' group. The Administrator stated staff received orientation training when they first arrived at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Orchard Park	740 North 300 East Orem, UT 84057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview, Centers for Disease Control (CDC) guidelines, and a review of Occupational Safety and Health Administration (OSHA) Respiratory Protection Guide, the facility failed to ensure all facility staff members had been fit tested for N95 respirators. This had the potential to affect 36 out of 36 residents residing in the facility. Findings included: The facility did not have a policy for fit testing N95 respirators. According to a United States Food and Drug Administration (FDA) publication, dated 10/21/2024, titled N95 Respirators, Surgical Masks, Face Masks, and Barrier Face Coverings, an N95 respirator is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. A CDC publication, titled Infection Control Guidance: SARS-CoV-2 [severe acute respiratory syndrome coronavirus 2, a strain of coronavirus that causes COVID-19] dated 06/24/2024, indicated under the section Personal Protective Equipment, HCP [healthcare personnel] who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH [National Institute for Occupational Safety and Health] Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Respirators should be used in the context of a comprehensive respiratory protection program, which includes medical evaluations, fit testing and training in accordance with the Occupational Safety and Health Administration's (OSHA) Respiratory Protection standard. A review of OSHA's Respiratory Protection Guide, not dated, indicated, Ensure that any worker using a tight-fitting respirator (e.g., N95 FFR [filtering facepiece respirators]) is fit-tested prior to initial use of the respirator, whenever a different respirator size, style, model or make is used, and at least annually thereafter. Passing a fit-test is important because it ensures that the size, make, and model of the respirator can provide a proper facial seal to offer the expected level of protection to the wearer. During an interview on 03/05/2025 at 9:48 AM, the Infection Preventionist (IP) stated the facility had not fit tested anyone for N95 respirators since she started working there two and a half years ago. During a follow up interview on 03/05/2025 at 11:45 AM, the IP stated she was not sure why the facility quit fit testing staff members for N95 respirators. The IP stated she was not aware fit testing was still a requirement. The IP stated the importance of fit testing staff for N95 respirators was to ensure the N95 respirators would be effective and stated the facility was going to resume fit testing of all staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465090	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Orchard Park	740 North 300 East Orem, UT 84057

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/05/2025 at 12:00 PM, the Director of Nursing (DON) stated he started working there about seven months prior and he had not been fit tested for an N95 respirator. The DON stated fit testing for N95s should be done annually and was required by the company. The DON stated fit testing was important, because without a proper fitting mask there could be an increase in transmission rates of COVID-19 and did not know why fit testing was not being done. The DON stated he would expect staff to be properly fit tested upon hire and annually but stated the facility did not have a policy for fit testing requirements. The DON stated the facility followed OSHA guidance. During an interview on 03/05/2025 at 12:12 PM, the Administrator stated he had been the Administrator at the facility for a year and a half. The Administrator stated nurse management helped with the process of fit testing staff for the N95 respirator, and he did not know how long the facility had not been fit testing staff. The Administrator stated as far as he knew the facility was fit testing staff but stated he had not been fit tested for an N95. The Administrator stated it was important to have a properly fitted N95 respirator to keep from transmitting viruses such as COVID-19 or the flu. The Administrator stated he was not aware of how often staff were supposed to be fit tested, but he would expect regulations to be followed when it came to fit testing staff.