

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

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 05/14/2024
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation and interview it was determined the facility did not provide a safe, clean, comfortable and homelike environment for each resident. Specifically, a resident had a red and orange substance on a piece of drywall secured to the wall by a residents bed. The drywall was protruding from the wall and the screws protruding from the wall. In addition, there were odors in the facility and mats next to residents beds were torn. Resident identifier: 8. Findings include: 1. Resident 8 was admitted to the facility on [DATE] with diagnoses which included other specific joint derangements of left hip, pain in left hip, Alzheimer's, chronic systolic heart failure, visual loss in both eyes and protein-calorie malnutrition. On 5/13/24 at 2:05 PM, an observation was made of resident 8's room. An observation of the wall on the right side of resident 8's was a protruding piece of dry wall, sticking out approximately a half inch from the wall. The dry wall was secured with 7 screws protruding from the drywall. An observation of an orange and red colored substance was on the drywall. On 5/14/24 at 7:35 AM, a second observation was made of resident 8's room. Resident 8 was in bed with his bed in the lowest position. There was a piece of dry wall protruding from the wall on the right side of the bed, sticking out approximately a half inch from the wall. The dry wall was secured with 7 screws protruding from the drywall. An observation of an orange and red colored substance was on the drywall. On 5/14/24 at 9:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she did not know there was drywall sticking out from the wall in resident 8's room. LPN 1 was observed to look at the dry wall. The bed was elevated and over where the drywall that had been attached to the wall. LPN 1 was observed to lower the bed and observed the piece of drywall attached with screws to the wall. There was an orange and red substance on the drywall. LPN 1 stated stated she did not know what the red and orange colored substance was. LPN 1 was observed to touch the the red and orange colored substance with her finger that was not gloved. There were 7 screws protruding from the piece of drywall. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 9:46 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated he had been the Director since 8/28/23. The Maintenance Director stated he did not notice there was drywall attached to the wall with screws not sunk into the drywall. The Maintenance Director was observed to look at the wall in resident 8's room and stated the dry wall should have been removed and cut to be flush in the wall. 2. Odors On 5/6/24 at 9:12 AM, an observation was made of the west hallway. The west hallway had a strong urine odor from the nurses station to room [ROOM NUMBER]. On 5/6/24 at 9:18 AM, an observation was made in the west hallway. There was a bowel movement odor outside room [ROOM NUMBER] and room [ROOM NUMBER]. On 5/6/24 at 9:20 AM, an observation was made of room [ROOM NUMBER]. room [ROOM NUMBER] had a bowel movement odor. On 5/6/24 at 11:56 AM, an observation was made of the dining room. There was a dirt and body odor. On 5/6/24 at 12:43 PM, an observation was made of the west hallway. There was a bowel movement odor in the hallway outside rooms [ROOM NUMBERS]. On 5/7/24 at 11:01 AM, an observation was made of the west hallway. There was a bowel movement odor in hallway from room [ROOM NUMBER] to room [ROOM NUMBER]. On 5/8/24 at 10:35 AM, an observation was made of the west hallway. There was a bowel movement odor from the nurses station to room [ROOM NUMBER]. On 5/13/24 at 11:40 AM, an observation was made of the west hallway. There was a strong urine odor by the west nurses station. On 5/14/24 at 8:09 AM, an observation was made of the west hallway. There was a bowel movement and vomit odor in the west hallway. At 9:52 AM, the same odor was observed in the west hallway. On 5/14/24 at 9:48 AM, an interview was conducted with Housekeeper (HK) 1. HK 1 stated there was an air freshener in the hallway. HK 1 stated she could not smell any odor in the west hallway. HK 1 stated sometimes the soiled linen room had garbage and soiled linens that smelled. HK 1 was observed to look at the soiled linen closet and stated the door was open. HK 1 was observed to go to the soiled linen and stated the garbage was full and needed to be emptied. On 5/14/24 at 9:50 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated there were odors in the west hallway. LPN 1 stated a resident had a blow out bowel movement and had been changed. LPN 1 stated she noticed the odor in the west hallway about 5 minutes ago. LPN 1 stated The odor just needs to evaporate. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 2:08 PM, an interview was conducted with the Marketing/Admissions Director. The Marketing/Admissions Director was observed in the west hallway. The Marketing/Admissions Director stated she had not noticed odors in the west hallway. The Marketing/Admission Director stated if she noticed an odor she would find the source and determine how to get rid of it. On 5/14/24 at 2:11 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated he did not notice an odor in the west hallway when he started his shift at 2:00 PM. CNA 1 stated if someone had a bowel movement or another odor, then he would find where it was coming from. CNA 1 stated at the end of each shift, or anytime the garbage was full then CNA's emptied the main garbage can and soiled linens. CNA 1 stated the garbage and linens were taken out of the closet at the end of every shift, if not more often. On 5/14/24 at 2:21 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that CNA's should be taking the garbage out when it was full and at the end of every shift. The DON stated CNA's were probably busy and did not have a chance to take out the garbage which caused the odors. 3. Fall Mats On 5/9/24 at 2:37 PM, an observation was made of room [ROOM NUMBER] A. There was a mat next to bed on the floor with tears in the cover. There was a foam pad that was exposed. On 5/14/24 at 7:32 AM, an observation was made of room [ROOM NUMBER] B. There was a mat next to bed on the floor with tears in the cover. There was a foam pad that was exposed. On 5/14/24 at 2:05 PM, an observation was made of room [ROOM NUMBER] A. There was a mat folded next to the residents dresser. On 5/14/24 at 2:07 PM, an interview was conducted with CNA 2. CNA 2 stated the cover to the mat was torn, the foam could get contaminated and it would be harder to clean and sanitize. On 5/14/24 at 2:08 PM, an interview was conducted with the Admissions/Marketing Director. The Admissions/Marketing Director stated she had not noticed any tears or rips in the mats by the beds. The Admissions/Marketing Director stated if any resident equipment was torn, ripped or broken then it should be reported to nursing staff and maintenance for it to be replaced. On 5/14/24 at 2:11 PM, an interview and observation was conducted with CNA 1. CNA 1 stated if a mat by the bed had a tear in it, then he found a replacement mat. CNA 1 was observed to enter room [ROOM NUMBER] A. The mat was observed to be folded in half propped up against the dresser. CNA 1 stated there was a tear on the mat. CNA 1 was observed to enter room [ROOM NUMBER] B, CNA 1 stated there was a tear in the fall mat. CNA 1 stated he had not noticed the torn mat before. CNA 1 stated if the cover was torn it was more prone to wear down because of the elements. CNA 1 stated it was harder to keep the foam clean and sanitized. On 5/14/24 at 2:16 PM, an interview was conducted with LPN 1. LPN 1 stated if there was a tear in a mat on the floor, then it should replace it. LPN 1 stated a torn cover could potentially cause a skin tear because of the plastic. LPN 1 stated she was not aware there were torn covers in room [ROOM NUMBER]A and 29B. LPN 1 stated the spongy material under the cover and was not sanitizable. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 2:21 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the mats should not have tears in the covers and should be replaced. The DON stated tears in the covers, could cause skin tears or something like that. The DON stated if there was foam coming out then staff should let the nurses or maintenance know to get another fall mat.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 38 sampled residents, that the facility did not ensure that the resident was free from abuse. Specifically, a resident reported physical and mental abuse when a nurse aide placed a sheet and towel over the resident's head and neck trapping them and preventing them from moving freely. Resident identifier: 258 and 261. Findings included: Resident 258 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included presence of right artificial knee joint, cellulitis right lower extremity, type 2 diabetes mellitus, morbid obesity, gout, edema, and hypertension. Resident 258 was discharged from the facility on 6/28/23. On 4/3/24, resident 258's medical record was reviewed. On 2/23/23, a Quarterly Minimum Data Set (MDS) Assessment documented that resident 258 had a Brief Interview for Mental Status (BIMS) score of 14 which would indicate that the resident was cognitively intact. The assessment further documented that resident 258 was an extensive one person physical assist for bed mobility, transfers, locomotion off the unit, dressing, toilet use and personal hygiene. Resident 258's progress notes revealed the following: a. On 5/12/23 at 11:00 PM, a nursing note documented, Resident notified LN [licensed nurse] tonight that her aide was acting strange when she went to put [resident 258] to bed. [Resident 258] states that her aide placed a looped gait belt around her (the aide's) neck and mimicked her hanging herself while standing at the foot of the bed while [resident 258] was on the commode. [Resident 258] then stated that her aide helped her into bed and pinned the top sheet down over the top of [resident 258's] head where she could not get out from under it. [Resident 258] stated that after her aide let the sheet go she proceeded to take a rolled up towel that the resident uses for therapy and held it against [resident 258] neck. [Resident 258] states that her aide made the comment 'this is what they do' and proceeded to grab the garbage and leave the room. After this was explained to me by the resident I proceeded to call our facility Administrator / Abuse Coordinator and reported the incident. I then returned to [resident 258's] room and completed a physical and emotional assessment on her. Residents VS [vital signs] are [blood pressure]149/66, [heart rate] 65, [temperature] 97.6, [oxygen saturation] 94% room air. No injuries observed during the assessment. [Resident 258] states that she feels shaken up but that she is okay. [Resident 258] also states that she feels safe at this time. The aide that was mentioned left the building at 2200. Frequent monitoring is in place. Residents daughter was notified of the incident by the facility Administrator. Staff will continue to monitor resident. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 5/16/23 at 1:56 PM, a nursing note documented, Spoke with resident and is happy with room moves felt more secured being closed [sic] to nurses station. Has not had episodes of anxiety and is socializing well with other people. Staff to ensure resident is safe and requires assistance with ADLS [activities of daily living]. Remained alert and oriented and able to make needs known. c. On 5/16/23 at 4:43 PM, a social services note documented, Current BIMS score 14 intact cognition. PHQ-9 [patient depression assessment] score 03 mood stable. Resident has support from daughter. Resident plans on going back home with home health services. d. On 5/19/23 at 5:08 PM, a social services note documented, Spoke with resident regarding recent events resident stated that she feels better she is happy with the room move. Resident stated that she would feel much more at ease if she could get a call back from the police. She would also like to file a protective order as well. Helped resident to reach out to the police they did not answer left a message for them to call her back. Also left a message with the police to file a protective order. Asked resident if she would like to speak with [behavioral health provider] she agreed to that. [Behavioral health provider] referral sent out. e. On 5/22/23 at 3:15 PM, a social service note documented, Psychosocial follow up with resident. Resident was playing bingo and interacting with other residents and staff. Resident appeared to be comfortable and did not show any signs of distress. Resident states she is feeling much better. Resident met with an officer today and she felt like she can move forward from the incident last week. She feels a weight lifted off of her. Resident also indicated she feels much better with the room move. Resident is not anticipating on being at the facility for much longer. She has a follow up with her Dr [doctor] in a few weeks and she anticipates being able to discharge home shortly after that. Offered resident the option to transfer to another rehab facility in the meantime. Resident declined and stating she feels comfortable at the facility, and she doesn't want to start over someone new. Offered resident to set up with mental health services. Resident did not feel like she will need any further mental health follow up after she discharges. Resident states that she receives a lot of peace from her faith. She states she prays daily and she receives comfort from her faith. RA [resident advocate] and LCSW [licensed clinical social worker] available to meet with patient for further psychosocial support as needed. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/23 at 11:48 PM, the facility reported to the State Survey Agency (SSA) that on 5/12/23 at 10:00 PM, resident 258 alleged that she was physically and mentally abused by the CNA [Certified Nurse Assistant] and is displaying signs of fear and anxiety. The Resident was assessed and showed no signs of injuries but stated she cannot sleep and has been placed on 1:1 [one on one]. The CNA has been placed on suspension pending investigation. The Facility Reported Incident, form 358, to the SSA documented, The alleged victim was evaluated and felt anxious. Immediate actions were taken by staff to ensure she felt more comfortable. The attending staff is staying with the alleged victim one on one to ensure she is feeling more comfortable. The attending nurse provided a head to toe assessment to make sure there was no needed medical attention. The [family member] of the alleged victim was contacted and reached out to provide further comfort. The alleged perpetrator has been suspended and they do not have access to the building or the resident. The facility Follow-up Investigation Report, form 359, to the SSA documented that resident 258 reported that Nurse Assistant (NA) 2 entered her room and was acting strange. The CNA took the gait belt in [resident 258's] room and put it around her own neck to pretend she was hanging herself, she then took the bed sheets and put them over [resident 258's] head and refused to remove them for about 10 seconds, after doing that, she took a towel and put it on [resident 258's] neck, she didn't apply pressure but said, 'this is what they'll do'. The facility investigation conclusion documented the allegation as Inconclusive. This abuse report is pending police investigation. The report documented that NA 2 was terminated and all staff had been notified that NA 2 was not allowed on the facility grounds. Review of the facility abuse investigation documentation revealed no other information other than form 358 and form 359. NA 2's timesheet was reviewed for May 2023. NA 2 clocked in on 5/12/23 at 2:00 PM and clocked out at 10:03 PM. NA 2's time card did not have any other dates worked after 5/12/24. On 5/19/23, NA 2's termination form documented the reason for termination was gross misconduct. Additional notes documented, Termination of employment deemed necessary after employee was involved in abuse allegation which, upon investigation, were substantiated. The form documented that the last day worked was 5/12/23. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/24 at 11:51, a telephone interview was conducted with Registered Nurse (RN) 2. RN 2 stated that she was informed of the incident after shift change at 10:00 PM. RN 2 stated that resident 258 told her that when NA 2 put her to bed she acted weird. Resident 258 reported that NA 2 was standing at the foot of the bed was making a noose with something and mimicked hanging herself. RN 2 stated that resident 258 asked NA 2 to cover her up and the aide grabbed the sheet and held it over the resident's face and then she let it go. RN 2 stated that resident 258 was scared, shaking, and reluctant to say things. RN 2 stated that resident 258 was alert and oriented times 4 to person, place, situation, time, and had not made any allegations like this in the past. RN 2 stated resident 258's long- and short-term memory were intact. RN 2 stated she had no reason to not believe what resident 258 was saying to her. RN 2 stated that NA 2 had already left for the evening when resident 258 had informed her of the incident. RN 2 stated that other residents had made comments that NA 2 was short tempered with them but nothing like what resident 258 had said that night. RN 2 stated she informed the Administrator (ADM) and she documented a progress note about the incident. RN 2 stated that the following day they moved resident 258's room. RN 2 stated that resident 258 was afraid that NA 2 was going to come back to the building through the back door to her room. RN 2 stated that resident 258 was really worried that NA 2 was going to be angry at her and go through the gate and then come into her room. RN 2 stated that the ADM instructed her that if NA 2 showed up they were to call the police immediately. RN 2 stated that resident 258 mentioned the following week that she spoke to the police and she was going to press charges. On 4/3/24 at 1:07 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 258 was alert and oriented times 4. The DON stated that resident 258 reported to the nurse that the aide was acting strange when she was putting her to bed. The DON stated that resident 258 reported that NA 2 pinned her head down under the sheet and she could not get out from under it, and then NA 2 held a rolled towel against the resident's neck. The DON stated that the incident was reported by the licensed nurse to the ADM and she was not involved in any of the investigation. The DON stated that when she spoke to resident 258 she was upset about it and wanted to move closer to the nurse's station for safety, and she felt safe with more staff present. The DON stated that she assured resident 258 that NA 2 was not working at the facility anymore. The DON stated that resident 258 wanted to file a police report about the incident. The DON stated that resident 258 had not made any accusations like this in the past, and there was no reason to not believe what the resident had said. On 4/3/24 at 2:20 PM, an interview was conducted with the CNA Coordinator (CNAC). The CNAC stated that she was NA 2's supervisor. The CNAC stated that NA 2 was fired for an incident with resident 258. The CNAC stated that she was informed of the incident the same night that it occurred. The CNAC stated that the incident happened between 8:30 PM and 9:00 PM, before NA 2's shift ended. The CNAC stated that resident 258 usually went to bed between this time. The CNAC stated that resident 258 was alert and oriented, did not have problems with the aides, and was super sweet to everyone. The CNAC stated that she was gone for a couple of days and when she returned she tried to speak to resident 258 about the incident, but she did not want to talk about it. The CNAC stated that the social worker talked to the resident a lot after the incident. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/24 at 2:38 PM, an interview was conducted with the ADM. The ADM stated that as part of his investigation into the incident between resident 258 and NA 2 he conducted interviews with resident 258's roommate and the staff on shift at the time the alleged incident occurred. The ADM stated that he did not document those interviews. The ADM stated that the police came to the facility and also conducted interviews. The ADM stated that he recalled that the other residents were complaining about the aide talking rudely but he did not have any documentation of those interviews. The ADM stated that resident 261 had said that NA 2 was acting weird that night. The ADM stated that resident 261 stated that NA 2 was spacey, was mumbling things that did not make sense, and was just more different than she usually was. The ADM stated that RN 2 notified him at approximately 10 PM the night of the incident and by that time NA 2 was gone for the evening. The ADM stated that he contacted NA 2 by phone and told her she was suspended pending an investigation, but he did not tell her what the allegation was about. The ADM stated that when he spoke to resident 258 she asked the ADM to promise not to tell NA 2 that she had reported her. The ADM stated that resident 258 was really scared and the entire situation was sad. The ADM stated that resident 258 was afraid of retaliation from NA 2. The ADM stated that because of this he had an additional CNA come in and sit with resident 258 that night. The ADM stated that when resident 258 retold the story to the police officer she cried again. The ADM stated that resident 258 reported to the police that NA 2 was acting strange and she put a blanket and placed it over her head, and set a chuck pad or towel on her neck that was folded up. The ADM stated then she took a gait belt and put it around her own neck and pretended to hang herself. On 4/3/24 at 3:54 PM, an interview was conducted with the Resident Advocate (RA). The RA stated that resident 258 told her that she wanted to talk to the police about the incident and she wanted her present when that occurred. The RA stated that resident 258 told her that NA 2 came into her room and put something around her neck. The RA recollection was that resident 258 had said that NA 2 was saying some stuff to her, almost like it was how would it be to die. The RA stated that resident 258 was nervous and said why was she doing this to me?. The RA stated that resident 258 was scared, why is she showing her the gait belt around her own neck?. The RA stated that resident 258 reported that NA 2 put a towel over the residents face. The RA stated that resident 258 told her about the incident the following day. The RA stated that they moved resident 258 to a different room because she was scared and worried that NA 2 might come back. The RA stated that the room change made resident 258 feel safer. The RA stated that she was present during the police interview and resident 258 reported the same story to the police. The RA stated that resident 258 wanted to get a protective order for herself against NA 2. The RA stated that once resident 258 was able to file a police report it made her feel like it had lifted from her chest. The RA stated that resident 258 was alert and oriented and had never made allegations like this in the past. The RA stated that resident 258 would not lie, and she would tell her if something was bothering her. The RA stated that she had no reason not to believe what resident 258 had reported. On 4/4/24 at 8:19 AM, a follow-up interview was conducted with the ADM. The ADM stated that he interviewed NA 2 over the phone and she had reported that everything went normal and smooth on her last shift. The ADM stated that he asked NA 2 if anything strange had happen with any resident, and she replied no. The ADM stated that he asked NA 2 would there be any reason for any residents to say that you were acting threatening towards them, and she replied no. The ADM stated that NA 2 reported that everything that night went smooth and normal and there was no reason for any accusation of any kind. The ADM stated that he did not tell the aide what the accusation was or who it was about. The ADM stated that NA 2 was first notified of the allegation, who it was about, and what it pertained to by the detective who called her. The ADM stated that he believed resident 258 and that the incident had occurred. It was so sad to see the resident scared, that whole situation was so sad. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 10:23 AM, a telephone interview was attempted NA 2. NA 2 stated that legally she could not speak on the incident and she directed the SSA to contact her lawyer for further comments. Review of the facility policy on Abuse Prevention of and Prohibition Against documented, The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be [free] from abuse, neglect, misappropriation of resident property, and exploitation. The policy was last revised in April 2019.		

