STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465092	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uintah Health Care Special Service District	510 South 500 West Vernal, UT 84078

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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 2 out of 22 sampled residents, that the facility failed to ensure that each resident received and the facility provided the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, the facility failed to provide behavioral health care and services to a resident who had expressed a desire to commit suicide and interventions and monitoring were not implemented prior to the resident successfully committing suicide. Additionally, another resident made statements of wanting to hang himself and behavioral health care and services were not provided and interventions and monitoring were not implemented. The deficient practice identified was cited at an Immediate Jeopardy level for both residents. Resident identifiers: 22 and 40. NOTICE On 9/24/25 at 5:31 PM, Immediate Jeopardy (IJ) was identified when the facility failed to implement Centers for Medicare and Medicaid Services recommended practices to ensure each resident had the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, resident 40 successfully committed suicide after expressing this desire to staff and behavioral health services, interventions, and monitoring were not implemented. Additionally, resident 22 made statements of wanting to hang himself and behavioral health services, interventions, and monitoring were not implemented. Notice of the Immediate Jeopardy was given verbally and in writing to the Administrator (ADM) and Director of Nursing (DON). On 9/25/25, the Administrator provided the abatement plan for the removal of the Immediate Jeopardy effective on 9/25/25 at 11:00 AM. The abatement plan for suicide prevention included the following:1. All residents will undergo a mental health screening by a qualified profession (sic) on September 27, 2025. Residents identified as being at risk for suicidal ideation and/or self-harm will receive intervention from the screening professional. Care plans will be updated to reflect these changs {sic} and interventions. In order to keep the residents safe, we will interview each resident today and ask the following questions. I'm here because we want to keep you safe. Have you had any thoughts of harming yourself or wanting to die? If yes: Do you have a plan - what, when, and how? (if yes escalate immediately). If the answer is yes, we will immediately implement our Suicide Prevention/Protocol. If the answer is no, there will be no further action. All documentation will be filed in the resident's chart.2. All current staff will receive suicide prevention training at the beginning of their next scheduled shift. New staff will receive this training during employee orientation. Additionally, all licensed nurses will be trained on the [NAME] Protocol and our suicide prevention policy who are working today and all other nurses will complete before their next shift.3. Charge nurses will monitor progress notes daily starting immediately, revieing the past 36 hours for resident safety risks to be communicated according to our suicide prevention policy/protocol. This monitoring will continue for 90 days. Charge nurses will sign a daily log confirming completion and the Director of Nursing (DON) will monitor this log weekly compliance, communicating any findings to the Administrator.4. [Registered Nurse (RN) 1] interviewed [Resident 22] on 9/25/2025 @ 10:45 using the [NAME] Protocol worksheet. RN 1 has had training from previous employment at the hospital and used this protocol during her employment there. [Resident 22] answered No to questions 1, 2 & 6. He will continue with his current care plan since he is not in immediate danger. On 9/25/25, while completing the recertification survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on 9/25/25. Findings included: 1. Resident 40 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, major depressive disorder, anxiety disorder and insomnia. Resident 40 passed away on 9/13/25 due to a successful suicide attempt. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 40's medical record was reviewed from 9/22/25 through 9/25/25. On 5/30/24, resident 40's admission Minimum Data Set (MDS) documented under the resident mood interview that the resident answered yes to “Little interest or pleasure in doing things”; “Feeling tired or having little energy”; “Trouble concentrating on things, such as reading the newspaper or watching television”; and “Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.” Resident 40 had a severity score of 10, indicating a moderate level of depression. On 8/29/24, resident 40's Quarterly MDS documented under the resident mood interview that the resident answered yes to “Little interest or pleasure in doing things”; “Feeling down, depressed, or hopeless”; “Trouble falling or staying asleep, or sleeping too much”; “Feeling tired or having little energy”; “Poor appetite or overeating”; “Feeling bad about yourself - or that you are a failure or have let yourself or your family down”; “Trouble concentrating on things, such as reading the newspaper or watching television”; “Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual”; and “Thoughts that you would be better off dead, or of hurting yourself in some way.” Resident 40 had a severity score of 26, indicating a severe level of depression. Resident 40's progress notes revealed the following: a. On 5/24/25 at 1:35 PM, the admission Note documented, “Patient is having a hard time; states he wants to hurry and get things going. Friend has brought patient's own brown smooth cover