

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/15/2025
NAME OF PROVIDER OR SUPPLIER  Paramount Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, it was determined for 2 of 7 sampled residents, that the facility failed to provide each resident with staff supervision to prevent accidents. Specifically, a resident who was on supervised smoking was left unattended in the smoking area, and had accidentally caught on fire, which resulted in burn injuries and the resident expiring at the hospital, along with burn injuries to another resident's hand who was attempting to put the fire out. Resident Identifiers: 1, 2. On [DATE], the surveyor reviewed the facility's investigation involving an incident with Resident 1, dated [DATE], which revealed the following: On [DATE], PRN Physical Therapist (PT) 1 took Resident 1 out to smoke. Two other residents (Resident 2 and Resident 3) were in the smoking area and there were no other staff present. PT 1 left Resident 1 in the smoking area with cigarettes and a lighter and went back into the facility. While smoking, Resident 1's shirt caught on fire and Resident 2 attempted to put the fire out with his hand, but was unsuccessful. Resident 3 went to the door and shouted for help from staff members. Certified Nursing Assistant (CNA) 1 was the first staff member to go outside, observed what was happening, and immediately called for a nurse. Nurse 1 grabbed a smoking blanket and bear hugged Resident 1, which put out the flames, while other staff called 911 and got a fire extinguisher. Nurse 1 stated that it all happened quickly, and the fire extinguisher did not need to be used, but was ready if the flames ignited again. The fire department arrived within 5-10 minutes, and Resident 1 was taken to the hospital. The facility's investigation included Nurse 1's statement, which documented, She [Nurse 1] came out and saw [Resident 1] was in flames. She rushed over to the smoking blanket and opened the packaging and bear hugged him with the blanket. She could see the skin slippage on the right side of his chest, right hand and fingers, burn on his right leg, and burn to his face, back of his head. He was alert and oriented and he just kept saying that he was in pain and was hurting. [Resident 2] had a surface burn on his hand from trying to put out the fire. [Nurse 1] was sitting down at the CNA Coordinator office and they heard [Resident 2] yelling from outside. [Nurse 1] and [CNA Coordinator] went sprinting down to see what was going on. A couple people did pour a small amount of [water] on him and other staff brought out the fire extinguisher, but they didn't use it. [Nurse 1] said that the fire department was there within 5-10 minutes after the incident. The facility's investigation included PT 1's statement, which documented So very sorry about this situation and what has transpired. I did not know that this resident is to be supervised during his time outside while smoking. Here is my incident report with my tx [treatment] session and interactions with [Resident 1]. I attempted to complete my tx session with the resident in the therapy gym but he requested to be taken outside to smoke his cigarettes. I assisted the resident to the facility's designated smoking section as per his request and set him up in his wheelchair right next to the table with the ashtray right next to his body. The resident then told me, I am fine right here, I'm good now that I can reach the ashtray. You can leave and let me smoke these 3 cigarettes, then come back and get me. I told the resident that I would be back in about 10 minutes to bring him back into the building. The resident said, Yes, that's fine. I then asked the resident, are you sure you are okay out here. The resident reiterated that, I'm fine right here next to the table. I then locked the wheelchair brakes, restated that, I would be back for him in about 10 minutes. As I was saying this to the resident, he had lit his own cigarette and was smoking it with the cigarette between his first and second fingers of his Right hand. I then turned away from the resident and walked back into the building. Inside the resident's room there is a sign about his bed that stated, Resident to be taken outside to smoke 2 times per day. However, there is no mention in the typed sign of supervision to be conducted while he is outside smoking. I did not know that supervision while smoking was part of the resident's care plan. I did receive the instruction and training document from you that I signed and dated, explaining that all care plans for each resident are to be read, understood, and followed prior to any future treatment sessions of any residents. The surveyor reviewed Resident 1's medical records, which revealed the following: A physician's order, dated [DATE], indicated, Resident [1] is a supervised smoking at all times. A care plan, initiated on [DATE], stated, Potential for injury r/t [related to] smoking. An intervention, dated [DATE], instructed staff to Provide 1:1 (one to one) observation while smoking due to seizure disorder. A quarterly smoking evaluation, completed on [DATE], had determined Resident 1 required supervision while smoking. On [DATE], the surveyor interviewed the Director of Nursing (DON), who stated Resident 1 required supervision while smoking and should not have been left to smoke unattended. The DON stated that the staff member who had taken Resident 1 out to smoke was a PRN employee who mainly worked at a different facility. The DON</p>		