STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465091	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Draper Rehabilitation and Care Center	12702 South Fort Street Draper, UT 84020

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide care to prevent pressure ulcers. Specifically, for 1 out of 26 sampled residents, a resident developed a pressure ulcer from wearing an ankle foot orthosis (AFO) device. This resulted in a harm. Resident identifier: 7.Findings included: Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, essential tremor, difficulty in walking, generalized muscle weakness, and unsteadiness on feet.On 11/17/25 at 10:23 AM, an interview and observation was conducted with resident 7. Resident 7 stated that she had a wound on her left heel that she had for a very long time. Resident 7 was sitting in her wheelchair with her left foot wrapped and in an off-loading boot. Resident 7's medical record was reviewed on 11/17/25 through 11/24/25.A review of resident 7's progress notes revealed the following:a. On 2/23/24 at 4:19 PM, an order note documented, REFER TO [name redacted] CLINIC TO REFIT/REPLACE AFO 2/28/24 @ [at] 11AM.b. On 1/7/25 at 3:11 PM, a nursing note documented, Noted swelling and indentation from brace. No open areas. Educated staff on removal while at rest and immediately at HS [bedtime] post transfer into bed. Reported to wound care team and to PT [physical therapy]. MD [medical doctor] aware.c. On 2/21/25 at 1:07 PM, a note documented, New R [right] buttock, sacral, and L [left] heel wounds.Tx [treatment] updated per [name redacted] NP [nurse practitioner]. Pt [patient] tol [tolerated] well. Pt to not wear AFO for now. Pt continues air mattress and pad for w/c [wheel chair]. Frequent repositioning. Pt started on liquacel, vitamin c, and multivitamin to promote wound healing. Family & provider aware of progress. WCTM [will continue to monitor].d. On 2/25/25 at 5:23 PM, a note documented, L HEEL BLISTER; PAINT SURE PREP THEN COVER WITH SILICON BORDERED FOAM QOD [every other day] AND PRN [as needed] every day shift every other day Start Date: 2/26/2025 clear fluid filled blister noted today that may have come from wearing AFO.e. On 3/7/25 at 4:33 PM, a note documented, Wound to L heel heel intact fluid filled blister continues, R buttock and sacral wound stage 2 continue. Pt tol tx well. Pt continues offloading boots and not to wear AFO for now.f. On 3/13/25 at 12:51 PM, a note documented, Seen by wound NP today. L heel blister is bigger with blood in it. Now a DTI [deep tissue injury] and NP assessed for any pressure causing the blister to get worst [sic]. Resident wears offloading boot all the time. Encouraged also to float with pillows. Consulted PT to make sure wheel chair is not causing pressure to heel. PT removed wheel chair foot strap to see if that makes a difference. Resident aware of TP [treatment plan].g. On 4/18/25 at 1:19 PM, a note documented, Wound to L heel continues, 100% dry eschar with new blood blister to wound margin. NP aware. Pt tol tx well. Pt continues air mattress and offloading boots. Pt continues supplements to promote wound healing. Family & [and] provider aware of progress. WCTM.h. On 6/12/25 at 12:49 PM, a note documented, L heel wound 75% unstageable 25% dry eschar. Pt continues air mattress and roho cushion. Pt to not wear AFO for now. Pt continues multivitamin, vitamin c, and liquacel to promote wound healing. Diabetic mgmt [management] perprovider [sic] orders. Family & provider aware of progress. WCTM.i. On 11/6/25 at 12:59 PM, a note documented,Seen by wound NP today and she debrided the L heel wound. Resident tolerated well. Scant bleeding noted from the debridement. Updated treatment started. Resident was (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 0686 Level of Harm - Actual harm Residents Affected - Few	notified of the TP and she verbalized understanding.A review of resident 7's wound notes revealed:a. On 2/27/25, a wound progress note documented, .Left Heel is a Stage 2 Pressure Ulcer acquired on 2/27/25 and has received a status of Not Healed.b. On 3/31/25, a wound progress note documented, .Wound #1 Left Heel is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer acquired on 2/27/25 and has received a status of Not Healed.There is no change noted in the wound progression.c. On 7/24/25, a wound progress note documented, . Wound #1 Left Heel is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer acquired on 2/27/25 and has received a status of Not Healed.small open area noted approx [approximately] 5-6 o'clock with epithelialization noted to area.d. On 8/7/25, a wound progress note documented, . Patient given update on stability of wound # 1 with the eschar remaining stable. Will talk with therapy to ensure no pressure is being applied to that area with her therapy sessions.e. On 11/6/25, a wound progress note documented, . The wound is deteriorating.eschar is no longer stable.f. On 11/13/25, a wound progress note documented, . Wound #1 Left Heel is a Stage 3 Pressure Injury Pressure Ulcer acquired on 2/27/25 and has received a status of Not Healed.Adipose is exposed. There is a Moderate amount of sero-sanguineous