STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465096	A. Building B. Wing	12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Canyon Rim	2730 East 3300 South Millcreek, UT 84109

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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 46232 Based on interview and record review, it was determined for 2 out of 10 sampled residents that in response to allegations of abuse, the facility failed to report allegations immediately. Specifically, allegations of abuse were not reported to the State Survey Agency (SSA), Adult Protective Services (APS), or the police. This was determined to have occurred at an Immediate Jeopardy level for resident 5. Resident identifiers: 1 and 5. On 12/12/2024, a finding of Immediate Jeopardy (IJ) (immediate threat to the health and safety of patients) was identified in the area of 483.12 Freedom from Abuse, Neglect, and Exploitation. The facility was notified of this finding verbally and in writing on 12/12/2024 at 10:20 AM. The facility submitted an IJ removal plan on 12/12/2024 at 3:41 PM, alleging removal as of 12/12/2024 at 2:30 PM. The plan was accepted, and the facility was notified at 5:36 PM on 12/12/2024. An onsite visit was conducted on 12/16/2024, and surveyors determined that the IJ had been removed on 12/12/2024 based on the steps the facility had taken. The facility was notified of this finding at 10:30 AM on 12/16/2024. Findings Included: 1. Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, suicidal ideation, muscle weakness, and dysphagia. (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: 465096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/11/2024 at 2:00 pm, an interview was conducted with resident 5, who stated that he had experienced verbal and sexual abuse from the Certified Nurse Assistant (CNA) 1. Resident 5 stated that at the end of the week before the interview, resident 5 had diarrhea and needed assistance from CNA 1 to help clean up. The resident stated that CNA 1 instructed the resident to hold their penis while the CNA used wet wipes to clean the resident's penis and scrotum. The resident stated they were having difficulty holding it up as the CNA instructed, and the CNA said, You're being stupid again, aren't you? and smacked my hands away. CNA 1 then Grabbed my penis between [CNA 1's] fingers and pulled on it as hard as [CNA 1] could and proceeded to scrub my penis on the sides while holding it up. When the resident complained about the rough treatment, the resident stated CNA 1 said, All men like to have that done to them and All men like to have it hurt like that. The resident then stated that when CNA 1 was finished cleaning them up, the CNA said, I hope when I go to college to be a nurse, I find a boyfriend who is as big as you are. The resident stated that they complained about the treatment to another CNA, CNA 2. The resident also said that the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) stated that CNA 6 talked with them the next day about the incident, but according to the resident, nothing was ever done about it. During the interview, resident 5 was tangential and perseverated on various complaints, requiring frequent redirection, but was consistent in their retelling of events throughout questioning. Resident 5's medical record was reviewed on 12/11/2024. On 11/27/2024, a quarterly Minimum Data Set (MDS) assessment was completed for resident 5. It was documented that resident 5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated resident 5 was cognitively intact. On 12/13/2024, a psychiatric evaluation for Resident 5 was completed by a physician. The physician documented what Resident 5 relayed as a horrible experience with the CNA, CNA 1, and how Resident 5 felt they had been sexually assaulted big time. The following narrative was documented, He reports that when the CNA entered the room, she said Ew, you stink, took his shirt off, pulled his pants down, and said, You are such a mess. He reports that she then took her gloves off, looked at him and it (referring to his penis), and told him, Hold it up like this as hard as you can . just hold it there. He reports that his hand slipped, and she got upset, told him she wanted him to hold it a certain way, then smacked his hand away and moved her hand up his penis to hold it. He reports that he told her it hurt, and she responded, ' Good. ' It is supposed to. All men want their penis to hurt like that. He reports that she held his penis and squeezed it tight while cleaning him and stated, Doesn't it feel good? while she wiped him with wipes. He reports that he was black and blue down there from cleaning so hard and that he thinks he needed a shower because he could have been cleaner. He reported that she told him, I am leaving Sandstone next week. I hope my next boyfriend or husband is as big as you. It should be noted that resident 5's progress notes and care plan were reviewed, and no documentation was located to indicate resident 5 had sexual behaviors. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/11/2024 at 3:00 pm, the DON was interviewed. The DON stated that they did talk with Resident 1 on Friday, 12/6/2024, the day after the incident, but did not have anyone else present during the conversation. When asked whether they were aware of the resident's complaint, the DON stated, Sure, I guess now that you say it, he told me about a CNA making like, swearing at him, touching him. He was saying that one CNA was swearing at him, saying 'you're covered in shit' and holding his anatomy while she was changing him. The DON also said that during their interview with the resident, they stated, [Resident 5] was talking about a brief change, and the CNA was making him do all the motions. [Resident 5] was trying to indicate that the CNA was wanting him to, I don't want to add words, [Resident 5] was trying to make it like [CNA 1] was trying to do something sexual. The DON stated that CNA 1 had no prior complaints about their performance of peri-care and that it was not normal practice for the resident to be asked to hold themselves while the CNA performed peri-care. The DON stated that they told the administrator about the incident the next day in the morning meeting but did not know if they reported it to the state or other agencies. On 12/11/2024, at 3:30 PM, the Administrator (ADMN)/abuse coordinator was interviewed. The ADMN stated that they were not aware of the abuse allegation made by resident 5 and stated that when they receive information of suspected abuse, they immediately contact the regional nurse, director of operations, family, notify the Department of Health on form 358, contact adult protective services, the long term care ombudsman and police if necessary. ADMN stated that the last abuse incident they were aware of and reported occurred on 10/10/2024 as a resident-to-resident incident. On 12/12/2024 at 9:08 AM, an interview was conducted with the ADON. The ADON stated they recently had to be a witness for the DON while they talked to Resident 5 about inappropriate patient care. The ADON stated the situation had been reported by CNA 2. The ADON stated resident 5 informed them CNA 1 had been using profanity and was talking inappropriately about their anatomy. The ADON stated resident 5 had complained to CNA 2 about what had occurred earlier in the day. The ADON stated resident 5 was told by CNA 1 they had a large penis. Resident 5's penis was then grasped tightly by CNA 1, and they did not relinquish their grip after Resident 5 voiced being in pain. The ADON stated Resident 5 was told they were a piece of shit and lazy. The ADON stated they interviewed CNA 1 the following morning. The ADON stated that CNA 1 said resident 5 had been moaning during the brief change. CNA 1 informed Resident 5 that those noises were inappropriate and that Resident 5 had never complained of any pain throughout the brief change. CNA 1 stated they felt awkward and uncomfortable with how resident 5 made them feel. The ADON stated they had switched CNA 1's assignment, so they no longer worked with resident 5. The ADON stated that this situation had been discussed in the morning meeting and that the Administrator had been made aware of it. The ADON stated the DON made notes of the incident, but to their knowledge, no notification had been made to any agency. It should be noted this allegation was made on 12/06/2024 and was not reported to the SSA, APS, or Law Enforcement. 2. Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, cirrhosis of the liver, pressure ulcer of unspecified site, altered mental status, mood disorder, bipolar disorder, hallucinations, and post-traumatic stress disorder. On 9/5/2024, an MDS assessment was completed for resident 1. It was documented resident 1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A care plan focus area initiated on 6/24/2024 and revised on 12/5/2024 documented that resident 1 had an alteration in their thought process due to moderate cognitive impairment. It should be noted resident 1's progress notes were reviewed, and there was no documentation located to indicate resident 1 had sexual behaviors or had been involved in a resident-to-staff interaction. On 12/10/2024 at 11:37 am, an interview was conducted with Resident 1. Resident 1 stated they required a lot of help from staff and needed to have their brief changed often due to diarrhea. Resident 1 stated they had no issues with staff being inappropriate with them. Resident 1 stated they had memory problems, which did not allow them to answer questions well. Resident 