electric chair. [Resident 40] states I want my own chair I don't want to sit in a chair that someone died in, I know how these places are. [Resident 40's] chair was set next to his bed. Medications taken from daughter and reviewed and counted. When going thru [sic] the check list of his room he states I'm not one of these people that are old I'm [AGE] years old and I can do things for myself. I just came in and lost my kids and everything I have to be here. I just want to go to sleep.” b. On 5/27/24 at 2:35 PM, the Behavioral Symptoms note documented, “Resident went into the dining room around 1300 (1:00 PM) and said, ‘I don't know what the hell that noise is, but somebody better get off their ass and fix it or I'm going to blow my fucking top.' Staff reported another resident's call light was going off and the noise upset him. When nurse went to residents room he appeared anxious, he kept rubbing his face with his hands, stating ‘that noise set me off' ‘I'm sorry, I'm too nice of a person for this, this isn't me' ”. c. On 5/27/24 at 4:04 PM, the Behavioral Symptoms note documented, “Resident states his Klonopin medication was increased prior to administration [sic] to [name omitted]. Dosage increase was not reflected in admission medication list. Due to increased agitation this afternoon and treats [sic] to leave the facility to self-medicate Physician was notified. [Physician name omitted], through thorough search of [physician name omitted] notes and clinic records was able to find note of resident's call to clinic on 5/20/24 and Klonopin increased to 2mg [milligram] TID [three times a day]. Dosage clarification received and telephone order to increase dose as follows; 1) Klonopin 2mg PO [by mouth] TID for anxiety.” (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	tt. On 9/13/24 at 3:00 PM, the note documented, “[Name of physician omitted] into see resident. Plan of care reviewed. Resident is c/o [complaining of] pain. Would like pain medication scheduled. [Name of physician omitted] inquired about location of pain. Resident states he has back pain from ‘sitting too much, laying too much, walking too much.' Resident states he is sleeping okay. Resident also states that he spends ‘17 hours a day in bed., but they [sic] denies being in bed. Resident also states that he had a back injury in his L [lumbar] 4-L5 from a car accident 20 years ago. States he has been ‘pissing himself'. Dr. [NAME] asked if resident if he has lost control of his bowel or bladder. Resident states ‘no.' Denies numbness in legs or in the saddle area of his crotch. Resident again states ‘no.' [Name of physician omitted] suggested increased activity and also attending facility activities. Resident states, ‘Not gonna happen.' [Name of physician omitted] inquired reason why? Resident states, ‘They are 80 and I'm not. That activity today was a wheelchair activity. I'm not going.' Resident states he wished marijuana was legal. [Name of physician omitted] states he will not order marijuana. Resident talked in circles and states that ‘this hospital doesn't even know what goes on here.' States he has been seeing his psychiatrist. [Name of physician omitted] stated he didn't know that resident was seeing a psychiatrist. Resident became angry and states, ‘How is it that you don't know me??' [Name of physician omitted] inquired who his psychiatrist is. Resident states, ‘[name omitted]' [Name of physician omitted] states he knows [name omitted] and that she is a counselor and not a psychiatrist. Resident then states he is not depressed and argued about his medication. [Name of physician omitted] states he is happy to help, but will not do it with bad medicine. When resident asks about pain medication, [Name of physician omitted] states he will not prescribe narcotics. Resident becomes upset and states the other stuff doesn't work. Resident states that he can't remember to ask for medication and wants medication scheduled. [Name of physician omitted] states he is able to ask. New orders received: 1) Discontinue flexaril 2) Methocarbamol 750mg 2 tabs Q 8 hours at 0800 [8:00 AM], 1400 [2:00 PM], and 2200 [10:00 PM] x [times] 3 days. then 3) Methocarbamol 750mg 2 tabs PO TID PRN [as needed]- back pain.” uu. On 9/13/24 at 11:33 PM, the note documented, “Call from East side nurse telling nurse to come over for help around 2040 [8:40 PM]. This nurse and [name omitted], RN [Registered Nurse] came over to East side immediately. All nurses ran into resident's room at that time. Curtain was pulled. Resident was laying sideways on the bed, left foot out on the floor and right foot and leg tucked under bottom. Black trash bag was over head and knotted tightly around neck with string, appeared to be from a jacket. Feet, hands, neck were blue. Resident's legs were assisted onto bed, small hand towel was placed over face, bag was ripped and cord was unable to be unknotted, so scissors were obtained to cut off. Face was blue. No pulse found. Resident with DNR [Do Not Resuscitate] status. DON, Administrator, 911, physician notified. All staff out of room at that time until police arrived. DON and Administrator arrived right before police arrived. Police took over investigation at that time.” On 5/31/24, resident 40's signed POLST order documented Do not attempt or continue any resuscitation (DNR) (Allow Natural Death). Resident 40's physician orders revealed the following: a. On 5/24/24, an order was initiated for Klonopin 1mg two times a day (BID) for anxiety disorder. b. On 5/24/24, an order was initiated for Quetiapine 100mg QHS for major depressive disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465092	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Uintah Health Care Special Service District	510 South 500 West Vernal, UT 84078

