STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465100	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paramount Health and Rehabilitation	4035 South 500 East Salt Lake City, UT 84107

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. 45470 Based on interview and record review, it was determined that the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property. Specifically, a nursing assistant who provided an invalid Social Security Number and failed to provide fingerprints was working in the facility for approximately three months. Findings Include. 1. On 12/3/24, Nursing Assistant (NA) 1's employee record was reviewed. NA 1 was hired at the facility on 9/4/24. NA 1 was reviewed in the Direct Access Clearance System (DACS). NA 1's current fitness determination was In Process and it was revealed that NA 1 did not submit fingerprints. NA 1 was involuntarily terminated on 12/2/24 due to providing the facility with an invalid Social Security Number. On 12/3/24 the facility's Pre-Employment Investigations Policy was reviewed. The policy revealed that employees are required to submit fingerprints electronically to the Department of Health within 15 working days of engagement. The policy revealed, An applicant or employee may not work or continue to work if the company discovers, knows, or has reason to believe that the results of the applicant's or employee's criminal background check or any other background inquiries are, or due to subsequent events have become, inaccurate. On 12/3/24 an interview with the administrator was conducted. The administrator stated that NA 1 was terminated due to discovering NA 1 provided an invalid Social Security Number. The administrator stated that he was aware that NA 1 had not submitted their fingerprints to the Department of Health.

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