drainage noted which has no odor.On 11/19/25 at 1:05 PM, an interview was conducted with the Wound Nurse. The Wound Nurse stated that resident 7's pressure ulcer had started as a blood blister and the facility tried to keep it from bursting, but it burst. The Wound Nurse stated that a Nurse Practitioner from an outside wound service came and rounded on the pressure ulcer weekly. The Wound Nurse stated that resident 7 got the pressure ulcer from wearing her AFO device. The Wound Nurse stated that the pressure ulcer was avoidable. On 11/19/25 at 1:33 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that she tried to round on every resident every two hours and would check for wet briefs. NA 1 stated that she would reposition residents only if they needed a brief change. On 11/19/25 at 1:35 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 7 could not move the left side of her body. CNA 1 stated that resident 7 frequently needed her feet and hips repositioned because she could not move them. CNA 1 stated that resident 7's feet would slip off the foot pedal of her wheelchair and would come out of her offloading boots often.On 11/20/25 at 8:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that CNAs were the nursing staff that repositioned residents and she expected them to reposition residents in a timely manner. The DON stated that therapy managed any braces that residents used and no order was placed in the resident's medical record. The DON stated that resident 7 had an AFO device and it caused a pressure ulcer. The DON stated that the therapy department was responsible for teaching staff about how to properly use an AFO device. The DON stated that AFO's can cause pressure and she hoped that they fit residents correctly. The DON stated that nursing staff should monitor the site because they put the device on and off resident 7. The DON stated that resident 7 had the AFO device placed in the morning and then it was removed at night before bed. On 11/20/25 at 8:23 AM, an interview was conducted with the Director of Rehab (DOR). The DOR stated that AFO devices should only be worn during weight-bearing or transferring for joint stability. The DOR stated that an AFO device was hard plastic and could cause skin irritation and wounds. The DOR stated that resident 7 did not need to have the AFO device on while she was sitting in her wheelchair because her foot was in the correct position and the AFO was not needed. The DOR stated that an AFO device should only be worn for 4-6 hours if the resident was doing any weight bearing activities.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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, there were undated food items stored in the refrigerator, dry storage, and freezer, a beardnet was not worn by a dietary aide; resident refrigerators' had undated and opened juice and food, and the sanitizer bucket was not testing at the required sanitation levels.Findings included:1. On 11/17/25 at 8:36 AM, an initial tour of the kitchen was conducted. The following observations were made:a. A box of fudgesicles was opened and undated in the freezer.b. Two Boston Cream pies were undated in the freezer.c. A container of sugar free lemonade was not labeled and undated in the refrigerator.d. A container of juice was not labeled and undated in the refrigerator.e. An opened and undated bag of hardboiled eggs was in the refrigerator.On 11/17/25 at 8:43 AM, during the initial tour of the kitchen, the Dietary Manager (DM) stated that the sanitizer bucket had been changed this morning at 7:00 AM. An observation was made of the DM testing the sanitizer bucket. The testing strip stayed orange which meant that no chemical was measured. The DM stated that he came in this morning and checked the sanitizer bucket logs and thought that it was done but it appeared that it had not been done.On 11/17/25 at 8:45 AM, the DM changed the sanitizer bucket solution and retested. The strip turned green and showed the level at 200 PPM (parts per million). The DM stated that 200 PPM was the correct level. 2. On 11/17/25 at 9:00 AM, an observation of the resident refrigerator was made. The following were observed:a. The resident fridge had an opened container of apple juice.b. The resident fridge had an opened container of prune juice with a date of 4/5 on the lid.c. The resident fridge had a container of macaroni and cheese and chicken nuggets with a date of 11/6/25.3. On 11/20/25 at 11:20 AM, a follow-up tour was conducted of the kitchen. The following was observed during the lunch tray line:a. The dietary aide was observed to have a beard and was not wearing a beard net.b. There was an opened bag of cabbage that was undated in the refrigerator.c. At 11:39 AM, the cook washed her hands and put gloves on. d. At 11:41 AM, the cook opened the oven while wearing the same gloves.e. At 11:42 AM, the cook touched the Brussels sprouts with the same gloved hands and then left the station to open a drawer and get another scoop. f. At 11:43 AM, the cook left her station with the same gloved hands and got a ladle. g. At 11:44 AM, the cook picked up a roll with gloved hands and touched Brussels sprouts