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

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. On 5/29/24, the Klonopin was increased to 2mg three times a day (TID) at 8:00 AM, 2:00 PM, and 10:00 PM for anxiety disorder. d. On 6/8/24, an order was initiated for Zyprexa 5mg daily (QD) for major depressive disorder. It should be noted that this medication was initiated because Rexulti was not covered by insurance. e. On 6/14/24, an order was initiated for Sertraline 50mg QD for major depressive disorder. f. On 7/12/24, an order was initiated to increase the Sertraline to 100mg QD for major depressive disorder. g. On 7/29/24, an order was initiated to decrease Zyprexa to 2.5mg QD for major depressive disorder. h. On 8/2/24, an order was initiated to discontinue Zyprexa. i. On 8/5/24 an order was initiated for Trazodone 50mg QHS for insomnia. j. On 8/22/24, an order was initiated to increase Sertraline to 150mg QD for major depressive disorder. k. On 8/20/24, an order was initiated for Quetiapine 25mg QHS, give with 100mg tablet to equal 125 mg for major depressive disorder. l. On 8/31/24, an order was initiated for Quetiapine 50mg QHS, give with 100mg tablet to equal 150 mg for major depressive disorder. Resident 40's Antipsychotic Medication Monitor Form Documented the following: a. On 5/26/24 and 5/27/24 for day shift, the Seroquel form documented 4 events for throwing objects and striking out at others. The form documented behavior management interventions utilized were positive reinforcement, “Live the Moment” validation, food/fluids offered, and music activity offered. The form documented that the outcome after intervention was effective or improved. b. June 2024 monitoring for the Seroquel documented zero events. It should be noted that documentation was missing for 6/3/24 day shift, 6/6/24 night shift, 6/23/24 night shift, 6/24/24 night shift, and 6/25/25 night shift. c. July 2024 monitoring for the Seroquel documented 2 events on 7/25/24, 2 event on 7/27/24, and 2 events on 7/29/24 for behaviors of delusions. The form documented behavior management interventions utilized were positive reinforcement, redirection, and “Live the Moment” validation. The form documented that the interventions were effective on 7/25/24 and 7/29/24. The form did not have documentation for the interventions or outcome for the 7/27/24 events. It should be noted that documentation was missing for 7/6/24 day shift. (continued on next page)

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	465092	A. Building B. Wing	09/25/2025

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. July 2024 monitoring for Zyprexa documented a behavior for suicidal thoughts. The form documented 2 events on 7/12/24 and interventions utilized were documented that all of the following interventions were provided: taken to bathroom, positive reinforcement, redirection, “Live the Moment” validation, food/fluids offered, music/activity offered, medication offered. The outcome was documented as “N” for not observed/unchanged. On 7/13/24 one event was documented, interventions were documented as all and outcome was “N”. On 7/14/24, 7/15/24, and 7/16/24 two events were documented, interventions were documented as all and outcome was “N”. It should be noted that no documentation could be found that the physician was notified of the suicidal thoughts on 7/13/24, 7/14/24, 7/15/24, or 7/16/24. e. August 2024 monitoring for the Seroquel documented 6 events on 8/7/24, 2 events on 8/8/24, 3 events on 8/17/24, 1 event on 8/18/24, 2 events on 8/19/24, and 3 events on 8/20/24 for behaviors of delusions. The form documented the interventions utilized were positive reinforcement, redirection, and “Live the Moment” validation. On 8/7/24, 8/8/24 and 8/17/24 the outcome was documented as not observed or unchanged. On 8/30/24 two events were documented for throwing things and on 8/31/24 one event was documented for throwing things. The interventions documented as utilized for the behavior of throwing things were “all” for taken to bathroom, positive reinforcement, redirection, “Live the Moment” validation, food/fluids offered, music/activity offered, medication offered. f. September 2024 monitoring for the Seroquel documented 1 event on 9/3/24 and 9/4/24, 2 event