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NAME OF PROVIDER OR SUPPLIER Paramount Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 4035 South 500 East Salt Lake City, UT 84107	
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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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 43212 Based on interview and record review, for 3 of 38 sampled resident, that the facility did not ensure that all violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation was made. Specifically, the facility did not report to the State Survey Agency (SAA) timely when a resident sustained a severe finger injury while in her wheelchair, a resident was not secured while being transported in a facility van, and a resident was not provided the ordered wound care to her foot. Resident identifiers: 20, 21, and 256. Findings include: 1. Resident 21 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, protein calorie-malnutrition, dysphagia, vitamin D deficiency, contracture in left and right knee, major depressive disorder, and cognitive communication deficit. The facility submitted a form titled exhibit 358 to the State Survey Agency (SSA). It was documented on the 358 that the Administrator reported the allegation on 2/21/24 at 8:07 PM. The 358 revealed the Administrator (ADM)/Abuse coordinator became aware of the incident on 2/24/24 at 5:05 PM. The resident's family member was listed as the person making the allegation. The entity report also stated, [Resident 21's] finger injury determined investigation measures from [Resident's family member's name removed]. The incident was alleged to have occurred on 2/21/24 at 1:50 PM outside of resident 21's room while being pushed in her wheelchair. The report stated, The fingernail of the resident was pushed back and the skin was raised and cut. Acquired L (left) 4th finger laceration & displaced fracture, distal phalanx of the L ring finger. The injury was described as, .injury on her finger was from her fingernail being raised and pulled off and pulled the skin back resulting in an open cut. Steps to ensure the resident was protected included, The resident was immediately assessed by two nurses head to toe and was then sent out to the hospital where she then was scheduled follow-up appointments for her finger. She was not admitted to the hospital The nurses were given orders to check for pain and she was scheduled both PRN [as needed] and scheduled pain medication. The witness was documented as a Certified Nursing Assistant (CNA) 4 at the facility. The 358 revealed that other agencies were notified, however, none were listed. It should be noted that according to the SSA, the report was submitted on 2/28/24 at 9:49 AM. In, addition, the incident occurred on 2/21/24 at 1:50 PM but it was documented the ADM reported to the SSA on 2/21/24 at 8:07 AM which was before the incident. According to the SAA the incident was reported 2/28//24 at 9:49 AM. Resident 21's medical record was reviewed 4/3/24 through 5/14/24. A quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 21 was totally dependent with transfers between bed/chair to her wheelchair. (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 - Minimal harm or potential for actual harm Residents Affected - Some	A hospital summary dated 2/21/24 revealed that resident 21 was treated for, closed displaced fracture of distal phalanx of left ring finger .laceration of left ring finger without foreign body with damage to nail. On 2/21/24 at 1:54 PM, a nursing progress note revealed, Resident being wheeled to her room when her finger hit the door jam and it was ripped from her nail and appears to need sutures. Order to send to [Hospital name removed] ED [emergency department] to be evaluated. Family notified. On 2/21/24 at 6:10 PM, a nursing progress note revealed, Resident has returned from ED department. She had to have the fingernail removed, the finger is fractured and there are stitches in place. She is to schedule an appt [appointment] for follow up on 2/23/24 with [physician's name removed]. On 4/3/24 at approximately 11:15 AM, an interview was conducted with the ADM. The ADM stated that he was the abuse coordinator. The ADM stated that if an incident occurred, the staff called him on his cell phone anytime. The ADM stated the 358 entity report should be submitted within 2 hours of becoming aware of an incident. The ADM stated the priority was to make sure that residents were safe, then he would notify appropriate agencies. The ADM stated the reason the incident was not reported within 2 hours was that CNA 4 came and told him directly what had happened with resident 21. The ADM stated that initially he did not think the incident was something that needed to be reported based on what CNA 4 had told him. The ADM stated he did not know to go to the Centers for Medicare and Medicaid (CMS) and complete the 358 form. The ADM stated he did get a verification from the SSA after he submitted it and the date was 2/29/24. The ADM stated the reason the dates were confusing on his 358 submission was that he did not fill out the 358 entity report until 2/28/24, and that he filled the form out thinking about the time of the incident. 45490 2. Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included functional quadriplegia, delusional disorder, bipolar disorder, traumatic brain injury (TBI), and cervical disc disorder. On 5/2/23 at 2:11 PM, a facility incident report documented, resident 20 came back from an appointment and told us about an incident while in the transport van. Resident claimed that he was sitting in his electric wheelchair inside the van but was not seat belted in the van. The van stopped abruptly, and he was thrown from his chair landing his bottom on the footrests of his w/c [wheelchair] and hitting his head and neck on the seat. He states he was helped back into the w/c then brought back to our facility. Resident 20 was checked for injuries, and neuro [neurological] checks started, No injuries seem [sic] at this time. Has some pain in neck, back and head. A section titled Witnesses documented a statement, Resident was sliding off of his wheelchair but did not completely off his seat. Parked the van and asked 2 bikers on the road to help him reposition back in his chair and placed a seatbelt on him. Resident 20's medical records were reviewed between 4/3/2024 and 5/14/2024. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/2/23 at 2:40 PM, a nursing progress note documented, resident 20 came back from his appointment with [a local urology clinic] and told us that he was sitting in his electric wheelchair inside the van but was not seat belted in the van. The van stopped abruptly, and he was thrown from his chair landing his bottom on the footrests of his w/c [wheelchair] and hitting his head and neck on the seat of the w/c. He states he was helped back into the w/c by driver and passersby then brought back to our facility. Pt. [Patient] checked for injuries. None seen at this time. Neuro checks started . It should be noted the incident was not reported to the state survey agency (SSA). On 4/4/24 at 2:29 PM, an interview was conducted with the Administrator (ADM). The ADM stated that he did not know a ton of details on the incident with resident 20, the ADM stated that he didn't think he reported the incident and didn't know why, and that he should have reported it. 3. Resident 256 was admitted to the facility on [DATE] with diagnoses which included surgical amputation, osteomyelitis, cognitive communication deficit, bipolar disorder, and arthritis due to other bacteria right ankle and foot. Resident 256's medical records were reviewed between 4/3/224 and 5/14/24. An admission MDS dated [DATE] documented resident 4 was limited 1 person assistance for bed mobility. On 7/22/23 at 3:20 PM an initial entity report, exhibit 358, was submitted to the SSA. The the facility reported that on 07/20/23 at an unknown time, the Resident's podiatrist alleged that wound care dressing changes were not being provided. The staff were notified and immediately began to change the wound dressing more frequently. The resident was assessed and no injuries or changes in behavior were noted. APS was notified. A document titled Referral to Physicians and Clinics dated 7/17/23 at 1:45 PM, physician assessment and findings revealed No one has regularly changed her dressing which is negligence [sic]. Pressure wound to anterior shin from improper dressing change/care . Nursing home negligent [sic] with dressing change, pressure excoriation to anterior shin which is new due to nursing home neglect. On 7/18/23 at 8:47 PM, a nursing progress note documented, a physician of a podiatry clinic called and asked why the dressing had not been changed regularly. It should be noted that this was reported 5 days after the facility became aware of the allegation of neglect. On 4/4/24 at 12:40 PM, an interview was conducted with the ADM. The ADM stated that he was unsure of exactly when or who notified him of the incident and that it was most likely the Director of Nursing (DON). The ADM stated that the word neglect used by the physician, made him decide to report it. On 4/4/24 at 12:43 PM, an interview was conducted with the DON. The DON stated that her and the Administrator might have been out of the facility when the resident came back from that podiatry appointment. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy on Abuse, Neglect, Exploitation, and Misappropriation documented that the facility objective was to protect the residents from abuse, neglect, exploitation, and misappropriation of property. The policy stated that the facility would provide staff orientation and training on abuse prevention, identification and reporting of abuse. The policy stated that all allegations of possible abuse would be investigated and reported to the appropriate State or Federal agencies in the applicable timeframes.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review it was determined, 4 of 38 sampled residents, that in response to allegations of abuse, neglect, exploitation, or mistreatment, the facility failed to thoroughly investigate and report the results of all investigations to the State Survey Agency (SSA) within 5 days of the incident. Specifically, the facility did not thoroughly investigate a resident's finger that was partially amputated after it became impinged in a tilting wheelchair hinge; a resident reported physical and mental abuse when a nurse aide placed a sheet and towel over the resident's head and neck trapping them and preventing them from moving freely; a resident was not secured in the van during transport and sustained injuries; and another resident was not provide wound care according to physician's orders. Resident identifiers: 20, 21, 256, and 258. Findings include: 1. Resident 21 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, protein calorie-malnutrition, dysphagia, vitamin D deficiency, contracture in left and right knee, major depressive disorder, and cognitive communication deficit. On 2/21/24 at 8:07 PM, a 358 entity report was submitted to the State Survey Agency (SSA) revealed that on 2/21/24 at 1:50 PM resident 21 acquired L (left) 4th finger laceration and displaced distal phalanx of L ring finger while being transported in her wheelchair. The report stated that resident 21's family member was the person who made the allegation. The report also stated, [resident's name removed] finger injury determined investigation measures from [resident family member]. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/24 at 4:05 PM, a 359 entity report was submitted to the SSA. Additional information related to the incident included, Finger injury was followed up on and resulted in no lasting damage. Steps taken to investigate the allegation included, interview with the resident's responsible party told us they did not notice enduring physical pain from the injury the resident sustained. They did not notice any psychosocial distress from the patient either. A summary of the witness interviews included, After speaking with the CNA [Certified Nursing Assistant] caring for [resident's name removed] at the time, the CNA told me that [resident's name removed] reached her hand into the door frame when he was rolling her into the room. This resulted in her left fourth finger injury. Other residents that were interviewed were summarized as, Other residents on the hallway and the resident's roommate did not describe seeing or feeling that there were any aides acting strange or them seeing abuse of any kind. A staff interview summary stated, Nurse who was overseeing the incident responded to the injury but did not see it occur. They are the ones who assessed her and then sent her out to the hospital. The report also included, Attending [NAME] station nurse was responsible for the oversight and supervision of the alleged perpetrator and all care on the hall. When we interviewed this nurse, they did not describe seeing anyone doing anything that would qualify as abuse. The nurse describe the injury [resident's name removed] sustained resulted from the resident herself stick her own arm out when the CNA was rolling her into her room. Clinical information provided included, Resident is non-verbal and will randomly at times move her arms like spasms. After her follow up the orthopedic surgeon determined her finger would fully rehabilitate and not end in lasting pain. The investigation concluded that abuse was not verified. The incident from the resident passing through the door resulted in an injury, not abuse. Corrective actions stated, Education was provided to CNA's about taking cares slows. The form also stated that Education and QAPI (Quality Assessment and Performance Improvement) was provided to staff about cares and to move carefully and slowly. According to the SSA, the 358 entity report was submitted on 2/28/24 at 9:49 AM, which was 2 days after the 359 entity report was completed and submitted. Resident 21's medical record was reviewed 4/3/24 through 5/14/24. A quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 21 was totally dependent with transfers between bed/chair to her wheelchair. Resident 21's care plan included, Laceration to left 4th fingertip from hitting against doorframe 2/21/24. Resolved 3/21/24. There was no goal for the care area related to resident 21's finger injury. Interventions included, Dressing to left ring finger and splint applied at ED on 2/21/24. Date initiated 2/27/24 .Educate staff on Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. When in w/c [wheelchair] resident can have pillow on lap, with hands resting on pillow as per family request. Date initiated: 2/27/24. A hospital summary dated 2/21/24 revealed that resident 21 was treated for, closed displaced fracture of distal phalanx of left ring finger .laceration of left ring finger without foreign body with damage to nail. On 2/21/24 at 1:54 PM, a nursing progress note revealed, Resident being wheeled to her room when her finger hit the door jam and it was ripped from her nail and appears to need sutures. Order to send to [Hospital name removed] ED [emergency department] to be evaluated. Family notified. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/24 at 2:12 PM, a nursing progress note revealed, Reported by staff while wheeling resident toward room resident struck out her hand and hit the doorframe and acquired a laceration on her left 4th fingertip. Cleaned and applied pressure dressing, cut is deep might require stitches. Provider notified and ordered to send to ED for possible suture. [Family members] was notified of incident. On 2/21/24 at 6:10 PM, a nursing progress note revealed, Resident has returned from ED department. She had to have the fingernail removed, the finger is fractured and there are stitches in place. She is to schedule an appt [appointment] for follow up on 2/23/24 with [physician name removed]. On 2/26/24 at 11:57 AM, a Skin Committee IDT [interdisciplinary team] note revealed, Reported by staff while wheeling resident towards room resident struck out her hand and hit the doorframe and acquired a laceration on her left 4 fingertip. Cleaned and applied pressure dressing, cut is deep might require stitches. Provider notified and ordered to send to ED for possible suture. [Family members] notified of incident. She had to have the fingernail removed, the finger is fractured and there are stitches in place. Intervention: Educate staff on use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Provider and family agree with POC [plan of correction]. On 4/3/24 staff interview documentation was provided. The staff interview questions included: a. During your shift on 2/21/24 did you notice any resident in distress or demonstrating physical or mental pain? b. Did you notice [resident 21's name removed] acting in a different way? c. Did you notice [resident 21's name removed] has non verbal signs of pain? Six staff were provided interview questionnaires to complete. Five were CNA's, and 1 was the nurse who did the assessment on resident 21. Some of the staff had not worked with resident 21 on the day of her injury, or worked with resident 21 for a very short period of time. The interview with Licensed Practical Nurse (LPN) 2 stated that as she came out of a resident's room she observed resident 21 in the hallway with CNA 4 and the resident's finger was bleeding. Also stated was that after assessing resident 21's injuries, both she and the Wound Nurse (WN) agreed that the resident should be sent to the emergency room . LPN 2's interview stated that resident 21 expressed some facial grimacing, but was at her baseline behavior . Resident 21 was not crying or screaming in pain. Five resident interview questionnaires were completed by residents on the same hallway as resident 21. The questions residents were asked included: a. On 2/21/24 do you feel any of [name of facility] Employees acting strange or different? b. Do you feel any [name of facility] residents acting strange or different? c. Did you/do you feel safe as a resident at [name of facility] Health? All residents who received the interview questionnaire responded no to the first 2 questions and yes to the last question. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that no additional staff educational materials were provided as a result of this incident. On 4/3/24, an interview was conducted with the Administrator (ADM) who stated he was the staff member who conducted abuse investigations. The ADM also stated his investigation depended on what the allegation was and what the interdisciplinary Team (IDT) provided to him. The ADM stated his first priority was to make sure that the residents were safe. The ADM stated he started his investigation with the victim, then to the person who supervised the resident, and then other cognitively intact residents who may have had contact with the perpetrator. The ADM stated suspending the involved staff member would help to make the residents safe until the investigation was complete. The ADM stated if the police needed to be called or the building needed to be locked down that was also available. The ADM also stated sometimes 1:1 staff supervision of a resident was provided. The ADM stated he kept the questions vague on the staff and resident questionnaires on purpose because he does not like to air other people's dirty laundry. The ADM stated many of his interviews were just verbal interviews. The ADM stated that CNA 4 was technically suspended on 2/29/24, but came back to work on the same day. The ADM stated 359 entity reports should be submitted 5 days after the 358 was submitted. [Cross refer to F689] 38031 2. Resident 258 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included presence of right artificial knee joint, cellulitis right lower extremity, type 2 diabetes mellitus, mobid obesity, gout, edema, and hypertension. Resident 258 was discharged from the facility on 6/28/23. On 4/3/24, resident 258's medical record was reviewed. On 5/12/23 at 11:00 PM, resident 258's the nursing note documented, Resident notified LN [licensed nurse] tonight that her aide was acting strange when she went to put [resident 258] to bed. [Resident 258] states that her aide placed a looped gait belt around her (the aide's) neck and mimicked her hanging herself while standing at the foot of the bed while [resident 258] was on the commode. [Resident 258] then stated that her aide helped her into bed and pinned the top sheet down over the top of [resident 258's] head where she could not get out from under it. [Resident 258] stated that after her aide let the sheet go she proceeded to take a rolled up towel that the resident uses for therapy and held it against [resident 258] neck. [Resident 258] states that her aide made the comment 'this is what they do' and proceeded to grab the garbage and leave the room. After this was explained to me by the resident I proceeded to call our facility Administrator / Abuse Coordinator and reported the incident. I then returned to [resident 258's] room and completed a physical and emotional assessment on her. Residents VS [vital signs] are [blood pressure]149/66, [heart rate] 65, [temperature] 97.6, [oxygen saturation] 94% room air. No injuries observed during the assessment. [Resident 258] states that she feels shaken up but that she is okay. [Resident 258] also states that she feels safe at this time. The aide that was mentioned left the building at 2200. Frequent monitoring is in place. Residents daughter was notified of the incident by the facility Administrator. Staff will continue to monitor resident. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/12/2023 at 11:48 PM, the facility reported to the State Survey Agency (SSA) that on 5/12/2023 at 10:00 PM, resident 258 alleged that she was physically and mentally abused by the CNA [Certified Nurse Assistant] and is displaying signs of fear and anxiety. The Resident was assessed and showed no signs of injuries but stated she cannot sleep and has been placed on 1:1. The CNA has been placed on suspension pending investigation. The Facility Reported Incident, form 358, to the SSA documented, The alleged victim was evaluated and felt anxious. Immediate actions were taken by staff to ensure she felt more comfortable. The attending staff is staying with the alleged victim one on one to ensure she is feeling more comfortable. The attending nurse provided a head to toe assessment to make sure there was no needed medical attention. The [family member] of the alleged victim was contacted and reached out to provide further comfort. The alleged perpetrator has been suspended and they do not have access to the building or the resident. The facility Follow-up Investigation Report, form 359, to the SSA documented that resident 258 reported that Nurse Assistant (NA) 2 entered her room and was acting strange. The CNA took the gait belt in [resident 258's] room and put it around her own neck to pretend she was hanging herself, she then took the bed sheets and put them over [resident 258's] head and refused to remove them for about 10 seconds, after doing that, she took a towel and put it on [resident 258's] neck, she didnt apply pressure but said, 'this is what they'll do'. The facility investigation conclusion documented the allegation as Inconclusive. This abuse report is pending police investigation. The report documented that NA 2 was terminated and all staff had been notified that NA 2 was not allowed on the facility grounds. Review of the facility abuse investigation documentation revealed no other information other than form 358 and form 359. On 4/3/24 at 2:38 PM, an interview was conducted with the ADM. The ADM stated that as part of his investigation into the incident between resident 258 and NA 2 he conducted interviews with resident 258's roommate and the staff on shift at the time the alleged incident occurred. The ADM stated that he did not document those interviews. The ADM stated that the police came to the facility and also conducted interviews. The ADM stated that he recalled that the other residents were complaining about the aide talking rudely but he did not have any documentation of those interviews. The ADM stated that resident 261 had said that NA 2 was acting weird that night. The ADM stated that resident 261 stated that NA 2 was spacey, was mumbling things that did not make sense, and was just more different than she usually was. The ADM stated that RN 2 notified him at approximately 10 PM the night of the incident and by that time NA 2 was gone for the evening. The ADM stated that he contacted NA 2 by phone and told her she was suspended pending an investigation, but he did not tell her what the allegation was about. On 4/4/24 at 8:19 AM, a follow-up interview was conducted with the ADM. The ADM stated that he interviewed NA 2 over the phone and she had reported that everything went normal and smooth on her last shift. The ADM stated that he asked NA 2 if anything strange had happen with any resident, and she replied no. The ADM stated that he asked NA 2 would there be any reason for any residents to say that you were acting threatening towards them, and she replied no. The ADM stated that NA 2 reported that everything that night went smooth and normal and there was no reason for any accusation of any kind. It should be noted that no documentation was available of the interview that the ADM conducted with NA 2. [Cross-refer F600] 45490 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included functional quadriplegia, delusional disorder, bipolar disorder, traumatic brain injury (TBI) and cervical disc disorder. On 5/2/23 at 2:11 PM, a facility incident report documented, resident 20 came back from an appointment and told us about an incident while in the transport van. Resident claimed that he was sitting in his electric wheelchair inside the van but was not seat belted in the van. The van stopped abruptly, and he was thrown from his chair landing his bottom on the footrests of his w/c [wheelchair] and hitting his head and neck on the seat. He states he was helped back into the w/c then brought back to our facility. Resident 20 was checked for injuries, and neuro checks started. No injuries seen [sic] at this time. Has some pain in neck, back and head. A section titled 'Witnesses' documented a statement, Resident was sliding off of his wheelchair but did not completely off his seat. Parked the van and asked 2 bikers on the road to help him reposition back in his chair and placed a seatbelt on him. Resident 20's medical records were reviewed between 4/3/2024 and 5/14/2024. On 3/10/23 an admission MDS assessment revealed, resident 20 required extensive two person assistance with bed mobility and transfers. Functional limitation in range of motion documented resident 20's upper extremity impairment on one side, and lower extremity impairment on both sides. Resident 20's used a wheelchair for mobility. Resident 20's Brief Interview of Mental Status (BIMS) was a 14 out of 15 which indicated cognition was intact. On 5/2/23 at 2:40 PM, a nursing progress note documented, resident 20 came back from his appointment with [a local urology clinic] and told us that he was sitting in his electric wheelchair inside the van but was not seat belted in the van. The van stopped abruptly, and he was thrown from his chair landing his bottom on the footrests of his w/c [wheelchair] and hitting his head and neck on the seat of the w/c. He states he was helped back into the w/c by driver and passersby then brought back to our facility. Pt. [Patient] checked for injuries. None seen at this time. Neuro checks started . On 5/2/23, a physician's order documented an X-ray bilateral hips. On 5/2/23 a Radiology Interpretation documented a left hip bilateral with pelvis 2 views. Findings included 1. No definite radiographic evidence of acute fracture or dislocation. If symptoms persist, follow-up radiographs or CT [computed tomography] in order to evaluate for initial radiographically occult fracture. 2. Chronic nonunion fracture of right femoral neck. 3. Moderate degree of osteopenia/osteoporosis. 4. Moderate osteoarthritis. [It should be noted, that no documentation of the x-ray results could be located in resident 20's medical record, the facility requested the results.] On 5/3/23 at 3:03 AM, a nursing progress note documented, resident 20 states that he is sore from the incident . On 9/9/23, resident 20's x-ray documented, Right Hip, 2 views comparison: 5/2/2023. Findings: .Chronic fracture of right femoral neck with absence of right femoral head. Right femoral head may have been surgically removed . (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 1:57 PM, an interview was conducted with transportation driver (TD) 1. TD 1 stated she was a transportation driver and had worked at the facility for 6 months. TD 1 stated that her training included shadowing the Transportation Manager (TM) for 3 to 4 days. TD 1 stated that the TM followed her to the first appointment, said she did a good job, and then she was on her own. TD 1 stated she Not sure what he was checking or observing for. TD 1 stated that the TM watched her load the passengers, buckle them in, drive them to the appointment, and take them out. TD 1 stated that she recalled the incident with resident 20. TD 1 stated that she positioned the resident front facing, tried to move a buckle strap from behind him, but it would not budge. TD 1 stated that resident 20 refused to be positioned sideways so that the buckle strap would secure into the latch. TD 1 stated she could not properly buckle resident 20. TD 1 stated that resident 20 requested to just go back to the facility without the seatbelt secured. TD 1 stated that they were traveling down a hill and he was wearing basketball shorts and slid. TD 1 stated that resident 20 did not have his w/c seat belt buckled and he slipped and his knees hit the front passenger chair. TD 1 stated that resident 20 did not fall out of his chair. TD 1 stated that the street they were on had an incline that could help get resident 20 back into his seat, and that he had slouched in his seat and half of his butt was in the chair and the other half was out of the chair. TD 1 stated that she did not notify anyone of the incident because resident 20 had asked her not to notify her supervisor. TD 1 stated later the administrator (ADM) called and spoke with her and stated that the way the resident was facing he could not have fallen out of his chair and broken his back based on the way he was facing in the van. TD1 stated that the ADM realized her story made a lot of sense. TD 1 stated that for an incident like that she should have immediately called 911 for assistance, taken pictures of the scene and should have not transported the resident without a seatbelt. TD1 stated that she was listening to the resident and did not buckle him because he was refusing to buckle. TD 1 stated that during her training they did not discuss what to do when a resident refused to be buckled or to inspect the vehicles before use. TD1 stated that after the incident she did not have any additional training, write ups, or changes to her schedule. TD 1 stated she received verbal teaching during transport to face the residents sideways in the vehicle and to make sure residents were buckled. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 2:29 PM, an interview was conducted with the Administrator (ADM). The ADM stated that he did not know a ton of details on the incident with resident 20, can't remember. I don't think I reported it and I don't know why. Looking at it now I should have. The ADM stated that resident 20 informed the nurse about the incident. The ADM stated that he called TD 1 and she told him a completely different story. The ADM stated that the TM said he would provide education and a warning. The ADM stated there was No paper trail, just verbal. The ADM stated that now he would perform an in-service form with education. The ADM stated that TD 1 reported that she helped resident 20 into the chair. The ADM stated that the nurse documented that resident 20 had fallen out of his wheelchair and his bottom landed on the footrest. The ADM stated that he believed TD 1's version of the events because there was not enough room for it to have occurred as the resident reported. The ADM stated that when the van returned from the incident that day he went outside and met with resident 20 and TD 1. The ADM stated that it would have been impossible for TD 1 to lift resident 20 if he really did fall down. It should be noted that the ADM did not know that TD 1 stopped bikers to aid in assisting resident 20 back into his w/c. The ADM stated that he took TD 1's word for it, and did not verify any of the details of the incident. The ADM stated that the van had a ramp, and once it was locked in there was maybe a foot and half a foot space. The ADM stated that he was outside while he was outside when resident 20 exited the van and he met them when they arrived back at the facility. The ADM stated that TD 1 called someone after the incident, can't remember who it was. The ADM stated that the TM notified the Director of Nursing (DON). The ADM stated that he spoke to the TD 1 and resident 20 outside and asked resident 20 if he was okay. The ADM stated that was when he got both of their stories. The ADM stated that the nurse performed a head-to-toe assessment. The ADM stated that it would be documented, but did not know where that information was located. It should be noted that no documentation of an assessment s/p (status post) fall could be found. The ADM stated that resident 20 did not complain of pain or injuries. The ADM stated that the drivers should contact TM when there was an incident and then the TM should contact him. The ADM stated that they would then determine what aid was necessary and contact the appropriate agencies. The ADM stated that the process was that they analyze the situation, give education and training, and spot check. The ADM stated that he would go out and do random audits to visualize that they were doing what should be done, whatever had not been done prior to the incident. The ADM stated that the drivers should follow the facility policy and procedures. The ADM stated that transportation staff should perform safety checks, adhere to whatever was in the fleet manual, verify that the mobility device was secured and that the resident was seat belted, yes of course. The ADM stated the drivers should not operate the vehicle without buckling the resident in. The ADM stated if a resident refused, he would involve the clinical team of the facility, and explain why they should buckle them in. The ADM stated that if a resident refused to be seat belted in the vehicles the staff should not transport the resident. The ADM stated, I can remember being outside, the way it was described over the phone, and then [TD 1] called [TM] and the [DON] was informed and then we met them outside the facility. The ADM stated that he recalled meeting resident 20 when he returned from his appointment and asked him if he was okay. The ADM stated that he met him outside at the van if I did. I don't really remember with certainty what happened. I recall hearing both stories and I recall both stories being different. The ADM stated he took TD 1's story at its word and did not investigate the incident. It should be noted that there was not any documentation of an investigation of the incident, or education provided. [Cross refer to F689] (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident 256 was admitted to the facility on [DATE] with diagnoses which included surgical amputation, osteomyelitis, cognitive communication deficit, bipolar disorder, and arthritis due to other bacteria right ankle and foot. On 7/22/23 at 3:20 PM, a form titled Exhibit 358 was submitted to the SSA. The form revealed that the the facility reported that on 7/20/23 at an unknown time, the Resident's podiatrist alleged that wound care dressing changes were not being provided. Staff was notified and immediately began to change the wound dressing more frequently. The Resident was assessed and no injuries or changes in behavior were noted. APS (Adult Protective Services) was notified. Resident 256's medical records were reviewed between 4/3/2024 and 5/14/2024. An admission MDS dated [DATE] documented resident 4 was limited 1 person assistance for bed mobility. A physicians order dated 6/7/23 documented, Wound care to Right leg to be completed every Wednesday and Friday. A skin evaluation dated 7/4/23, documented resident 256 continues to have surgical wound to RLE [right lower extremity]. No other skin concerns at this time. A skin evaluation dated 7/11/23, documented resident 256 continues to have surgical wound to RLE. No other skin concerns at this time. A document titled 'Referral to Physicians and Clinics' dated 7/17/23 at 1:45 PM, the physician assessment and findings revealed No one has regularly changed her dressing which is negligence [sic]. Pressure wound to anterior shin from improper dressing change/care . Nursing home negligent [sic] with dressing change, pressure excoriation to anterior shin which is new due to nursing home neglect. On 7/18/23 at 8:47 PM, a nursing progress note documented, a physician of a podiatry clinic called and asked why the dressing had not been changed regularly. A Skin Ulcer non-Pressure Weekly assessment dated [DATE], documented resident 256 continues to have surgical site to rle has a small a small brown scabs to right shin and right anterior ankle, irregular wound edges and no sign of infection . Resident and provider updated on wounds. A form titled Exhibit 359 documented the follow-up investigation report. The report documented caregivers and nurses attending [resident 256] were interviewed . The corrective actions documented an inservice was done and staff was educated on proper wound care treatment and frequency. DON or designee will do an audit every week for 4 weeks . DON will oversee audits to ensure proper wound care is being done and bandages are changed frequently. [It should be noted interview with staff were not documented and the 4 week audit could not be located.] On 4/4/24 at 12:40 PM, an interview was conducted with the ADM. The ADM stated that he was unsure of exactly when or who notified him of the incident and that it was most likely the DON. The ADM stated that the word neglect used by the physician that he decided to report it. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 12:43 PM, an interview was conducted with the DON. The DON stated that her and the administrator might have been out of the facility when the resident came back from that podiatry appointment and did not know about the incident immediately. The DON stated that education was provided about wound management. [It should be noted that documentation of wound management education and wound audits could not be located.] Review of the facility policy on Abuse Prevention of and Prohibition Against documented, The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be [free] from abuse, neglect, misappropriation of resident property, and exploitation. The policy further documented, 4. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee. 5. The investigation will include the following: - An interview with the person(s) reporting the incident; - An interview with the resident(s); - Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; - A review of the resident's medical record; - An interview with staff members (on all shifts) who may have information regarding the alleged incident; - Interviews with other resident to whom the accused employee provides care or services or who may have information regarding the alleged incident; - An interview with staff members (on all shifts) having contact with the accused employee; and - A review of all circumstances surrounding the incident. The policy also documented that the facility investigation and the results of the investigation should be documented. The policy was last revised in April 2019.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review, it was determined for 3 of 38 sampled residents, that the facility did not develop and implement a comprehensive care plan that included measurable objectives and time frames to meet resident's medical, nursing, and mental and psychosocial needs. Specifically, a resident with at risk for developing pressure ulcers did not have interventions implemented and another resident had interventions to have the call light within reach and observations were made of call light out of reach. Resident identifiers: 8, 17 and 36. Findings include: 1. Resident 8 was admitted to the facility on [DATE] with diagnoses which included other specific joint derangements of left hip, pain in left hip, Alzheimer's, chronic systolic heart failure, and protein-calorie malnutrition. On 5/7/24 at 10:59 AM, an observation was made of resident 8's left inner foot. The bandage had a date of 5/3/24 on it. On 5/9/24 from 2:37 PM until 3:15 PM, an observation was made of resident 8. Resident 8 was observed in the hallway across from the nurses station. Resident 8 was in a tilt back wheelchair with his legs crossed. There was a black sore on the outside of right side of shin on the right leg. There was a break on the wheelchair where resident 8 was observed to repeatedly bang the outside of his right shin where there was a black spot on the leg. There was redness around the black spot. Resident 8's medical record was reviewed 5/6/24 through 5/14/24. An annual Minimum Data Set (MDS) dated [DATE] revealed a clinical assessment was completed to determine resident 8's pressure ulcer risk. The MDS revealed resident 8 was at risk for developing pressures ulcers and did not have any unhealed pressure ulcers. The MDS revealed there were no venous or arterial ulcers. The MDS further revealed resident 8 had a pressure reducing device for his chair and bed, an application of non-surgical dressings other than to feet and an application of dressing to feet. A care plan dated 5/24/19 and updated on 4/10/24 revealed resident 8 Has potential impairment to skin integrity r/t [related to] weakness, decreased mobility, pain, cognitive impairment, incontinence. Open wounds from resident scratching to bilateral knees and left medial thigh 10/13/23- resolved. Open wound to right ischium from resident scratching 1/11/24: Resolved 1/26. Wound to Metatarsal head of left foot 3/26/24. Chronic scratches to right lateral thigh and left forearm, tip of nose 3/30/24. The goal was Will have no complications r/t open wounds from resident scratching the review date. Interventions included Encourage good nutrition and hydration in order to promote healthier skin; Ensure fingernails are clean and trimmed; Float Heels; Follow facility protocols for treatment of injury; Keep skin clean and dry. Use lotion on dry skin. Do not apply on surgical incision; Mupirocin ointment BID [twice daily] for infection 3/30-4/12; Pressure relieving/reducing mattress, cushion in wheelchair and; Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 7:35 AM, an observation was made of resident 8's feet and legs with the DON. Resident 8 was observed to be laying in bed with no heel float. The DON stated that the black area on the right side of his right shin did not look like it was infected and he had other areas from scratching. The DON stated that it was not a pressure sore but a scab. The DON stated the black spot did not look red around it and was not infected. The DON stated resident 8 was to have his heels floated while in bed. The DON stated there was a dressing on the left metatarsal head of left foot wound. The DON was observed to look for a heal float in resident 8's room. The DON stated she was unable to find the heal float. 2. Resident 36 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, seizures, hyperglycemia, diabetes mellitus, protein calorie malnutrition, dysphagia, and personal history of traumatic brain injury. On 5/6/24 from 9:24 AM until 10:22 AM, an observation was made of resident 36. Resident 36 was observed to have his call light around a light fixture by his bed. The call light was out of resident 36's reach. Resident 36's medical record was reviewed 5/6/24 through 5/14/24. A care plan dated 6/1/22 and revised on 2/2/23 revealed Alteration in musculoskeletal status r/t [related to] MVA [motor vehicle accident] w/ [with] Poly Trauma and fractures Fracture to right 4th finger- refused to keep splint in place. The goal was Will remain free of injuries or complications through review date. One of the interventions developed was Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Another care plan dated 6/1/22 and revised on 6/17/22 revealed At risk for a communication problem r/t Head Injury, Hearing deficit, sometimes has difficulty making self understood. The goal revealed, Will be able to make basic needs known on a daily basis through the review date. One intervention included Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. Another care plan dated 6/1/22 and revised on 4/3/24 revealed At risk for falls r/t actual fall, Hydrocephalus; traumatic brain injury; dysphagia; encephalopathy; bilateral hearing loss; seizure d/o [disorder] Actual fall-11/18/23, 3/13/24, 4/3/24. A goal was Minimize risk of falls through the review date. One of the interventions included Be sure the call light is within reach and encourage to use it to call for assistance as needed. On 5/13/24 at 11:49 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 36 was easily re-directed, but was confused quiet a bit. LPN 1 stated resident 36 had seizures and was confused for a few days after. LPN 1 stated after a seizure his condition changed for the worst but then he came around. LPN 1 stated resident 36 was a little forgetful to use the call light but he might use it sometimes. LPN 1 stated resident 36's call light should be within reach. On 5/14/24 at 8:07 AM, an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated sometimes resident 36 was able to use his call light. CNA 4 stated resident 36 should have his call light within reach at all times. CNA 4 stated the call light tied to the light fixture would be out of reach of resident 36. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 8:27 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 36 was able to use his call light but sometime with his cognition he did not use it. The DON stated she provided education to staff regarding call lights which included making sure the call light was within reach of the resident. The DON stated she provided education because resident council had complained of long wait for call lights. The DON stated call lights within reach was part of the education. 3. Resident 17 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease, intracranial and intraspinal phebities and thrombophlebitis, diabetes mellitus, adult failure to thrive, and protein-calorie malnutrition. On 5/7/24 at 3:18 PM, an interview and observation were made of resident 17. Resident 17 had a half side rail on the left side of her bed. Resident 17 stated that she would like another half side rail to the right side of her bed but was told that the nurse and doctor had to evaluate her for it. Resident 17 stated she asked the Maintenance Director about three weeks ago for the other half side rail. Resident 17 stated the half side rail would help her to reposition in bed. Resident 17's medical record was reviewed 5/7/24 through 5/14/24. There was no information located in resident 17's medical record regarding an evaluation of a half side rail. A care plan dated 3/14/24 and revised on 5/6/24 revealed, ADL [activities of daily living] Self Care Performance Deficit r/t [related to] CVA [cerebral vascular accident], depression, hx [history] of falls, ., RUE [right upper extremity] tremor, . Contracture management to lle [left lower extremity]. The goal was Will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene with supervision through the review date. Interventions included Explain all procedures/tasks before starting; Promote dignity by ensuring privacy; Wears AFO [ankle-foot orthosis] to lle; Encourage to participate to the fullest extent possible with each interaction; Encourage to use bell to call for assistance and; Monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. On 5/8/24 at 10:26 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated if a resident needed a mobility assistance devise. The Maintenance Director stated he referred the resident to the clinical/nursing department. The Maintenance Director stated he installed the devices and inspected them monthly. The Maintenance Director stated resident 17 had a mobility assistance device on the left side of her bed. The Maintenance Director stated he was not aware resident 17 wanted another half side rail for positioning and would talk to the Director of Nursing (DON) about it. On 5/8/24 at 10:30 AM, an interview was conducted with Director of Therapy (DOT). The DOT stated therapy did an evaluation and if a resident was having a hard time sitting up without an assistive device. The DOT stated after the evaluation, the Maintenance Director was contacted to install the positioning device. The DOT stated positioning device was also care planned. The DOT stated she was not aware that resident 17 had a half side rail. The DOT stated if the bed was against the wall, then the resident did not need a side rail on that side. The DOT stated she had not heard that resident 17 requested a side rail to the other side of her bed. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 11:46 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated if a resident asked for side rail then she would talk to DON and DOT. LPN 1 stated a half side rail would be considered a restraint, so the resident would have to sign a release. LPN 1 stated she did not complete care plans. LPN 1 stated management completed care plans. LPN 1 stated resident 17 had a half side rail on one side of her bed. LPN 1 stated resident 17 pulled herself up in the seated position with it. LPN 1 stated she did not have an evaluation for the side rail because therapy would have it. On 5/14/24 at 8:17 AM, an interview was conducted with the DON. The DON stated if a resident requested a half side rail, then a consent was signed. The DON stated the resident was educated on the risks such as entrapment or hitting head. The DON stated physician's orders were obtained and it was care planned. The DON stated side rail assessment was completed. The DON stated there was not a care plan prior for resident 17's half side rail. The DON stated resident 17 did not have a consent. The DON stated she started a list of residents with side rails and she was going to be talking to therapy about getting evaluations completed.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review, it was determined for 1 of 38 sampled residents, that the facility did not provide the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living. Specifically, a resident was not provided feeding assistance or supervision. Resident identifiers: 36. Findings include: Resident 36 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, seizures, hyperglycemia, diabetes mellitus, protein-calorie malnutrition, dysphagia, and personal history of traumatic brain injury. On 5/6/24 from 9:24 AM until 10:22 AM, an observation was made of resident 36. Resident 36 was in bed with the head of bed elevated approximately 30 degrees with a tray of food on an over bed table. Resident 36 was observed to have his eye closed. At 10:01 AM, an observation was made of resident 36's meal tray. There was a biscuit with gravy, ground meat with gravy, half of a banana, and a bowl of cooked cereal. There was no food eaten from the tray. At 10:22 AM, an observation was made of Physical Therapy Assistant (PTA) 1 entering resident 36's room and stated there was breakfast he had not eaten. PTA 1 was observed to ask resident 36 if she could sit him up in bed to eat. PTA 1 was observed to shut the door. On 5/13/24 from 8:32 AM through 9:12 AM, an observation was made of resident 36. Resident 36 was in the dining room. Resident 36 was observed to be eating food from a plate with a plate guard, cereal from a bowl and a yogurt. Resident 36 observed to feed himself after staff had set-up his food. Resident 36's medical record was reviewed 5/6/24 through 5/14/24. Resident 36's Minimum Data Set (MDS) dated [DATE] revealed resident 36 required supervision with set-up assistance for eating. A care plan dated 6/1/22 and revised on 2/9/23 revealed ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Hydrocephalus; traumatic brain injury; dysphagia; encephalopathy; bilateral hearing loss; The goal was Will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene with extensive assist through the review date. Interventions included Explain all procedures/tasks before starting; Promote dignity by ensuring privacy; R [right] bed cane to bed for ease of bed mobility and re-positioning; Therapy evaluation and treatment as per MD [Medical Doctor] orders; Encourage to participate to the fullest extent possible with each interaction; Encourage to use bell to call for assistance and; Monitor/document/report to MD PRN [as needed] any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Certified Nursing Assistant (CNA) documentation in the tasks section from 4/7/24 through 5/6/24 revealed resident 36 ate independently one time. Resident 36 required setup assistance 18 times, supervision 5 times, partial/moderate assistance 4 times, substantial/maximal assistance 16 times and was dependent 35 times. On 5/6/24, CNA's documented resident 36 required setup or clean-up assistance for breakfast and lunch and was dependent for dinner. On 5/13/24 at 11:49 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 36 was easily re-directed, but was confused quiet a bit. LPN 1 stated resident 36 had seizures and was confused for a few days after. LPN 1 stated after a seizure his condition changed for the worst but then he would come around. LPN 1 stated resident 36 got up early and ate breakfast in his wheelchair. LPN 1 stated resident 36 could eat by himself but needed to be reminded to eat. LPN 1 stated resident 36 required supervision when he was eating. On 5/14/24 at 8:02 AM, an interview was conducted with CNA 4. CNA 4 stated resident 36 needed limited assistance with eating. CNA 4 stated resident 36 was able to drink after a staff member put a cup in his hands. CNA 4 stated resident 36 needed to be watched and needed help cutting up his food. CNA 4 stated resident 36 was unable to eat in his room without supervision and he always ate in the dining room. CNA 4 stated staff needed to make sure resident 36 did not fall asleep. CNA 4 stated new employees were confused and sometimes did not know to take resident 36 to the dining room. On 5/14/24 at 8:25 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 36 required set up assist for eating. The DON stated there was sometimes in the previous weeks resident 36 had been sleepy and needed staff to feed him. The DON stated it was not safe for resident 36 to eat in his room by himself. The DON stated resident 36 needed to be in the dining room to make sure he was eating and getting enough nutrition.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review, for 1 of 38 sampled residents, the facility did not ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming. Specifically, a resident with contractures to his hands had long fingernails. Resident identifier: 30. Findings include: Resident 30 was admitted to the facility on [DATE] with diagnoses that included aphasia following cerebrovascular disease, hemiplegia affecting right dominant side, third nerve palsy, intellectual disabilities, restlessness and agitation, and contracture of muscle upper right arm. On 5/7/24 at 12:46 PM, an observation was made of resident 30's hands. Resident 30's right hand was observed to be in a tightly clenched fist with the exception of his thumb, which was outside of his fist. The nail on resident 30's thumb nail was observed to be long, going beyond the end of his thumb. Resident 30 was wearing a padded device on his right wrist that extended to the middle of his hand. Resident 30's left hand was observed to be open, and he was able to move it. The nails on his left hand were also observed to be long. On 5/7/24 at 12:50 PM, an observation was made of resident 30's right hand. The Assistant Director of Nursing (ADON) was observed to open his hand. The palm of resident 30's right hand was pink, but had no indentations from his nails. The skin was intact. An interview was conducted with the ADON who stated resident 30 had the padded device on his right hand to keep from scratching himself. The ADON stated the padded device was removed every 4 hours and resident 30's right hand was washed and dried. On 5/8/24 at 11:41 AM, an observation was made of resident 30. Resident 30 was observed to have a padded device on his right hand, and the hand was fully covered. Resident 30's left hand was observed and the nails had been trimmed. On 5/8/24 at 12:04 PM, resident 30 was observed trying to remove the padded device covering his right hand. A staff member came over to check resident 30 and removed the device from his hand. Resident 30's finger nails on the right hand were observed to be long. Resident 30 used a communication board to ask for a towel to be put in the palm of his left hand. The staff member asked if resident 30 wanted the padded device on his left hand and he stated, no. On 5/14/24 at 7:31 AM, resident 30 was observed wearing the padded device on his left hand. Resident 30's right hand was observed to be in a fist with the nails outside of the fist. Resident 30's right hand finger nails were observed to extend past the finger tip. Resident 30's medical records were reviewed between 5/6/2024 and 5/14/2024. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Minimum Data Set (MDS) dated [DATE] revealed that resident 30 had a BIMS (Brief Interview for Mental Status) of 3, indicating severe cognitive impairment. The assessment also revealed resident 30 had impairment to one side to his upper extremity, relied on a wheelchair for ambulation, required substantial/maximal assistance for eating, dependent for oral hygiene, required substantial/maximal assistance for toileting, and required substantial/maximal assistance for showering or bathing. Physician orders dated 12/29/23 stated, Needs to have gloves to left hand applied and released q [every] 4 hours to check skin integrity. Certified Nursing Assistant (CNA) tasks were reviewed. The area for nail trimming had no documentation. Shower sheets were reviewed for the period between 3/1/24 and 5/10/24. Findings included: a. On 3/1/24, the shower sheet revealed resident 30 had scratches to his right arm and left leg area at the knee. Need clipping/Nails clipped were blank. b. On 3/4/24, the shower sheet had comments, scratch marks all over body. Need clipping was marked no. c. On 3/6/34, the shower sheet did not indicate any scratches. Need clipping/Nails clipped were blank. d. On 3/11/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped had x's for both areas. e. On 3/13/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped had x's for both areas. f. On 3/15/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped both stated no. CNA comments included that a PM (evening) shower was provided. g. A second shower sheet for 3/15/24 did not indicate any scratches. Need clipping/ Nails clipped both stated no. h. An undated shower sheet did not indicate any scratches. Need clipping/Nails clipped were blank. CNA comments included, no skin issues. i. On 3/18/24, the shower sheet did not indicate any scratches. Need clipping/ Nails clipped both stated no. j. On 3/20/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped both stated no. k. On 3/22/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped both stated no. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	l. On 3/25/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped had x's for both areas. m. On 3/27/24, the shower sheet did not indicate any scratches. Need clipping/ Nails clipped both stated no. n. On 4/1/24, the shower sheet did not indicate any scratches. Need clipping was marked with an x. o. On 4/3/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped had x's for both areas. p. On 4/3/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped were both blank. q. On 4/12/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped both stated no. r. On 4/19/24, the shower sheet did not indicate any scratches. Need clipping stated no. CNA comments were, no new skin conditions. s. On 4/22/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped had x's for both areas. t. On 4/24/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped were both blank. u. On 5/6/24, the CNA comments revealed, scratch marks all over body. Need clipping stated no. Nails clipped was blank. v. On 5/10/24, the shower sheet did not indicate any scratches. Need clipping stated no. Nails clipped was blank. w. On 5/13/24, the shower sheet did not indicate any scratches. Need clipping/Nails clipped were both blank. On 5/14/24 at 8:04 AM, an interview was conducted with CNA 7 who stated resident 30's nails should be trimmed or filed every time he had a shower. CNA 7 stated resident 30 showered every other day, or at the request of his family. CNA 7 stated the CNA's were supposed to document if resident 30's nails were trimmed. CNA 7 stated resident 30 kept a sponge or a rolled wash cloth in his right hand and used it pretty frequently. CNA 7 stated resident 30 was able to say if he wanted to wear it or not.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 1 of 38 sampled residents, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choice. Specifically, a resident had skin breakdown that did not have the dressing changed according to orders and was observed to bump another area on the wheelchair. Resident identifier: 8. Findings include: Resident 8 was admitted to the facility on [DATE] with diagnoses which included other specific joint derangements of left hip, pain in left hip, Alzheimer's, chronic systolic heart failure, and protein-calorie malnutrition. On 5/7/24 at 10:59 AM, an observation was made of resident 8's left inner foot. The bandage had a date of 5/3/24 on it. On 5/9/24 from 2:37 PM until 3:15 PM, an observation was made of resident 8. Resident 8 was observed in the hallway across from the nurses station. Resident 8 was in a tilt back wheelchair with his legs crossed. There was a black sore on the outside of right side of shin on the right leg. His right leg was observed to have a black sore on the outside of the right shin. There was a protruding break handle on the wheelchair where resident 8 was observed to repeatedly bang the outside of his right shin where there was a black spot on the leg. There was redness around the black spot. Resident 8's medical record was reviewed 5/6/24 through 5/14/24. An annual Minimum Data Set (MDS) dated [DATE] revealed a clinical assessment was completed to determine resident 8's pressure ulcer risk. The MDS revealed resident 8 was at risk for developing pressures ulcers and did not have any unhealed pressure ulcers. The MDS revealed there were no venous or arterial ulcers. The MDS further revealed resident 8 had a pressure reducing device for his chair and bed, an application of non-surgical dressings other than to feet and an application of dressing to feet. A care plan dated 5/24/19 and updated on 4/10/24 revealed resident 8 Has potential impairment to skin integrity r/t [related to] weakness, decreased mobility, pain, cognitive impairment, incontinence. Open wounds from resident scratching to bilateral knees and left medial thigh 10/13/23- resolved. Open wound to right ischium from resident scratching 1/11/24: Resolved 1/26. Wound to Metatarsal head of left foot 3/26/24. Chronic scratches to right lateral thigh and left forearm, tip of nose 3/30/24. The goal was Will have no complications r/t open wounds from resident scratching the review date. Interventions included Encourage good nutrition and hydration in order to promote healthier skin; Ensure fingernails are clean and trimmed; Float Heels; Follow facility protocols for treatment of injury; Keep skin clean and dry. Use lotion on dry skin. Do not apply on surgical incision; Mupirocin ointment BID [twice daily] for infection 3/30-4/12; Pressure relieving/reducing mattress, cushion in wheelchair and; Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's orders were reviewed and revealed the following: a. On 4/23/24 and discontinued on 5/7/24 Left Metatarsal Head of left foot: Cleanse with WC [wound cleaner], apply collagen/hydrogel mix. Secure with dry dressing. Every day. It should be noted on 5/7/24 an observation was made of the date 5/3/24 on resident 8's bandage. b. On 5/8/24, Left Metatarsal Head of left foot; Cleanse with WC, apply collagen to wound bed, secure with foam dressing .every Tue [Tuesday], Thu [Thursday], Sat [Saturday]. The bandage was changed 4/9/24 and 5/11/24 according to the May 2024 Treatment Administration Record. Resident 8's progress notes revealed the following entries: a. On 3/26/24 at 3:40 PM, a nursing skin/wound note revealed, Therapy notified nurse of wound to resident left foot. Wound nurse in to assess. Resident has full thickness wound to left metatarsal head measuring 2X2XUTD [unable to determine]. Wound bed is 20% slough, 80% clean non granulating tissue. Peri skin hyperkeratotic. Small serous drainage. Minimal odor after cleansing. Edges are attached. Mechanical debridement provided during cleansing of wound. Peri skin CDI [clean dry intact]. Resident has pain during cleansing. Unable to explain rating and intensity. Wound nurse contacted wound NP. Wound NP reviewed chart. Suspects neuropathic ulcer. New orders to clean with wound cleaner, apply anasept gel to wound bed, calcium alginate on top, secure with foam daily. Orders in. NP and family updated b. On 4/8/24 at 8:37 PM, a nursing progress note revealed, Resident was assessed by provider and noted to have some redness and warmth to RLE [right lower extremity], has complaint of pain appears to be cellulitis. Provider ordered abx [antibiotic] and CBC [complete metabolic panel], CMP [comprehensive metabolic panel] and xray of RLE. [Family member] was notified of change in condition and new orders. c. On 4/17/24 at 2:11 PM, a skin/wound note revealed Wound nurse and wound NP in to assess. Resident has full thickness neuropathic wound to left metatarsal head measuring 1.0X0.7XUTD. Wound bed is 100% hypo granulating tissue. Peri skin thin/fragile. Scant serous drainage. No odor after cleansing. Edges are attached. Mechanical debridement provided during cleansing of wound. Peri skin CDI. Resident has less pain during tx [treatment] this shift. Pain improving. Pain medication given prior to tx. Patient is not compliant with wearing footwear. Discoloration of BLE when up in wheelchair. Pedal pulses intact bilaterally, no edema present. Wound is painful with cleansing or touching of the area. Cont [continue] orders to clean with wound cleaner, apply topical metronidazole to wound bed, secure with bordered dressing 2X daily. Scratches improving as well. No s/s [signs and symptoms] of infection. cont abx ointment to areas. Cellulitis to RLE. Oral abx in place. No openings at this time. NP and family updated. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. On 5/1/24 at 6:11 PM, a skin/wound note revealed Wound nurse and wound NP in to assess. Resident has full thickness neuropathic wound to left metatarsal head measuring 0.8X0.7X0.1. Wound is stable. Light sharps debridement provided by wound NP to stimulate cell growth. Wound bed is 100% hypo granulating tissue. Peri skin thin/fragile. Scant serous drainage. No odor after cleansing. Edges are attached. Mechanical debridement provided during cleansing of wound. Peri skin CDI. No pain observed during tx. Pain medication given prior to tx. Patient is not compliant with wearing footwear. Discoloration of BLE when up in wheelchair. Pedal pulses intact bilaterally, no edema present. Cont current orders to clean with wound cleaner, apply collagen sheet to wound bed, place hydrogel sheet on top, secure with tegaderm dressing daily. Scratches improving as well. No s/s of infection. cont [continue] abx ointment to areas. PRN [as needed] hydroxyzine available for resident. Cellulitis to RLE resolved. NP and family updated. A Wound Nurse Practitioner note dated 4/2/24 revealed wound to left medial metatarsal head was a neuropathic ulcer. The size was measured as 1.2 cm length x 1.0 cm wide x unable to determine depth. The short term goal documented was reduction of devitalized/non-viable tissue minimize [sic] moisture [sic] [sic]/friction, reduction of batheral burden, offloading of pressure, prevent infection, maintain skin barrier. The long term goal was for complete wound healing. A Skin Evaluation dated 5/8/24 revealed Skin assessment completed. Scratches to nose, thigh and arms are healing with no s/s of infection noted. Wound to L [left] foot has no s/s of infection, daily dressing changes. No other skin issues noted at this time. It should be noted there was no documentation of the black spot on the right outside shin. On 5/9/24 at 3:00 PM, an interview was conducted with Nursing Assistant (NA) 4 and Certified Nursing Assistant (CNA) 3. NA 4 stated resident 8 had been sitting in his wheel chair since after lunch. NA 4 stated resident 8 needed to be repositioned in his wheelchair. On 5/13/24 at 8:32 AM, an observation was made of resident 8 in the dining room in his wheel chair eating. Resident 8 was in tilt back wheel chair with the seat upright for eating. Resident 8 was observed to have his feet crossed at the ankles. At 9:34 AM, the ADON was observed to recline resident in tilt back wheel chair. At 9:47 AM, resident 8 was offered water by a staff member. At 10:02 AM, resident 8's legs were observed to be crossed at the ankles. Resident 8 did not move his legs from the crossed position. On 5/13/24 at 11:53 AM, an interview was conducted with LPN 1. LPN 1 stated resident 8 had some scratches from scratching himself. LPN 1 stated resident 8 did not have any other skin breakdown. LPN 1 stated usually she cleaned resident 8's scratches with an antibiotic ointment. LPN 1 stated dressings were placed on scratches if they were bad enough. LPN 1 stated she thought resident 8's left foot wound was resolved. LPN 1 stated there was some physician's orders to have bandages changed when soiled to the left foot. LPN 1 confirmed resident 8 had orders to have dressing changes to left foot daily until 5/8/24 when it was changed to three times per week. Resident 8's legs were observed with LPN 1. LPN 1 was observed to removed resident 8's left sock and there was no dressing. There was a white area next to the wound. LPN 1 stated the wound was a pressure sore. LPN 1 was observed to look at resident 8's right side of his leg. LPN 1 stated the black spot on the side of his shin hit at the foot rests and LPN 1 stated that resident 8 probably hit his shin on that spot. LPN 1 stated the black spot could be a pressure sore from the wheelchair. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/24 at 2:05 PM, an interview was conducted with the Wound Nurse (WN). The WN stated resident 8 was a chronic scratcher and picker at his skin. The WN stated resident 8 had a wound on his Left Metatarsal Head of left foot. The WN stated it was a neuropathic wound and was treated by the Nurse Practitioner (NP). The WN stated she was not sure what a neuropathic wound was but it was documented in the NP notes. An observation was made of resident 8's wound with the WN. Resident 8 was observed in his wheelchair. The WN was observed to removed both socks from resident 8. There was no dressing on resident 8's feet. There was a small white area next to the wound that was dry. The WN was observed to change gloves and use gauze with wound cleaner. The WN started from the inside of the wound to the outside. The WN stated the white area next to the wound was a collagen sheet. The WN stated she needed to educate the nurses regarding putting the collagen sheet onto the wound. The WN stated that the collagen sheet probably absorbed into the wound. The WN stated the wound should be covered with a foam dressing. The WN stated when resident 8 laid in bed, neither side of his shins touched the mattress. The WN stated that an ankle brachial index (ABI) was completed and came back fine so the wound was determined to be a neuropathic wound. The WN was observed to look at the outside of resident 8's right shin. The WN stated the black spot was an old picking site. The WN stated when he was in bed, he put his knees close to him and he scratched his legs. The WN stated the black spot was 100% scabbed over and no drainage with no signs or symptoms of infection. The WN stated when the wound NP came in, she would have the black spot assessed and make sure no treatment was needed. The WN stated staff were monitoring the black area. The WN stated there was some redness around the black spot and it looked irritated. The WN stated whenever a wound was discovered, a pressure assessment was completed. The WN stated she documented the wound ideology in a skin/wound progress notes. The WN stated resident 8 crossed his legs and she had not seen resident 8 touching the black spot onto the wheelchair break. The WN stated the floor nurses should notify the WN, if they notice someone was rubbing a body part on a part of the wheelchair. On 5/13/24 at 3:28 PM, an interview was conducted with the Director of Nursing (DON). The DON stated when there was a new wound, the nurse on the floor notified DON and WN. The DON stated the WN assessed the wound and then refer to Wound NP. The DON stated skin checks were done weekly by floor nurse for every resident. The DON stated CNA's documented skin issues on shower sheets and reported to the nurse. The DON stated she was aware of the wound on resident 8's left foot. The DON stated she was not sure how long resident had the wound on the bottom of his foot. The DON stated resident 8 had other areas he scratched On 5/14/24 at 7:35 AM, an observation was made of resident 8's feet and legs with the DON. Resident 8 was observed to be laying in bed with no heel float. The DON stated that the black area on the right side of his right shin did not look like it was infected and he had other areas from scratching. The DON stated that it was not a pressure sore but a scab. The DON stated the black spot did not look red around it and was not infected. The DON stated resident 8 was to have his heels floated while in bed. The DON stated there was a dressing on the left metatarsal head of left foot wound. The DON was observed to look for a heal float in resident 8's room. The DON stated she was unable to find the heel float. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 7:45 AM, an interview was conducted with the facility NP. The NP stated resident 8 had cellulitis to the right leg a few weeks ago. The NP stated antibiotics were started on 4/8/24 and then he followed up with resident 8 on 4/12/24 and 4/16/24. The NP stated the cellulitis was warm from the knee down and from the shin down resident 8's leg was red and angry. The NP stated resident 8 always had scratches on his legs because he continuously scratched and had scabs. The NP stated the scabs did not look it had anything to do with the cellulitis. On 5/14/24 at 9:36 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that most of resident 8's movements were voluntary. The DON stated resident 8 occasionally jumped and she was not sure if it was from confusion or surprise.		