with the same gloved hands.h. At 11:45 AM, the cook touched pasta on the plate with the same gloved hands, picked up a roll and placed it on a plate, and then left her station to get into the oven to get pot pies out to check the temperature. The pot pies were not at the correct temperature and the cook put them back into the oven while wearing the same gloves.On 11/20/25 at 11:33 AM, an interview was conducted with the DM. The DM stated that everything in the refrigerator, freezer, and dry storage should have a date of when it was received and when it was opened. The DM stated that the sanitizer bucket was changed every 2-3 hours and was changed before every meal service. The DM stated that he got rid of all the food and beverages that were undated after the initial walk through of the kitchen was done. On 11/20/25 at 12:50 PM, a follow-up interview was conducted with the DM. The DM stated that facial hair was a gray area and that the Dietary Aide should have a beard net on. The DM stated that his expectations of the kitchen staff were to change gloves when you change what you were doing or if you were dishing up food then gloves stay on unless they were ripped or dirty. The DM stated that if you leave your area and go to the oven then you need to change gloves. On 11/24/25 at 9:06 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that housekeeping cleaned out the resident refrigerator. The DON stated that resident food should be labeled and dated. The DON stated that food in the resident refrigerator was usually good for five days after it had been opened.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents who use psychotropic drugs received a gradual dose reduction (GDR), unless clinically contraindicated, in an effort to discontinue these drugs. Specifically, for 4 out of 26 sampled residents, residents did not have an attempted GDR for psychotropic medications. Resident identifiers: 4, 9, 10, and 11.Findings included:1. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, cognitive communication deficit, dementia, generalized anxiety disorder, and mood disorder due to known physiological condition with depressive features. Resident 4's medical record was reviewed. A physician's order dated 1/12/23, documented to monitor hours of sleep every shift. According to the November 2025 Medication Administration Record (MAR) resident 4 slept an average of six hours during the night time hours. A physician's order dated 8/8/24, documented valproic acid capsule 125 milligrams (mg) two times (BID) a day for mood. A physician's order dated 8/9/24, documented mood stabilizer: monitor episodes every shift of behavior: angry outbursts. According to the November 2025 MAR there were no behaviors documented. A physician's order dated 8/20/24, documented temazepam capsule 7.5 mg at bedtime for insomnia. The Psychotropic Medication Review Form dated February 2025, documented GDR not indicated related to ongoing depressive and agitated behaviors. The form did not indicate which medications were not to have a GDR. Valproic acid documented zero angry outbursts. No documentation could be found stating a GDR of the valproic acid or temazepam had been attempted since 2024, or that a dose reduction was contraindicated. It should be noted the medical record did not reflect the date of a GDR attempt, the outcome of the dose reduction attempt, or a documented physician rationale for why GDR attempts were clinically contraindicated for each medication. On 11/24/25 at 1:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the resident 4 did not sleep and that was why they had not done a GDR. The DON stated the valproic acid did not have a GDR because resident 4 still had very aggressive behaviors. 2. Resident 11 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, schizophrenia, anxiety disorder, obsessive compulsive disorder, major depressive disorder, and cognitive communication deficit. Resident 11's medical record was reviewed. A physician's order dated 2/3/2020, documented number of hours slept. According to the November (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025 MAR resident 11 slept an average of seven hours during the night time hours. A physician's order dated 7/15/21, documented to monitor episodes of depression every shift as evidenced by negative statements about self/situation. According to the November 2025 MAR there were no behaviors documented. A physician's order dated 8/29/23, documented Lamictal tablet 25 mg. Give two tablets BID for major depressive disorder. A physician's order dated 9/18/23, documented mood stabilizer: monitor episodes every shift of behavior crying/tearfulness. According to the November 2025 MAR there were no behaviors documented. A physician's order dated 9/18/23, documented mood stabilizer: monitor episodes every shift of behavior: angry outbursts. According to the November 2025 MAR there were no behaviors documented. A physician's order dated 10/4/23, documented Cymbalta capsule delayed release 60 mg daily for major depressive disorder. A physician's order dated 7/26/24, documented trazodone tablet 50 mg at bedtime for insomnia. No documentation could be found stating