1 stated their memory was bad. On 12/10/2024 at 12:00 PM, an interview was conducted with RN 1. RN 1 stated Resident 1 was completely dependent on care and occasionally refused his care. RN stated resident 1 had cognitive deficits, dementia, and exhibited negative symptoms of schizophrenia. RN 1 stated that resident 1 sometimes forgot who they were and often said they were missing certain body parts, such as their mouth, head, and legs. RN 1 stated resident 1 was not aware of what was going on. On 12/10/2024 at 1:35 PM, an interview was conducted with the DON. The DON stated they recently had a resident come to them and inform them about concerns with a nighttime aide and suggestive conversations that had been going on. The DON stated that resident 1's roommate had informed them on the morning of 11/16/24 about the nighttime care concern that occurred on 11/15/24. Resident 1's roommate had been adamant that there had been a suggestive conversation between the night aide and resident 1 during a brief change. The DON stated they believed resident 1's roommate interpreted resident 1 and the night aide's interaction as something sexual. The DON stated resident 1's roommate could hear parts of the conversation that occurred but was unable to confirm the entire conversation and any actions due to the curtain being closed.The DON stated after they had spoken to resident 1's roommate and then asked resident 1 about any concerns they had with recent cares approximately within 12 hours of the incident. The DON stated resident 1 shrugged their shoulders after being asked if they could recall any incidents about the night before and were unable to get anything. The DON stated resident 1 did not seem distressed or upset. The DON stated resident 1's cognition fluctuates daily, and they had cognitive deficits. The DON stated there were times when resident 1 complained about a missing limb or body part. Resident 1 mentioned they were satisfied with the care they had been receiving. The DON stated once this had been reported to them, they immediately talked to the staff involved. On 12/10/2024 at 1:55 PM, an interview was conducted with resident 6. Resident 6 stated that something inappropriate had happened to his roommate with one- or two-night aides. Resident 6 stated the staff involved had crossed a boundary and had taken advantage of resident 1. Resident 6 stated it occurred about 1 month ago during a nighttime brief change, but they could not recall what had been said and did not want to accuse a staff member of something due to their memory. Resident 6 stated they had informed the DON of what had occurred. (continued on next page)

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/10/2024 at 2:52 PM, an interview was conducted with CNA 1. CNA 1 stated they had received abuse training during their orientation. They had only heard of two abuse allegations in the six months they had been here. CNA 1 stated the first one occurred a month ago with resident 1. CNA 1 stated resident 1 often stated they did not have certain body parts such as a mouth or head. CNA 1 stated they had received a report from CNA 2, who informed them at that time resident 1 had stated they did not have a penis during one of the brief changes. CNA 2 stated they held up resident 1's penis for them to see it themselves. CNA 1 stated they reported the incident to the DON after resident 1 had brought up the situation multiple times throughout the day. CNA 1 stated they assumed CNA 2 had informed the nurses about what happened because it had occurred during their shift. CNA 1 stated resident 1's roommate also brought up the situation. CNA 1 stated they reported what happened to resident 1 to RN 1 sometime in the morning. CNA 1 stated the DON had interviewed them about the incident the same day. On 12/11/2024 at 12:28 PM, a follow up interview was conducted with RN 1. RN 1 stated there was no logic when resident 1 informed staff they did not have a mouth, legs, or head, and they were difficult to reorient. RN 1 stated they were aware of a situation where resident 1 had informed a nighttime aide they did not have a penis. RN 1 stated the night aide had shown resident 1 their penis in an attempt to re-orient resident 1. RN 1 stated they were made aware of the situation by resident 1's roommate, who stated a weird conversation had occurred during a brief change. RN 1 stated resident 1's roommate reported this 24 hours after it had occurred. RN 1 stated they immediately notified the DON of the situation, and the DON later interviewed CNA 1. On 12/11/2024 at 3:30 PM, an interview was conducted with the ADMN. The ADMN stated they were the abuse coordinator. The ADMN stated that anytime abuse was identified, it was reported to the regional nurse consultant, regional operations, Adult