a GDR of the Lamictal or Cymblata had been attempted since 2023, or that a dose reduction was contraindicated. In addition, no documentation could be found stating a GDR of the trazodone had been attempted since 2024, or that a dose reduction was contraindicated. It should be noted the medical record did not reflect the date of a GDR attempt, the outcome of the dose reduction attempt, or a documented physician rationale for why GDR attempts were clinically contraindicated for each medication. On 11/24/25 at 10:55 AM, an interview was conducted with the DON. The DON stated they had only increased resident 11's medications and just got the resident stable. The DON stated when resident 11 first arrived at the facility resident 11 would cry the entire time. The DON stated they tried reducing the Seroquel and the resident continued to have behaviors, so they added the Seroquel back. The DON stated there was a period where resident 11 was stable and doing really well and then resident 11 started the crying again. The DON stated they tried adding Depakote and that was too sedating so the Lamictal was added and resident 11 was stable on the Lamictal. The DON stated that resident 11's husband did not want the medications decreased without his permission. The DON stated there was more of a focus on the high risk medications and they forgot about the antidepressant. 3. Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, anxiety disorder due to known physiological condition, major depressive disorder, cognitive communication deficit, and altered mental status. Resident 10's medical record was reviewed. A physician's order dated 11/30/23, documented monitor episodes every shift of depression as (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evidenced by crying and tearfulness. According to the November 2025 MAR there were no behaviors documented. A physician's order dated 11/30/23, documented monitor and document number of psychotic behavior every shift as evidenced by mood swings. According to the November 2025 MAR there were no behaviors documented. A physician's order dated 12/19/23, documented duloxetine capsule delayed release 30 mg. Give two capsules daily for depression. No documentation could be found stating a GDR of the duloxetine had been attempted since 2023, or that a dose reduction was contraindicated. It should be noted the medical record did not reflect the date of a GDR attempt, the outcome of the dose reduction attempt, or a documented physician rationale for why GDR attempts were clinically contraindicated for each medication. On 11/20/25 at 11:38 AM, an interview was conducted with the DON. The DON stated the psychotropic medication reviews were done on admission and quarterly. The DON stated that all residents were reviewed at the same time. The DON stated the pharmacist, DON, Assistant Director of Nursing, Minimum Date Set (MDS) Coordinator, social services, and the Medical Director attended those meetings. The DON stated they would review behavior tracking and anything that had been done on the floor. The DON stated that they would make medication changes as necessary and review for dose reductions. The DON stated the MDS coordinator would come to the meeting and care plan as they went. The DON stated they were doing other reductions with resident 10 and the team liked to only adjust one medication at a time. The DON stated that resident 10 had been more depressed lately because the granddaughter was going to take her home and then she could not. On 11/20/25 at 11:59 AM, an additional interview was conducted with the DON. The DON stated in April 2024 they were trying to decrease resident 10's Zyprexa because the duloxetine was increased. The DON stated they waited to make sure resident 10 was stable and in January 2025 the Ativan was decreased. The DON stated they waited again and in April 2025 they did not make changes because resident 10 had an infection. The DON stated in July 2025 the Zyprexa was decreased again and in August 2025 they wanted to make sure resident 10 was stable. The DON stated that resident 10 would be reviewed again this month. The DON stated they were trying to decrease the high risk medications first to be free from antipsychotics, benzodiazepines, and be stable. The DON stated that duloxetine was part of resident 10's chronic pain. 4. Resident 9 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, anxiety disorder, and post-traumatic stress disorder. Resident 9's medical record was reviewed from 11/18/25 through 11/24/25. A physician order dated 4/11/22, documented Ativan tablet 0.5 mg BID for anxiety. A review of resident 9's anxiety behavior monitoring revealed resident 9 had no complaints of anxiety or episodes of extreme restlessness during the months of September and November 2025. Resident 9 had eight days during the month of October 2025 where she exhibited symptoms of anxiety and extreme restlessness. Resident 9 complained of anxiety on two days in October 2025. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A psychotropic medication review was conducted. a. On 8/20/24, Ativan 0.5 mg BID; diagnosis: anxiety; Increase/start date: 4/11/22; Target behavior #1: c/o [complaints of] anxiety- 0 episodes. The recommendation was to maintain the dose. b. On 11/19/24, Ativan 0.5 mg BID; diagnosis: anxiety; Increase/start date: 4/11/22; Target behavior #1: Anxiety-0 episodes. The recommendation was to maintain the dose. c. On 2/18/25, Ativan 0.5 mg BID; Increase/start date: 4/11/22; Target behavior #1: c/o anxiety-0 episodes; Target behavior #2: extreme restlessness-0 episodes. Recommended action was to review again in 90 days. d. On 5/20/25, Ativan 0.5 mg BID; diagnosis anxiety; Increase/start date: 4/11/22; Target behavior #1: c/o anxiety-0 episodes. The recommendation was to maintain the dose. No documentation could be found stating a GDR of the Ativan had been attempted since 2022, or that a dose reduction was contraindicated. On 11/24/25 at 12:32 PM, an interview was conducted with the DON who stated resident 9's Ativan had been decreased from four times a day to two times a day a few years ago, but no additional GDR had been attempted. The DON stated that she looked at the dates on the psychotropic meeting forms to determine if and when a dose reduction should be attempted. The DON stated they had reviewed resident 9's orders, psychotropic review meeting notes, and provider notes. The DON stated she was unable to find any documentation stating that there was a contraindication to a GDR of the Ativan. The DON stated that contraindication documentation was something that should be documented and she would discuss it with the team reviewing psychotropics at the next meeting.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that the resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, and metabolic abnormalities. Specifically, for 1 out of 26 sampled residents, a resident was observed lying flat during an enteral tube feed infusion. Resident identifier: 6.Findings included:Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, protein calorie malnutrition, profound intellectual disabilities, dysphagia, and gastrostomy status. On 11/17/25 at 10:31 AM, an observation was conducted of resident 6. Resident 6 was observed laying flat in bed with the tube feeding running and resident 6 had an occasional wet cough. The head of the bed was elevated but resident 6 was laying flat. On 11/17/25 at 10:33 AM, another surveyor verified that resident 6 was laying flat. A bag of Nutren 2.0 was infusing at a rate of 60 milliliters per hour (ml/hr). The water flush bag was infusing at a rate of 75 ml/hr.On 11/18/25 at 1:08 PM, an observation was conducted of resident 6. Resident 6 was observed to be positioned on his left side, laying flat in bed with the tube feeding running. Resident 6 had an occasional wet cough.On 11/19/25 at 1:19 PM, an observation was conducted of resident 6. Resident 6 was observed in bed laying flat with the tube feeding running.Resident 6's medical record was reviewed.A care plan Focus initiated on 12/13/22, documented [Resident name redacted] requires tube feeding r/t [related to] Dysphagia, Swallowing problem, Weight Loss, malnutrition, healing pressure ulcer. 2cal [calorie] tube feeding as ordered.The care plan interventions initiated on 12/13/22, included, but were not limited to, head of bed (HOB) elevated 45 degrees during and thirty minutes after tube feed and elevate HOB at least 30-45 degrees at all times during feeding.A physician's order dated 12/21/23, documented Enteral Feed Order every shift ELEVATE HOB AT LEAST 30 DEGREES DURING FEEDING AND ONE HOUR AFTER.A physician's order dated 9/23/25, documented Enteral Feed Order every shift 2CAL HN (high nitrogen) 60ml/hr with 75ml/hr free h20 [water] continuous.On 11/19/25 at 1:32 PM, an observation and interview was conducted with the Director of Nursing (DON). The DON stated that resident 6 was wiggly in bed. The DON stated that it looked like the staff tried to get resident 6 at 30 degrees. The DON stated that resident 6 would slide down in bed. The DON stated that resident 6 always had a wet cough because resident 6 was unable to swallow his secretions and resident 6 needed suctioning all the time. The DON stated that resident 6 had a peg tube. During the observation the DON adjusted resident 6's HOB. The DON stated that resident 6 was now at a 45 degree angle. The DON observed a pillow that had been placed under resident 6's left side. The DON stated that the pillow that was under resident 6's left side was propping resident 6's belly up so it was even with his chest. The DON stated that she was not aware that the pillows were causing resident 6 to be laying flat. The DON stated that resident 6 was on an air mattress with bolsters. On 11/19/25 at 2:09 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that resident 6's mom was very particular with how resident 6 was positioned in bed and the pillows. LPN 2 stated that resident 6's mom was putting the pillows around resident 6 and not the staff. LPN 2 stated that she would speak with resident 6's mom about not placing the pillows under resident 6. LPN 2 stated that resident 6 moved around in the bed and the staff had to constantly reposition him. LPN 2 stated when resident 6 was awake the staff had to check on him almost every 15 minutes.