Protective Services (APS), Ombudsman, and law enforcement. The ADMN stated they submitted a 358 form within 2 hours to the state survey agency. The ADMN stated they had not conducted any abuse investigations in November or December 2024. The ADMN stated they were informed resident 1 stated they did not have a penis, and the CNA assured the resident, they did have one. The ADMN stated when resident 1 was interviewed, they denied anything had occurred, and staff had not witnessed a change in behavior. The ADMN stated resident 1's roommate had speculated what had occurred. The ADMN stated they did not believe it was an allegation of abuse because of resident 1's roommate's mental history. Based upon the evidence provided by the DON, the ADMN did not believe it was a substantial event because what had been perceived was not accurate to what the caregiver did. The ADMN stated they were alerted very timely by the DON. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/11/2024 at 4:03 PM, an interview was conducted with CNA 2. CNA 2 stated during their second rounds, resident 1 informed them they did not have a penis. CNA 2 stated they informed resident 1 it had been there last time they changed their brief and was pretty sure it was still there. CNA 2 opened resident 1's brief and stated, look it's right there. CNA 2 stated resident 1 lifted their head up and started pulling at their penis in their direction. CNA 2 stated resident 1 then asked them what they would do if they wanted to kiss them. CNA 2 informed resident 1 that was not an appropriate thing to talk about, and resident 1 kept pulling at his penis. CNA 2 informed resident 1 they did not need to pull at their penis, and then resident 1 stated CNA 2 needed a man. CNA 2 told resident 1 they did not need a man and were not going to go there. CNA 2 informed resident 1 they needed to finish their brief change and left the room after completion. CNA 2 stated they informed the nurse of what had occurred and charted that resident 1 was sexually inappropriate. CNA 2 stated that it had been unusual behavior for resident 1. CNA 2 stated they had been contacted by the DON the following day and was notified that resident 1's roommate had stated that something different had occurred. CNA 2 stated that resident 1's roommate had twisted what had occurred. It should be noted there was no evidence that CNA 2 documented that resident 1 was sexually inappropriate in resident 1 ' s medical record or that the allegation of abuse that was made on 11/15/2024 had been reported to the SSA, APS, or Law Enforcement. 19354 A review of the facility's policy and procedure for abuse prevention was conducted. The policy defined verbal abuse as the use of oral, written or gestured language that expresses disparaging and derogatory terms to residents within their hearing/seeing distance and sexual abuse as non-consensual sexual contact of any type with a resident. It was further documented that the facility would, 2. Notify the appropriate/designated organization/authority (State Agencies) that an investigation is being initiated immediately following intervention for the resident's safety 6. Notify law enforcement authorities and press charges, if indicated. 7. Report the investigation findings to the appropriate State Agencies, as required by law .

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F 0610

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46232

Based on interview and record review, it was determined that in response to allegations of abuse, the facility failed to have evidence that all alleged violations were thoroughly investigated for 2 of 10 sampled residents and prevent further potential abuse while an investigation was being processed for 1 of 10 sampled residents. Specifically, the facility did not have evidence that abuse allegations were thoroughly investigated and allowed an alleged perpetrator to continue to have access to the alleged victim and other vulnerable residents. This was determined to have occurred at an Immediate Jeopardy level for resident 5. Resident identifiers: 1 and 5.

On 12/12/2024, a finding of Immediate Jeopardy (IJ) (immediate threat to the health and safety of patients) was identified in the area of 483.12 Freedom from Abuse, Neglect, and Exploitation. The facility was notified of this finding verbally and in writing on 12/12/2024 at 10:20 AM. The facility submitted an IJ removal plan on 12/12/2024 at 3:41 PM, alleging removal as of 12/12/2024 at 2:30 PM. The plan was accepted, and the facility was notified at 5:36 PM on 12/12/2024. An onsite visit was conducted on 12/16/2024, and surveyors determined that the IJ had been removed on 12/12/2024 based on the steps the facility had taken. The facility was notified of this finding at 10:30 AM on 12/16/2024.

Findings Included:

1. Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, suicidal ideation, muscle weakness, and dysphagia.

On 12/11/2024 at 2:00 pm, an interview was conducted with resident 5, who stated that he had experienced verbal and sexual abuse from the Certified Nurse Assistant (CNA) 1. Resident 5 stated that at the end of the week before the interview, resident 5 had diarrhea and needed assistance from CNA 1 to help clean up. The resident stated that CNA 1 instructed the resident to hold their penis while the CNA used wet wipes to clean the resident's penis and scrotum. The resident stated they were having difficulty holding it up as the CNA instructed, and the CNA said, You're being stupid again, aren't you? and smacked my hands away. CNA 1 then Grabbed my penis between [CNA 1's] fingers and pulled on it as hard as [CNA 1] could and proceeded to scrub my penis on the sides while holding it up. When the resident complained about the rough treatment, the resident stated CNA 1 said, All men like to have that done to them and All men like to have it hurt like that. The resident then stated that when CNA 1 was finished cleaning them up, the CNA said, I hope when I go to college to be a nurse, I find a boyfriend who is as big as you are. The resident stated that they complained about the treatment to another CNA, CNA 2. The resident also said that the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) stated that CNA 6 talked with them the next day about the incident, but according to the resident, nothing was ever done about it. During the interview, resident 5 was tangential and perseverated on various complaints, requiring frequent redirection, but was consistent in their retelling of events throughout questioning.

Note: CNA 1 was observed in the building providing direct care to residents on 12/12/2024.

Resident 5's medical record was reviewed on 12/11/2024.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/27/2024, a quarterly Minimum Data Set (MDS) assessment was completed for resident 5. It was documented that resident 5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident 5 was cognitively intact. On 12/13/2024, a psychiatric evaluation for Resident 5 was completed by a physician. The physician documented Resident 5's horrible experience with the CNA, CNA 1, and how Resident 5 felt they had been sexually assaulted big time. The following narrative was documented, He reports that when the CNA entered the room, she said, Ew, you stink, took his shirt off, pulled his pants down, and said, You are such a mess. He reports that she then took her gloves off, looked at him and it (referring to his penis), and told him, Hold it up like this as hard as you can . just hold it there. He reports that his hand slipped, and she got upset, told him she wanted him to hold it a certain way, then smacked his hand away and moved her hand up his penis to hold it. He reports that he told her it hurt, and she responded, Good. It is supposed to. All men want their penis to hurt like that. He reports that she held his penis and squeezed it tight while cleaning him and stated, Doesn't it feel good? while she wiped him with wipes. He reports that he was black and blue down there from cleaning so hard and that he thinks he needed a shower because he could have been cleaner. He reported that she told him, I am leaving Sandstone next week. I hope my next boyfriend or husband is as big as you. It should be noted that resident 5's progress notes and care plan were reviewed, and no documentation was located to indicate resident 5 had sexual behaviors. On 12/11/2024 at 3:00 pm, the DON was interviewed. The DON stated that they did talk with Resident 5 on Friday, 12/6/2024, the day after the incident, but did not have anyone else present during the conversation. When asked whether they were aware of the resident's complaint, the DON stated, Sure, I guess now that you say it, he told me about a CNA making like, swearing at him, touching him. He was saying that one CNA was swearing at him, saying 'you're covered in shit' and holding his anatomy while she was changing him. The DON also said that during their interview with the resident, they stated, [Resident 5] was talking about a brief change, and the CNA was making him do all the motions. [Resident 5] was trying to indicate that the CNA was wanting him to, I don't want to add words, [Resident 5] was trying to make it like [CNA 1] was trying to do something sexual. The DON stated that CNA 1 had no prior complaints about their performance of peri-care and that it was not normal practice for the resident to be asked to hold themselves while the CNA performed peri-care. The DON stated that they told the administrator about the incident the next day in the morning meeting. The DON was asked if an incident report was completed or if a note in the electronic medical record, or anywhere else, was made, to which they said: I don't know, I would have to double check, but I'd have to backtrack and look. The DON was asked to provide any documentation that was made concerning the incident but did not provide any. On 12/11/2024, at 3:30 PM, the Administrator (ADMN)/abuse coordinator was interviewed. The ADMN stated that they were not aware of the abuse allegation made by resident 5 and subsequently did not complete an investigation. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/2024 at 9:08 AM, an interview was conducted with the ADON. The ADON stated they recently had to be a witness for the DON while they talked to Resident 5 about inappropriate patient care. The ADON stated the situation had been reported by CNA 2. The ADON stated resident 5 informed them CNA 1 had been using profanity and was talking inappropriately about their anatomy. The ADON stated resident 5 had complained to CNA 2 about what had occurred earlier in the day. The ADON stated resident 5 was told by CNA 1 they had a large penis. Resident 5's penis was then grasped tightly by CNA 1, and they did not relinquish their grip after Resident 5 voiced being in pain. The ADON stated Resident 5 was told they were a piece of shit and lazy. The ADON stated they interviewed CNA 1 the following morning. The ADON stated that CNA 1 said resident 5 had been moaning during the brief change. CNA 1 informed Resident 5 that those noises were inappropriate and that Resident 5 had never complained of any pain throughout the brief change. CNA 1 stated they felt awkward and uncomfortable with how resident 5 made them feel. The ADON stated they had switched CNA 1's assignment, so they no longer worked with resident 5. The ADON stated that this situation had been discussed in the morning meeting and that the Administrator had been made aware. The ADON stated the DON made notes of the incident Note: The facility provided no evidence that this allegation was thoroughly investigated. 2. Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of chronic obstructive pulmonary disease, type 2 diabetes mellitus, cirrhosis of the liver, pressure ulcer of unspecified site, altered mental status, mood disorder, bipolar disorder, hallucinations, and post-traumatic stress disorder. On 9/5/2024, an MDS assessment was completed for resident 1. It was documented that resident 1 had a BIMS score of 10, which indicated moderate cognitive impairment. A care plan focus area initiated on 6/24/2024 and revised on 12/5/2024 documented that resident 1 had an alteration in their thought process due to moderate cognitive impairment. It should be noted resident 1's progress notes were reviewed, and there was no documentation located to indicate resident 1 had sexual behaviors or had been involved in a resident-to-staff interaction. On 12/10/2024 at 11:37 am, an interview was conducted with Resident 1. Resident 1 stated they required a lot of help from staff and needed to have their brief changed often due to diarrhea. Resident 1 stated they had no issues with staff being inappropriate with them. Resident 1 stated they had memory problems, which did not allow them to answer questions well. Resident 1 stated their memory was bad. On 12/10/2024 at 12:00 PM, an interview was conducted with RN 1. RN 1 stated Resident 1 was completely dependent on care and occasionally refused his care. RN stated resident 1 had cognitive deficits, dementia, and exhibited negative symptoms of schizophrenia. RN 1 stated that resident 1 sometimes forgot who they were and often said they were missing certain body parts, such as their mouth, head, and legs. RN 1 stated resident 1 was not aware of what was going on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Canyon Rim	2730 East 3300 South Millcreek, UT 84109

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/10/2024 at 1:35 PM, an interview was conducted with the DON. The DON stated they recently had a resident come to them and inform them about concerns with a nighttime aide and suggestive conversations that had been going on. The DON stated that resident 1's roommate had informed them on the morning of 11/16/24 about the nighttime care concern that occurred on 11/15/24. Resident 1's roommate had been adamant that there had been a suggestive conversation between the night aid and resident 1 during a brief change. The DON stated they believed resident 1's roommate interpreted resident 1 and the night aide's interaction as something sexual. The DON stated resident 1's roommate could hear parts of the conversation that occurred but was unable to confirm the entire conversation and any actions due to the curtain being closed. The DON stated after they had spoken to resident 1's roommate and then asked resident 1 about any concerns they had with recent cares approximately within 12 hours of the incident. The DON stated resident 1 shrugged their shoulders after being asked if they could recall any incidents about the night before and were unable to get anything. The DON stated resident 1 did not seem distressed or upset. The DON stated resident 1's cognition fluctuates daily, and they had cognitive deficits. The DON stated there were times when resident 1 complained about a missing limb or body part. Resident 1 mentioned they were satisfied with the care they had been receiving. The DON stated once this had been reported to them, they immediately talked to the staff involved. The survey team requested all documentation gathered throughout the investigation. The DON stated they had a soft file that included resident and staff interviews. The DON stated that a soft file was created due to significant concerns resident 1's roommate had. The DON stated it had been hard to determine if the situation happened due to the varying responses during the interviews with staff, resident 1, and resident 1's roommate. The survey team immediately requested the soft file documentation. Note: On 12/10/2024, the soft file for the allegation made by resident 1 ' s roommate was provided to the survey team. The soft file included brief interviews with resident 1, resident 6, CNA 1, and CNA 2. It was documented that during Resident 6 ' s interview, they stated that an inappropriate conversation had occurred, but they had not witnessed anything. There was no clarification as to what was said to make resident 6 think the conversation was inappropriate. Per the documentation, Resident 1, who had cognitive deficits, was asked if any abuse or neglect had occurred with their care and if anyone had been inappropriate with them. Resident 1 denied any concerns. In the documentation of the interview with CNA 1, they stated resident 1 believed they were missing limbs and needed to be re-oriented. Per the documentation of CNA 2 ' s interview, CNA 2 stated resident 1 had been inappropriate and had made suggestive comments. It should be noted no further details were included to indicate what was said between CNA 2 and resident 1 and what limbs resident 1 believed to be missing. The DON stated a soft file was a simple document that helped them track patterns, behaviors, and performance. On 12/10/2024 at 1:55 PM, an interview was conducted with resident 6. Resident 6 stated that something inappropriate had happened to his roommate, resident 1, and one- or two-night aides. Resident 6 stated the staff involved had crossed a boundary and had taken advantage of resident 1. Resident 6 stated it occurred about 1 month ago during a nighttime brief change, but they could not recall what had been said and did not want to accuse a staff member of something due to their memory. Resident 6 stated they had informed the DON of what had occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER: Sandstone Canyon Rim		STREET ADDRESS, CITY, STATE, ZIP CODE: 2730 East 3300 South Millcreek, UT 84109	

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/10/2024 at 2:52 PM, an interview was conducted with CNA 1. CNA 1 stated they had received abuse training during their orientation. They had only heard of two abuse allegations in the six months they had been here. CNA 1 stated the first one occurred a month ago with resident 1. CNA 1 stated resident 1 often stated they did not have certain body parts such as a mouth or head. CNA 1 stated they had received a report from CNA 2, who informed them at that time resident 1 had stated they did not have a penis during one of the brief changes. CNA 2 stated they held up resident 1's penis for them to see it themselves. CNA 1 stated they reported the incident to the DON after resident 1 had brought up the situation multiple times throughout the day. CNA 1 stated they assumed CNA 2 had informed the nurses about what happened because it had occurred during their shift. CNA 1 stated resident 1's roommate also brought up the situation. CNA 1 stated they reported what happened to resident 1 to RN 1 sometime in the morning. CNA 1 stated the DON had interviewed them about the incident the same day. On 12/11/2024 at 12:28 PM, a follow up interview was conducted with RN 1. RN 1 stated there was no logic when resident 1 informed staff they did not have a mouth, legs, or head and they were difficult to reorient. RN 1 stated they were aware of a situation where resident 1 had informed a nighttime aid they did not have a penis. RN 1 stated the night aid had shown resident 1 their penis in an attempt to re-orient resident 1. RN 1 stated they were made aware of the situation by resident 1's roommate, who stated a weird conversation had occurred during a brief change. RN 1 stated resident 1's roommate reported this 24 hours after it had occurred. RN 1 stated they immediately notified the DON of the situation, and the DON later interviewed CNA 1 of what they had been told. On 12/11/2024 at 3:30 PM, an interview was conducted with the ADMN. The ADMN stated they were the abuse coordinator. The ADMN stated once they were alerted of an allegation of abuse, they conducted an initial investigation to verify if there was any evidence of abuse and to gather information to rule out hearsay or speculation. The ADMN stated during the investigation process, they conducted interviews with the residents and staff involved and did chart reviews. The ADMN stated they also look to see if a resident has had a change in behavior and see if there was any derogatory outcome from the event. The ADMN stated the investigation was a collaborative effort. The ADMN stated they had not conducted any abuse investigations in November or December 2024. The ADMN stated they were informed resident 1 stated they did not have a penis, and the CNA assured the resident they did have one. The ADMN stated that when resident 1 was interviewed, they denied anything had occurred and that the staff had not witnessed a change in behavior. The ADMN stated resident 1's roommate had speculated what had occurred. The ADMN stated they did not believe it was an allegation of abuse because of resident 1's roommate's mental history. Based upon the evidence provided by the DON, the ADMN did not believe it was a substantial event because what had been perceived was not accurate to what the caregiver did. The ADMN stated they were alerted very timely by the DON. Note: The ADMN did not complete an investigation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Sandstone Canyon Rim		STREET ADDRESS, CITY, STATE, ZIP CODE: 2730 East 3300 South, Millcreek, UT 84109	

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/11/2024 at 4:03 PM, an interview was conducted with CNA 2. CNA 2 stated during their second rounds, resident 1 informed them they did not have a penis. CNA 2 stated they informed resident 1 it had been there last time they changed their brief and was pretty sure it was still there. CNA 2 opened resident 1's brief and stated, look it's right there. CNA 2 stated resident 1 lifted their head up and started pulling at their penis in their direction. CNA 2 stated resident 1 then asked them what they would do if they wanted to kiss them. CNA 2 informed resident 1 that was not an appropriate thing to talk about, and resident 1 kept pulling at his penis. CNA 2 informed resident 1 they did not need to pull at their penis, and then resident 1 stated CNA 2 needed a man. CNA 2 told resident 1 they did not need a man and were not going to go there. CNA 2 informed resident 1 they needed to finish their brief change and left the room after completion. CNA 2 stated they informed the nurse of what had occurred and charted that resident 1 was sexually inappropriate. CNA 2 stated that it had been unusual behavior for resident 1. CNA 2 stated they had been contacted by the DON the following day and was notified that resident 1's roommate had stated that something different had occurred. CNA 2 stated that resident 1's roommate had twisted what had occurred. Note: There was no evidence that CNA 2 documented that resident 1 was sexually inappropriate in resident 1 ' s medical record or that the allegation of abuse that was made on 11/15/2024 had been reported to the SSA, APS, or Law Enforcement. 19354 A review of the facility's policy and procedure for abuse prevention was conducted. The policy defined verbal abuse as the use of oral, written or gestured language that expresses disparaging and derogatory terms to residents within their hearing/seeing distance and sexual abuse as non-consensual sexual contact of any type with a resident. It was further documented that the facility would, .1. Take immediate steps to assure the protection of the resident(s). This may involve separation from the alleged abuser and/or provision of medical care. 2. Notify the appropriate/designated organization/authority (State Agencies) that an investigation is being initiated immediately following intervention for the resident's safety. 3. Conduct a careful and deliberate investigation centering on facts, observations and statements from the alleged victim and witnesses . 5. Take actions related to resolving resident and family issues/concerns/allegations, educating staff, communicating with families and others (as relevant) and record .