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review, for 1 of 38 sampled residents, the facility did not ensure that each resident with limited mobility received appropriate services, equipment and assistance to maintain or improve mobility with the maximal practical independence unless a reduction in mobility was demonstrated unavoidable. Specifically, a resident with limited range of motion to his hand was not being provided range of motion services or devices to prevent further contracture. Resident identifier: 30. Findings include: Resident 30 was admitted to the facility on [DATE] with diagnoses that included hemiplegia affecting right dominant side, third nerve palsy, intellectual disabilities, restlessness and agitation, adult failure to thrive, cognitive communication deficit, and hydrocephalus. On 5/6/24 at 11:55 AM, an observation was made of resident 30 in the dining room. Resident 30 was observed to have a padded device on his right wrist. The padded device was observed to not be in residents hand but around his wrist. There was nothing observed in his other hand. On 5/7/24 at 12:46 PM, an observation was made of resident 30's right hand. Resident 30's thumb nail was observed to go beyond the end of his thumb. The remaining 4 fingers were clenched very tightly in a fist. Resident 30 had a padded device on his right arm above his wrist. The ADON (Assistant Director of Nursing) opened resident 30's right hand at the request of the State Survey Agency (SSA) surveyor. Resident 30's right hand finger nails were observed to be long past the end of his fingers. In the palm of his hand, the skin was intact. On 5/8/24 at 6:31 AM, an observation was made of resident 30 in the dining room area. Resident 30's right hand was observed and was closed in a clenched fist. Resident 30 had a padded device on his right wrist that extended to the end of his fist. On 5/8/24 at 11:41 AM, an observation was made of resident 30 in the dining room area. Resident 30 was not wearing a glove on his left hand. The right hand had a padded device that encircled his hand. Resident 30 was observed to have unintentional movements of his head and left arm. The finger nails on resident 30's left hand were observed to be trimmed to the tips of his fingers. On 5/8/24 at 12:04 PM, an observation was made of resident 30 trying to remove the padded device from his right hand. A staff member came to check on resident 30. The staff member removed the padded device from resident 30's right hand. The nails on resident 30's right hand were observed to be longer than those on the left. Resident 30 used a communication sheet to ask to have a towel put in the palm of his left hand. The staff member asked if resident 30 wanted the padded device on his left hand and resident 30 nodded his head to indicate No. The staff member left and stated she would get a towel for resident 30. Resident 30's medical records were reviewed 5/6/24 through 5/14/24. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	An admission Minimum Data Set (MDS) dated [DATE] revealed that resident 30 had a BIMS (Brief Interview for Mental Status) of 3, indicating severe cognitive impairment. The assessment also revealed resident 30 had impairment to one side to his upper extremity, relied on a wheelchair for ambulation, required substantial/maximal assistance for eating, dependent for oral hygiene, required substantial/maximal assistance for toileting, and required substantial/maximal assistance for showering or bathing. Physician orders revealed: a. On 12/27/23 OT [Occupational Therapy] eval and treatment. b. On 12/28/24 PT [Physical Therapy] eval [evaluation] and treatment. c. 3/6/24 PT eval and treatment; OT eval and treatment. d. 4/7/24 Needs to have glove to left hand applied and released q (every) 4 hours to check skin integrity. It should be noted that resident 30 did not have orders for any devices or treatments related to his right hand. A care plan focus area initiated on 12/22/23 revealed, Resident has cerebral palsy. The goal was, Will be able to function at the fullest potential possible as outlined by the treatment team. Interventions included, . Maintain good body alignment to prevent contractures. Use braces and splints as ordered; Therapy to monitor/document and treat as indicated. Encourage resident/caregivers to use and correctly apply all splints and braces . (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Another care plan focus area initiated on 12/22/23 revealed, ADL [activities of daily living] self care performance deficit r/t [related to] severe malnutrition; hx [history] of intellectual impairment following radiation for cerebral AVM [arteriovenous malformation]; nonverbal; failure to thrive; dysphagia; hydrocephalus; 3rd cranial nerve palsy; R [right] hemiparesis; tremor to LUE [left upper extremity]; agitation; picks at left arm and eye; has contracture management of right elbow and hand. The goal was, Will safely perform bed mobility, transfers, eating, dressing, grooming, toilet use and personal hygiene with limited assist through the review date. Interventions included, Apply hand roll to right hand for 4 hours a day, being managed by skilled therapy (initiated on 4/24/24); Therapy evaluation and treatment as per MD [medical doctor] orders; . A care plan focus area initiated on 12/29/23 revealed, Mother wants [resident's name removed] to wear gloves to left hand to prevent resident from scratching face. The goal was, Will remain free of complication related to gloves to left hand use including contractures, skin breakdown, altered mental status, isolation or withdrawal through review date. Interventions included, Evaluate/record continuing risk/benefits, alternative need for ongoing use, reason for glove to left hand use; Discuss with resident, family/caregivers, the risk and benefits, when should/will be applied, routines while restrained and any concerns or issues regarding gloves to left hand use and record; Ensure that resident is positioned correctly with proper body alignment; Ensure valid consent on chart prior to initiating gloves to left hand; Monitor/document/report to MD PRN changes regarding effectiveness of gloves to left hand less restrictive device, if appropriate, any negative or adverse effects noted included: decline in mood, change in behavior, decrease in adl self performance, decline in cognitive ability or communication, contracture formation, skin breakdown, s/s [signs and symptoms] of delirium, falls/accidents/injuries, agitation, weakness; Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. A daily skilled progress note dated 12/24/23 at 1:39 PM revealed, .Assistive device Patient has contractures to both arms .Waiting for PT eval .Active SX (symptoms) : contractures or limited ROM (range of motion). Other observations and interventions include Patient has contractures to both arms. Has involuntary movements with left arm. A safety device evaluation dated 3/29/24 revealed, Identified medical condition: developmental delay; Associated health conditions: poor impulse control, impaired cognition; and unsteady gait; Measures tried before implementing the recommended device: supervised activities; Device recommended: .gloves to left hand due to history of scratching face and causing injury; Explain why or why not: does not limit resident's mobility; What does this device enable the resident to do: potentially prevents the resident from injury; Consent received from: mother. A Visual Bedside Kardex report which was current as of 5/8/24 revealed, Special Instructions: .picks at skin and left eye. Care to be provided by Certified Nursing Assistants (CNAs) included, Other: Maintain good body alignment to prevent contractures; Use braces and splints as ordered. CNA tasks were reviewed which included nail trimming for the past 30 days. There was no documentation that resident 30's nails had been trimmed. On 2/5/24 at 8:16 PM, the eMAR (electronic Medication Administration Record) note revealed, Needs to have gloves to left hand applied and released q (every) 4 hours to check skin integrity. every 4 hours . Resident does not have glove on and nursing staff unable to find it at this time. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 2/6/24 at 12:17 AM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Resident does not have glove on and nursing staff unable to find it at this time. On 2/6/24 at 4:17 AM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Resident does not have glove on and nursing staff unable to find it at this time. On 2/6/24 at 9:47 AM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Resident does not have glove on and nursing staff unable to find it at this time. On 2/6/24 at 12:48 PM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Resident does not have glove on and nursing staff unable to find it at this time. On 2/6/24 at 5:26 PM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Resident does not have glove on and nursing staff unable to find it at this time. On 4/8/24 at 8:12 PM, an eMAR Medication Administration Note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Mother took the glove home to wash. Resident was given wash cloth to protect it. On 4/8/24 at 11:07 PM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Mother took the glove home to wash. Resident was given wash cloth to protect hand. On 4/9/24 at 4:12 AM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Mother took the glove home to wash. Resident was given wash cloth to protect hand. On 4/10/24 at 12:40 AM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Mother took the glove home to wash and still had not returned it. Resident was given wash cloth to protect hand. On 4/10/24 at 4:41 AM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Mother took the glove home to wash and still had not returned it. Resident was given wash cloth to protect hand. On 5/5/24 at 2:40 AM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Glove with mom per resident. On 5/5/24 at 4:50 AM, an eMAR note revealed, Needs to have gloves to left hand applied and released q 4 hours to check skin integrity. every 4 hours .Mom has it per resident (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	A PRN/Weekly Skin Evaluation dated 5/8/24 revealed, Resident has advanced healed scratches on bilateral, lateral forearms near elbows. Tx [treatment] RN [Registered Nurse] notified. No s/s [signs and symptoms] of infection at site, scratches ar [sic] in advanced stage of healing. Order is to keep open to air and monitor for s/s of infection until resolved. Provider notified. An Occupational Therapy Progress Report and Updated Therapy Plan with certification period of 3/6/24 - 3/19/24 revealed, #6-New Goal: Pt [patient] will tolerate gentle PROM [passive range of motion] to R [right] hand as well as regular cleaning/drying coupled with the use of hand rolls to reduce tone/contracture and decrease risk of skin breakdown/infection. An Occupational Therapy Progress Report and Updated Therapy Plan with certification period of 5/1/24-5/28/24 revealed, Goal #6-Continue .Pt will tolerate gentle PROM to R hand as well as regular cleaning/drying coupled with use of hand rolls to reduce tone/contracture and decrease risk of skin breakdown/infection .baseline (3/19/24) Pt tolerates PROM, g/h [glenohumeral], hand rolls; Previous (4/16/24) Pt tolerates PROM, g/h, hand rolls; Current (5/1/24) Pt tolerates PROM, g/h, hand rolls . On 5/7/24 at 12:50 PM, an interview was conducted with the ADON who stated the padded device on resident 30's right hand was to prevent him from scratching himself. The ADON stated every 4 hours the device needed to be removed and resident 30's hand should be washed and dried. On 5/8/24 at 12:08 PM, an interview was conducted with Physical Therapy Assistant (PTA) 3. PTA 3 stated the padded device on resident 30's hand was a Mit. PTA 3 stated the mit was for resident 30's protection. PTA 3 stated resident 30 cognitively could pick and choose which hand he wanted to have the mit on. PTA 3 stated resident 30 did not have a glove for his left hand, but could use the mit. PTA 3 stated when resident 30 had the mit on his right hand he was usually doing things with his left hand. PTA 3 stated that occupational therapy had been working with resident 30 using a hand roll. On 5/8/24 at 1:28 PM, an interview was conducted with Physical Therapist (PT) 1 who stated resident 30 was getting physical therapy 5 times weekly. PT 1 stated he was not sure how often resident 30 received occupational therapy or speech therapy. PT 1 stated he was working with resident 30 on sitting, balance, and walking. PT 1 stated resident 30 was using towel rolls for his right hand and coordination training for his left hand. On 5/8/24 at 2:21 PM, an interview was conducted with Registered Nurse (RN) 3 who stated resident 30 wore mit on his right hand or his left hand. RN 3 stated the mit was taken off when resident 30 was in bed. RN 3 stated resident 30 would tend to scratch the inside of his elbows while in bed. RN 3 stated she would put a monitor note in the computer to ensure resident 30 was checked on frequently. On 5/13/24 at 9:06 AM, an interview was conducted with RN 1. RN 1 stated resident 30 wore the mit on his right hand and liked it on to prevent himself from scratching his face. RN 1 stated resident 30 was able to tell staff if he wanted the mit off. RN 1 stated it was usually taken off every 4 hours to check his skin integrity in and around resident 30's hand. RN 1 stated resident 30 used the rolled up wash cloth during the day to prevent contractures, and he did not like anything in his hand at night. (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	On 5/13/24 at 9:29 AM, an interview was conducted with CNA 3 who stated resident 30 wore the mit a lot during the day. CNA 3 stated sometimes resident 30's mother took the mit home to wash it. CNA 3 stated the glove was to protect his hand and help the contracture. CNA 3 stated resident 30 wore the mit at night to protect from scratching himself. CNA 3 also stated that resident 30 wore the mit while taking a nap. CNA 3 stated resident 30 was able to let staff know if he did not want to wear the mit. CNA 3 stated he just got the mit last week. CNA 3 stated she did not know if the mit came from physical therapy, occupational therapy or his mother. On 5/14/24 at 7:35 AM, an interview was conducted with Nursing Assistant (NA) 1 who stated resident 30 was wearing the mit on his left hand. NA 1 stated she had not seen resident 30 use anything for his right hand. On 5/14/24 at 7:54 AM, an interview was conducted with the Director of Therapy (DOT). The DOT stated resident 30 came in with a glove and was supposed to wear it on his left hand. The DOT stated sometimes resident 30 preferred to wear it on his right hand. The DOT stated therapy staff were trialing a couple of devices for his right hand. The DOT stated devices for resident 30's right hand were received last week. The DOT stated resident 30 did not have anything for his right hand prior to last week. The DOT stated resident 30 had his hands stretched twice daily. The DOT stated resident 30 usually clenched his hand with the fingernails outside of his palm, but that depending on his shaking. On 5/14/24 at 8:04 AM, an interview was conducted with CNA 7. CNA 7 stated that resident 30 had his nails trimmed or filed every time he had a shower and that he showered every other day. CNA 7 also stated resident 30's nails were trimmed at the request of his family. CNA 7 stated resident 30 used a sponge or a wash cloth in his hand pretty frequently and was able to let staff know if he wanted to use it or not. On 5/14/24 at 3:18 PM, a second interview was conducted with the DOT. The DOT stated therapy staff had not measured resident 30's contractures. The DOT stated staff kept progress reports. The DOT stated resident 30 could do active range of motion. On 5/14/24 at 3:18 PM, an interview was conducted with OT 1. OT 1 stated resident 30 would not complete range of motion exercises if therapy staff did not remind him. OT 1 stated resident 30's range of motion was improving. OT 1 stated during the next recertification period staff would start setting goals for resident 30. OT 1 stated resident 30's next recertification period started on 5/29/24. OT 1 stated recertification was completed once per month unless something happened at which time they could do it sooner. OT 1 stated measuring contractures was case by case and once there started to be some movement the therapy staff would start measuring. OT 1 stated resident 30 had started to get some movement in his hand within the last week and a half.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review it was determined, for 5 of 38 sampled residents, that the facility did not ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident's finger was partially amputated after it became impinged in a tilting wheelchair hinge; a resident sustained multiple falls with one resulting in a hip fracture; a resident sustained multiple falls with two falls resulting in head lacerations; two residents transported in the facility vehicle were not properly secured and sustained falls; and a resident sustained a burn while smoking unsupervised. Resident identifiers: 13, 20, 21, 31, 35, and 257. Findings include: 1. Resident 21 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease, protein calorie-malnutrition, dysphagia, vitamin D deficiency, contracture in left and right knee, major depressive disorder, and cognitive communication deficit. Resident 21's medical records were reviewed between 4/3/24 and 5/16/24. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that resident 21 was totally dependent with transfers between bed/chair to her wheelchair. A hospital admission record dated 2/21/24 revealed that resident 21 received diagnoses of: a. Closed displaced fracture of distal phalanx of left ring finger, primary. b. Laceration of left ring finger without foreign body with damage to nail. The hospital document stated, [AGE] year old female presenting with left ring finger injury. Patient was at her nursing facility and her finger got caught in the wheel of the wheelchair. The physical examination revealed, partially amputated distal left ring finger. An imaging report dated 2/21/24 revealed, Motion artifact limits evaluation. A bandage also limits evaluation. Acute minimally displaced fracture involving the distal tuft of the fourth digit. Osteopenia is present. No definitive additional fracture. Soft tissues are grossly within normal limits. No radiopaque foreign bodies. On 2/21/24 at 1:54 PM, a nursing progress note revealed, Resident being wheeled to her room when her finger hit the door jam and it was ripped from her nail and appears to need sutures. Order to send to [Hospital name removed] ED [emergency department] to be evaluated. Family notified. On 2/21/24 at 2:12 PM, a nursing progress note revealed, Reported by staff while wheeling resident toward room resident struck out her hand and hit the doorframe and acquired a laceration on her left 4th fingertip. Cleaned and applied pressure dressing, cut is deep might require stitches. Provider notified and ordered to send to ED for possible suture. [Family members] was notified of incident. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/21/24 at 6:10 PM, a nursing progress note revealed, Resident has returned from ED department. She had to have the fingernail removed, the finger is fractured and there are stitches in place. She is to schedule an appt (appointment) for follow up on 2/23/24 with [physician name removed]. On 2/21/24 at 6:45 PM, a nursing progress note revealed, Resident came back from ED with orders to start Keflex 500 mg [milligrams] BID [twice daily] x 5 days clarified with provider and ordered may give Keflex and staff to monitor for any allergic reactions and notify if has reactions. [Family members] came with resident from hospital and was aware of new order for abx [antibiotics]. On 2/21/24 at 10:41 PM, a nursing progress note revealed, Orders received from NP [nurse practitioner] for Tramadol 50 mg PO [by mouth] BID x 7 days and Tramadol 50 mg every 8 hours as needed for breakthrough pain for finger fracture. Orders entered in MAR [Medication Administration Record] and first dose administered. On 2/21/23 at 11:23 PM. a nursing progress note revealed, Alert Charting: Closed displaced fracture to distal phalanx of L [left] ring finger, Laceration to L 4th finger. Document signs and symptoms (purulent drainage, heat, redness, swelling, tenderness, acute functional decline, pain), if symptoms have improved or worsened every shift for 8 days. Dressing to left pinky finger is CDI [Clean, dry and intact] . No swelling is observed beneath bandage. No ASE [adverse side effects] from ordered abx. Orders given for Tramadol to treat pain. Resident is currently in bed. Staff wctm [Will Continue to Monitor]. On 2/22/24 at 8:35 AM, a nursing note revealed, Alert Charting: Closed displaced fracture to distal phalanx of L ring finger, laceration to L 4th finger. Document signs and symptoms (purulent drainage, heat, redness, swelling, tenderness, acute functional decline, pain), if symptoms have improved or worsened every shift for 8 days. Resident's dressing is dry and intact. No drainage noted. Continues on Keflex with no s/s [signs and symptoms] of ASE noted. LOC [Level of consciousness] is at baseline. On 2/26/24 at 11:57 AM, a Skin Committee IDT (interdisciplinary team) note revealed, Reported by staff while wheeling resident towards room resident struck out her hand and hit the doorframe and acquired a laceration on her left 4 fingertip. Cleaned and applied pressure dressing, cut is deep might require stitches. Provider notified and ordered to send to ED for possible suture. [Family members] notified of incident. She had to have the fingernail removed, the finger is fractured and there are stitches in place. Intervention: Educate staff on use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Provider and family agree with POC [plan of care]. On 2/29/24 at 12:20 PM, a nursing note revealed, Resident seen by ortho [orthopedics] today regarding L hand 4th finger fracture. Orders to splint as needed for pain control. No follow up needed unless still having pain in 5 weeks. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/6/24 at 6:18 AM, a Nurse Practitioner Progress note revealed, .2/21/24 evaluated secondary to nursing staff reporting patient with noted previous distal left ring finger fracture, laceration transferred to emergency room with surgical fixation, fractures splint in place. Unable to review Review of Systems 2/2 [secondary to] memory loss, noting noted wincing, discomfort with hand assessment, discussed with nursing staff pain management use of Tramadol: to treatment plan .3/6/24 -L finger laceration continues to improve & heal, nursing staff reporting pain is managed .Injuries details: Injury: L finger laceration; hospitalization s/surgeries details: Surgery: L finger laceration surgical repair .consult & refer wound team for wound management further evaluation and treatment. On 4/3/24 at 10:49 AM, an interview was conducted with Certified Nurse Assistant (CNA) 4 who stated that resident 21 was in the dining room and it was time to change her brief. CNA 4 stated he pushed resident 21 in her reclining wheelchair to her room. CNA 4 stated he was preparing to provide a brief change and was changing the position of resident 21's chair when he heard resident 21 yell ouch. CNA 4 stated he looked a resident 21's hands and noticed her finger was bleeding. CNA 4 stated he got some paper towels to wipe the blood from resident 21's finger. CNA 4 stated he then brought resident 21 back out into the hallway. CNA 4 stated Licensed Practical Nurse (LPN) 2 was coming down the hallway in his direction. CNA 4 stated LPN 2 looked at resident 21's finger and tried to clean it. CNA 4 stated that the wound nurse Wound Nurse (WN) was called and also came to look at resident 21's finger. CNA 4 stated that resident 21 did not show any signs of being in pain once she was taken into the hallway. CNA 4 stated that after the nurses attended to resident 21's finger, he brought her back to her room, and with the assistance of another staff member, and changed her brief. On 4/3/24 at 10:57 AM, an interview was conducted with LPN 2. LPN 2 stated that she had assessed resident 21's finger when she was brought into the hallway and the WN was already walking down the hall toward them. LPN 2 stated resident 21's fingernail was lifted from her finger, but was still attached at the cuticle, and bleeding. LPN 2 stated that resident 21 was okay unless her finger was touched. LPN 2 stated she and the WN decided that resident 21 should be taken to the hospital for evaluation. LPN 2 stated she called an ambulance, got the required paperwork together and notified the physician. LPN 2 stated she also called resident 21's family members to notify them. On 4/3/24 at 12:20 PM, an interview was conducted with the WN who stated she was told by LPN 2 that resident 21 was being wheeled back to her room for a brief change when her finger got caught in the doorway. The WN stated the injury was a laceration from the base of the tip of the nail and down the side of the nail. The WN stated she knew resident 21 was in need of stitches and possibly a finger brace. The WN stated she did not notice any other injuries to resident 21's hand. The WN stated that when resident 21 returned she was notified that resident 21 had a fracture to her finger and the nail had been removed. The WN stated resident 21 received stitches to her finger and was wearing a finger brace. The WN stated she and the NP had monitored resident 21's finger wound. The WN stated resident 21 was monitored for pain using facial grimacing, moaning, or looking away during wound care. The WN stated that after a while resident 21 had no signs of pain. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/4/24 at 11:19 AM, an interview was conducted with resident 21's family member who stated the staff at the facility would not tell her what happened to resident 21's finger. Resident 21's family member stated she asked CNA 4 about the injury and the CNA would not tell her how resident 21 obtained the injury. Resident 21's family member stated later she was told that resident 21 got her hand caught on the striker plate of the door while going into her room. Resident 21's family member stated if resident 21 had caught her finger on the door it would have been the right hand and not the left hand. Resident 21's family member stated she met resident 21 at the hospital and watched as resident 21's finger was stitched and treated. On 4/4/24 at 12:45 PM, the surveillance camera footage of resident 21's hallway was viewed by the State Survey Agency (SSA) surveyors. The 6 second footage showed CNA 4 pushing resident 21 in her wheelchair in a tilted position through the doorway of her room. Resident 21's arms were not observed to be to the side of the wheelchair at that time. It was observed that there was no hesitation by CNA 4 while passing through the doorway. On 4/4/24 at 12:51 PM, an interview was conducted with the facility Administrator (ADM) who stated resident 21 was in her room and the injury possibly occurred while she was being pushed into the hallway by CNA 4. The ADM stated he had noticed that resident 21 had blood on her finger. The ADM stated that a nurse had come and assessed resident 21. The ADM stated the tip of resident 21's finger was completely sliced and pushed up. The ADM stated he did not know if the finger was partially cut off. The ADM stated he did not know how that type of injury could happen in a door frame. The ADM stated he had interviewed CNA 4 and CNA 4 was unsure what had happened to resident 21's finger during the interviews. The ADM stated he did not document the interview with CNA 4. The ADM stated he needed to investigate all possible scenarios that could have happened. The ADM stated he did talk to resident 21's family member and resident 21 was watched all day. The ADM stated that CNA 4's first language was Spanish so there were communication issues, and he interviewed CNA 4 in English. The ADM stated that he did speak Spanish, but had not interviewed CNA 4 in Spanish. On 5/8/24 at 3:27 PM, a follow up interview was conducted with CNA 4. CNA 4 stated at first he thought that resident 21 had caught her finger in the door, but after thinking about it, he believed resident 21 injured her finger on the wheelchair. CNA 4 stated resident 21 was in a tilted chair. CNA 4 stated when he brought resident 21 back to her room, his process was to sit the resident up in the chair, then go ask another staff member for help transferring the resident to her bed. CNA 4 demonstrated how the chair was put into an upright position from the tilted position. CNA 4 stated he was putting the chair in an upright position when resident 21 yelled ouch. CNA 4 stated he immediately brought resident 21 back out into the hallway so he could have her finger assessed. CNA 4 stated he told the nurse he thought resident 21 had injured her finger in the doorway, but as he thought more about it he believed the injury came while adjusting the chair. CNA 4 stated he did not know if any inspection had been completed on resident 21's chair to see how the injury may have occurred. CNA 4 stated when the resident said ouch he observed her hand was at the side of her wheelchair. CNA 4 stated that prior to the resident saying ouch he had not noticed any blood on her hand. CNA 4 stated resident 21 had the same chair as the one she had when the injury occurred. CNA 4 stated resident 21's chair now had padding on it to prevent her hand coming in contact with sharp areas. The black padding was observed to be over the joints of the chair and on the side of the arm rests. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/8/24 at 3:42 PM, a second interview was conducted with LPN 2. LPN 2 stated that when she first saw resident 21, she had a wipe on her finger, was in her wheelchair, and was facing the nurses station. LPN 2 stated the WN was already approaching in the hallway. LPN stated she asked CNA 4 what had happened and he stated that resident 21's hand flew out in the doorway and hit the door frame. On 5/13/24 at 9:48 AM, an observation was made of resident 21 in her wheelchair. The chair was observed to have duct tape and Coban wrapped around the lower portion of her chair near the back wheels in addition to the black padding. On 5/13/24 at 10:43 AM, an interview was conducted with Nursing Assistant (NA) 3 who stated she did not know why resident 21's wheelchair had duct tape and Coban on it. On 05/13/24 at 11:40 AM, an interview was conducted with CNA 6 who stated the Coban was for padding on the chair. CNA 6 stated when staff were trained for the first time, the CNA providing the training would show how to adjust the chairs for residents who had tilted or adjustable wheelchairs. CNA 6 stated after moving a resident in their wheelchair, she made sure the wheels were locked so the chair would not move if the resident moved in the chair. CNA 6 also stated if the chair had a lap belt she would put that on the resident to ensure they would not slip out of the chair. CNA 6 stated the tilted chairs were to ensure that residents did not slide out of the chairs. CNA 6 stated if she did not know how to adjust a resident's chair she would go and ask one of the physical therapists. On 5/13/24 at 11:49 AM, an interview was conducted with Physical Therapy Assistant (PTA) 2 and Occupational Therapy Assistant (OTA) 1. PTA 1 stated that resident 21's family member requested that some padding be put on the resident's chair to prevent accidents. OTA 1 stated there was no special education that was needed to operate a tilted wheelchair. OTA 1 stated most tilted chairs had a release that allowed the chair to tilt back. OTA 1 stated there was a tilt feature on resident 21's wheelchair. OTA 1 stated she was aware of the black padding on resident 21's wheelchair, and that it was placed there for the resident's safety. OTA 1 stated if there were a situation where a CNA needed to know more information about how to adjust a resident's wheelchair, there were trainings that could be viewed. OTA 1 also stated that in-services were provided to staff about the chairs and the care plan would be updated with information to provide instruction. On 5/13/24 at 12:04 PM, an interview was conducted with the Director of Therapy (DOT) who stated resident 21's family member had called a couple of times to request that padding be put on any sharp edges on the wheelchair so resident 21 would not injure herself. The DOT specified that she received the first request on 3/14/24. The DOT stated she ordered cushions for the chair and they were applied to the chair. The DOT stated, sometimes her sister would put things on the chair for additional safety referring to the duct tape and Coban that was on resident 21's chair. The DOT stated that resident 21 frequently dropped her arms down to the side of the chair. The DOT stated safety precautions such as locking the brakes, were encouraged so the chairs would not roll unintentionally. The DOT stated she did not have any documentation about when she first spoke with resident 21's family members regarding the safety of the wheelchair. 38031 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. Resident 13 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which included dementia, Alzheimer's disease, presence of right artificial hip joint, dysphagia, cognitive communication deficit, major depressive disorder, history of falling, type II diabetes mellitus, wedge compression fracture of T (thoracic) 11-T12, hypertension and osteoporosis. On 5/6/24 at 9:39 AM, an observation was made of resident 13. Resident 13 was observed in a manual wheelchair (w/c) in the hallway with pressure alarm on the chair. The alarm was observed turned on. The resident's wander guard sensor was observed on the back of the w/c. On 4/4/24, resident 13's medical records were reviewed. On 2/9/24, resident 13's MDS Assessment documented that a Brief Interview for Mental Status (BIMS) assessment was not completed due to the resident being rarely/never understood. Resident 13's functional abilities assessment documented that the resident had an impairment on one side of the upper extremity and lower extremity. The assessment documented that the resident utilized a wheelchair for mobility. On 2/20/24 at 2:19 PM, resident 13's Fall Risk Evaluation score was a 13, which indicated a high risk for falls. The evaluation documented that resident 13 was disoriented times two, but did not indicate if it was person, time, situation or place. The evaluation documented that the resident had 1-2 falls in the past 3 months, was regularly incontinent, and required the use of an assistive device such as a wheelchair. Resident 13's progress notes, incident reports, fall risk evaluations, and care plan revealed the following: a. On 4/9/23 at 5:08 PM, the nurse note documented, Resident was found by the CNA on the floor on the blue mat by her bed around 1520 [3:20 PM]. Resident was sitting upright and did not appear to have hit her head or was injured. Resident was covered in vomit and diarrhea when found. Her VS [vital signs] were 167/90 [blood pressure], HR [heart rate]: 97, RR [respiratory rate]: 16, O2 [oxygen saturation]: 93%, T [temperature] 97.9. Her vitals slowly came down after she was more calm. Resident is A&O[alert and oriented] x1 [person] per baseline. No neurological deficits have been observed. Left message for family and NP. Neuro checks in place. On 4/14/23 at 2:55 PM, the Fall Committee IDT note documented, Resident fell on the floor on 4/9/23 with bed low and mat beside the bed, neurovital signs initiated. No complaint of pain or limitations with mobility. Provider and family was notified of incident and staff educated on ensuring resident is positioned in the middle of the bed to prevent from rolling off the bed. Provider and family agreed with plan of care. On 8/4/19, a care plan for At risk for falls related to actual fall; poor safety awareness; dementia; impulsivity and unsteady gait; Mobility alarm to bed and w/c to help alert staff was initiated for resident 13. On 4/14/23, resident 13's care plan for at risk of falls related to actual fall documented a new intervention to educate staff to position resident in the middle of the bed to prevent the resident from rolling off the edge of the bed. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. On 8/13/23 at 3:56 PM, the nurse note documented, Staff reported that tried to stand up from her wheelchair. She fell forward and hit her head and r. [right] knee. Pt. [patient] was helped up into her wheelchair and given a head to toe assessment. She has a large bump on her forehead and red area to her R. [right] knee. Vital signs are WNL [within normal limits]. She is showing signs of pain. I gave her a PRN [as needed] Norco for pain. neuro check initiated and provider and son was notified of incident. On 8/13/23 at 8:35 PM, the nurse note documented, Resident had episodes of vomiting with elevated blood pressure tried to call [family members name omitted] but did not pick up the phone. Was able to contact [name omitted] and agreed to send resident to be evaluated at ED. Paramedics called. On 8/14/23 at 4:30 AM, the nurse note documented, LN [licensed nurse] called [hospital] for update on resident. Resident was admitted to hospital for R hip fracture. Family aware. Hospital's current plan of care is to have family meet with ortho in morning to decide to operate or not. Provider and DON [Director of Nursing] notified. On 8/14/23, the hospital orthopaedic surgery hip fracture consult note documented that resident 13 fell out of her wheelchair, landing on her face and right side. After this, she had severe pain with any type of motion and also nausea and vomiting. The physical exam documented, Right Leg is shorted [sic] and painful with any attempted ROM [range of motion]. Imaging of the pelvis revealed a fracture of the right femoral neck hip. The note documented that resident 13's family elected surgical repair. On 8/13/23 at 3:30 PM, the incident report documented resident 13's witnessed fall. The report documented that no injuries were observed at the time of the incident. Resident 13 had a Pain Assessment in Advanced Dementia Scale (PAINAD) score of 4 for negative vocalization, facial expressions, body language, and consolability. On 8/16/23, resident 13's care plan for at risk of falls related to actual fall documented that the resident was admitted to the hospital for a hip fracture. No new interventions to prevent falls was identified. c. On 9/19/23 at 3:24 PM, the nurse note documented, Pt. was found lying on her fall mat next to her bed. Pt. was given a head to toe assessment. No injuries or noticeable pain. MD [Medical Director], DON, and Son notified. Neuro checks in place with vitals being WNL. On 9/22/23 at 4:13 PM, the Fall Committee IDT note documented, Staff did not hear bed alarm going off when resident rolled off the bed. Staff was reeducation on fall interventions and ensuring sensor alarm in bed to be placed and make sure it is working. On 9/19/23 at 3:00 PM, the incident report documented resident 13's unwitnessed fall. The report documented that no injuries were observed at the time of the incident, and resident 13 had a PAINAD score of 0. On 9/22/23, resident 13's care plan for at risk of falls related to actual fall documented a intervention to re-educate staff on ensuring the bed alarm was in place and working properly when in bed. No new interventions to prevent falls was identified. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	d. On 11/6/23 at 5:12 PM, the nurse note documented, Resident was found on the floor next to her bed on the fall mat. She was lying on her back. Pt. given a head to toe assessment. No injuries, redness, or bruising noted at that time. Neuro checks started. Vitals WNL. Provider, DON, and son were notified. On 11/6/23 at 3:30 PM, the incident report documented resident 13's unwitnessed fall. The report documented that no injuries were observed at the time of the incident. Resident 13 had a PAINAD score of 4 for facial grimacing, tensed, distressed pacing, and distracted or reassured by voice or touch. On 11/13/23, resident 13's care plan for at risk of falls related to actual fall documented a new intervention to change the resident's bed to a wider bed and mattress. e. On 12/3/23 at 5:15 PM, the nurse note documented, Pt. was found lying on the fall mat next to her bed. Given a head to toe assessment. No injuries or bruising noted at that time. Neuro checks started. Family, DON, and NP notified. On 12/2/23 at 3:15 PM, the incident report documented resident 13's unwitnessed fall. The report documented that no injuries were observed at the time of the incident. Resident 13 had a PAINAD score of 3 for a sad, frightened or frown facial expression, tensed and distressed pacing for body language, and distracted or reassured by voice or touch. On 12/7/23, resident 13's care plan for at risk of falls related to actual fall documented to re-educate staff on bed alarm placement, low bed, mat on the floor and ensuring resident was laying in the middle of the bed. No new interventions to prevent falls was identified. f. On 1/26/24 at 3:30 PM, the nurse note documented, [Resident 13] rolled off the bed and was on the mat next to bed with bed in low position. Has noted to have vomited stomach contents and had a large BM [bowel movement]. Assessed for injuries pupils equally reactive to light. Assessed by PT [physical therapy] able to move extremities with no pain or limitation. NVS [neuro vital signs] initiated, mental status at baseline. Got her in the shower and changed into clean clothes and resident appears to be feeling better. Provider and son was notified of incident and questions and concerns were addressed. BP 131/76, Temp 98.1, P 89, O2 sat 98%, RR 18. No skin injuries noted r/t [related to] fall. On 1/26/24 at 3:10 PM, the incident report documented resident 13's unwitnessed fall. The report documented that no injuries were observed at the time of the incident, and resident 13 had a PAINAD score of 0. On 1/30/24, resident 13's care plan for at risk of falls related to actual fall documented a new intervention to ensure that resident 13 was not put into bed until two hours after meals. g. On 2/20/24 at 3:35 PM, the nurse note documented, resident found on her floor mat next to her bed. Her bed was lowered, and she must have rolled off the bed onto the mat. Resident not able to give a description of fall. Given head to toe assessment. No injuries noted. Pt. is complaining of a headache. Neuro checks started. Vitals WNL. Son and Provider notified. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/20/24 at 2:15 PM, the incident report documented resident 13's unwitnessed fall. The report documented that no injuries were observed at the time of the incident. Resident 13's PAINAD score was a 2 for sad, frightened, or frown in facial expressions, and tensed, distressed pacing. On 2/22/24, resident 13's care plan for at risk of falls related to actual fall documented a new intervention to place a mattress for a fall mat, and re-educate nurses and aides on resident positioning in bed. No new interventions to prevent falls was identified. On 5/13/24 at 9:16 AM, an observation was made of resident 13 in a wheelchair self propelling down the hallway. Resident 13's pressure alarm was in the off position. On 5/13/24 at 9:17 AM, an interview was conducted with Nurse Assistant (NA) 3. NA 3 stated that resident 13 had a history of falls. NA 3 stated that interventions to prevent falls were a bed alarm, keep the bed in a low position, non slip shoes, and visual checks. NA 3 stated that resident 13 was an extensive one person assist for dressing and showering, and was a totally dependent for toileting and transfers. NA 3 stated that she used a gait belt to pivot transfer resident 13. NA 3 stated that the aides were responsible for checking the bed/chair alarm with every transfer or visual checks. NA 3 stated that she checked it this morning and when she checked it just now it was turned off. On 5/13/24 at 9:22 AM, an interview was conducted with Medication Technician (MT) 3. MT 3 stated that resident 13 had a history of falls but she was not sure if she had sustained any injuries. MT 3 stated that interventions to prevent falls were a bed alarm, meals in dining room for observation, a fall mat when the resident was in bed, and constant monitoring. MT 3 stated that the CNA's, MTs, and the DON were responsible for checking the bed alarms. MT 3 stated that the alarms should be on at all times. On 5/13/24 at 2:05 PM, an observation was made of resident 13 self propelling in a wheelchair in the west hallway. The wheelchair did not have a pressure alarm located on it. On 5/13/24 at 2:30 PM, an interview was conducted with LPN 1. LPN 1 confirmed that resident 13 did not have a pressure alarm on the wheelchair. LPN 1 stated that resident 13 had a pressure alarm on the bed but she was not sure if she had one on her wheelchair. She usually doesn't get out of her wheelchair. LPN 1 reviewed the orders and stated that she had an order to check if the bed alarm was in place and functioning properly. LPN 1 stated that the care plan for falls stated to have a mobility alarm to bed and wheelchair to alert staff. It looks like she should have one. LPN 1 stated that the purpose of the care plan was to know what was going on with the patient and to identify interventions for the day to day care to keep them safe. LPN 1 stated that resident 13 should have a pressure alarm in her w/c. The facility policy and procedure for Fall Management System documented that it was the policy of the facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The policy further documented that residents with a high risk factor for falls would have a care plan developed that included measurable objectives and timeframe's. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk. The policy stated that the care plan would need to be updated and the Quality Assessment and Assurance Committee would analyze trends to falls to determine if further interventions were needed. The policy was last revised in December 2023. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. Resident 35 was admitted to the facility on [DATE] with diagnoses which included wedge compression fracture of the lumbar vertebra, chronic kidney disease, type II diabetes mellitus, muscle weakness, abnormalities of gait and mobility, unsteadiness on feet, mixed incontinence, hypertension, and repeated falls. On 4/3/24, resident 35's medical records were reviewed. On 2/13/24, the MDS Assessment documented that resident 35 had a BIMS score of 11, which would indicate that the resident had a moderate cognitive impairment. The assessment documented that resident 35 did not have any indicators of psychosis such as hallucinations or delusions. The assessment documented that resident 35 required a limited one-person physical assist for transfers and toilet use. Review of resident 35's progress notes, incident reports, fall risk evaluations, and care plan revealed the following: a. On 8/25/23 at 5:02 PM, the nurse note documented, Resident was found on the floor next to the commode call light was not on. Per resident she was trying to transfer from chair to commode without calling for assistance and her left knee buckled and she fell on the floor hitting her head on the commode. Assessed for injuries, no skin injuries noted, ROM of extremities normal and remained alert and oriented x 4 [person, place, time and situation]. Assisted back to bed and changed as resident had an incontinence episodes. Resident was educated on using call light before transfers as has history of frequent falls. Verbalized understanding. Provider was notified of incident and resident agreed to be moved closer to the nurses station. On 8/25/23 at 9:23 PM, the nurse note documented, Resident reported turning on the call light, and started to wait for assistance. She then reported not being able to wait and stood up to go to the restroom. She lost her ba [TRUNCATED]		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review, for 2 of 38 sampled residents, the facility did not ensure residents maintained acceptable parameters of nutritional status. Specifically, resident's tube feedings were not administered as ordered, and a resident was not being positioned appropriately while the tube feeding was administered. Resident identifiers: 26 and 39. Findings include: 1. Resident 26 was admitted to the facility initially on 8/31/21 and readmitted on [DATE] with diagnoses that included alcoholic polyneuropathy, chronic obstructive pulmonary disease, severe protein-calorie malnutrition, major depressive disorder, anxiety disorder, dysphagia, hypo-osmolality and hyponatremia. On 5/7/24 at 3:25 PM, an interview was conducted with resident 26 who stated she received tube feedings for 4 hours every night. Resident 26 was observed to be very thin. Resident 26 stated she normally had a tube feeding pump in her room, but it was not there and she did not know why. Resident 26's medical records were reviewed between 5/6/24 and 5/14/24. An annual Minimum Data Set (MDS) assessment dated [DATE] revealed resident 26 had a BIMS (Brief Interview for Mental Status) of 12 indicating moderate cognitive impairment. The assessment also revealed resident 26 required extensive 1 person physical assistance with eating, which included tube feeding. Physician orders dated 4/3/24 revealed, Osmolite 1.5 at 70 ml [milliliters]/hr [hour] x 10 hours, 120 ml H2O [water] flush q [every] 4 hours. On at 1800 [6:00 PM] off at 0600 [6:00 AM]. Two times a day for dysphagia. Orders dated 4/4/24 included, Regular diet, mechanical soft-ground texture, thin liquids, pleasure feeds as tolerated. A care plan focus area initiated on 3/26/22 revealed, [Resident 26] has nutrition problem or potential nutrition problem r/t [related to] ETOH [alcohol] w/ [with] withdrawal and seizure; chronic hyponatremia; malnutrition . Low BMI [body mass index]. She receives a fortified diet. She has appropriate PO [oral] intake. Is on supplemental enteral NOC [nocturnal] feeds after surgery on neck. PO feeds have been started. The goal was, [Resident 26] will maintain adequate nutritional status as evidenced by maintaining weight with no s/sx [signs and symptoms] of malnutrition through review date. Interventions included, .Diet as ordered by the physician. Fortified meals . 1/10/23- diet order per MD [medical doctor]: pleasure feeds as tolerated; . Monitor/record/report to MD PRN s/sx of malnutrition: emaciation (Cachexia), muscle wasting, significant weight loss; Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated; Provide, serve diet as ordered, Monitor intake and record q meal. RD [Registered Dietitian] to evaluate and make diet change recommendations PRN; Supplement per order: MedPass tid [three times daily], enteral NOC feeds per order. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A care plan focus area initiated on 10/11/22 revealed, Requires tube feeding r/t dysphagia, swallowing problem for tonsillar cancer resection and removal. The goal was, Will maintain adequate nutrition and hydration status aeb weight stable, no s/sx of malnutrition or dehydration through review date. Interventions included, HOB [head of bed] elevated 45 degrees during and thirty minutes after tube feed; Check for tube placement and gastric contents/residual volume per facility protocol and record; Discuss with family/caregivers any concerns about the tube feeding, advantages, disadvantages and potential complications; Elevate HOB at least 30-45 degrees at all times during feeding; Monitor/document/report to MD PRN: Aspiration-fever, SOB [shortness of breath], tube dislodged, infection at tube site, self-extubation, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distention, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydration; Needs assistance with tube feeding and water flushes. See MD orders for current feeding orders; Provide local care to feeding tube site as ordered and monitor for s/sx of infection; RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs, make recommendations for changes to tube feeding as needed . Resident 26's MAR/TAR (Medication Administration Record/Treatment Administration Record) was reviewed for the months of March 2024, April 2024 and May 2024. a. March enteral feed order initiated on 3/27/24 revealed, Two times a day for dysphagia, Osmolite 1.5 at 70 ml/hr x 8 hours, 120 ml H2O flush q r hours. On at 2000 [8:00 PM], off at 0600 [6:00 AM]. Order date 3/27/24, discontinued on 4/3/24. b. April enteral feed order initiated on 4/3/24 revealed, Two times a day for dysphagia, Osmolite 1.5 at 70 ml/hr x 10 hours, 120 ml H2O flush q 4 hours. On at 1800, off at 0600. Discontinued on 5/8/24. c. May enteral feed order initiated on 5/8/24 revealed, Two times a day for dysphagia, Osmolite 1.5 at 70 ml/hr x 10 hours, 120 ml H2O flush q 4 hours, On at 2000, Off at 0600. The order was revised to read x 12 hours, back to x10 hours, then revised again to 12 hours with, On at 2000, Off at 0800. The revisions were all made on 5/8/24. It should be noted that after staff were asked about the timing and number of hours the tube feeding was being infused, the order revisions were made. It should also be noted that no documentation was found with information regarding the times tube feedings were started and stopped or the amount of formula that was administered. A physician note dated 11/3/23 revealed, Weight 95.4 pounds, an increase of 4 pounds in 7 months .Regular diet, mechanical soft texture. A physician note dated 3/8/24 revealed, .weight 97 lbs [pounds], an increase of 2 pounds in 5 months . Protein Calorie Malnutrition: Feeding tube cares per protocol. Osmolite 1.5 at 70 ml/hour over 8 hours. A physician note dated 4/7/24 revealed, .weight 91.9 pounds, no change in 4 months .Protein calorie malnutrition: Regular diet, pureed texture. Aspiration precautions. Feeding tube care as per protocol. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A NP [Nurse Practitioner] progress note dated 4/8/24 at 11:29 AM revealed, Past History Medical: .ongoing medical history of malignant mass of tonsil status post surgical resection .RD follow-up, with recent recommendation for diet texture change. A nutrition progress note dated 2/28/24 at 10:09 AM revealed, Discussed in NAR [nutrition at risk] committee meeting with wound nurse, DM [dietary manager]. Wt 96.4 Previous wt 97.6 Wt change: wt is within UBW [usual body weight]; 90-100 lbs but has been trending down Diet order: Regular mechanical soft/ground pleasure food as tolerated. Intakes: variable avg [average]. 50% Enteral feeds: Osmolite 1.5 @ 70 cc [cubic centimeters]/hr NOC feeds x 6 hours + 120 ml H2O flush q 4 hours. Skin is intact A/P [assessment/plan]: non-significant wt change x 30 days (3.8% loss) Wt appears to be trending down. Recommend increasing enteral feeding hours to 8 hour NOC feeds. This will provide TV [total volume] = 560, 840 kcal [kilocalories], 38 g protein, 425 ml H2O + 720 ml from flush for total fluids of 1145 provided via feeding tube. Enteral feeds continue to be supplemental to po feeds. Will monitor weekly. A nutrition progress note dated 3/6/24 @ 7:05 PM revealed, Discussed in NAR committee meeting with wound nurse, DM. Wt 97 Previous wt: 96.4 Wt change: wt is within UBW; 90-100 lbs Diet order: Regular mech soft/ground pleasure foods as tolerated. Intakes: variable. avg. 50% Enteral feeds: Osmolite 1.5 @ 70 cc/hr NOC feeds x 8 hours + 120 ml H2O flush q 4 hours. Skin is intact Labs: no new labs. A/P: non-significant wt change x 30, 90, 180 days. No changes recommended at this time. Continue weekly wts. A nutrition progress note dated 3/13/24 at 12:50 PM revealed, Discussed in NAR committee meeting with wound nurse, DM. Wt: 96.3 Previous wt: 97 lbs. BMI 17.1 [Resident 26] receives enteral NOC feeds + po meals. Please see recent quarterly nutrition assessment for additional information. Have recommended SLP [Speech Language Pathologist] eval and tx r/t some increased difficulty with swallowing. A Weight Change Note dated 3/27/24 at 2:42 PM revealed, NAR committee meeting with RD, wound nurse, SLP. Resident was unavailable for RD to interview which was attempted several times. Wt: 93.6 Previous wt: 95.9 Wt change: -8.1% x 90 days. wt is within UBW: 90-100 lbs but trending down for several weeks. BMI: 16.6 Diet order: Regular mech soft/ground pleasure foods as tolerated. Intakes: variable. avg: 50% Enteral feeds: Osmolite 1.5 @ 70cc/hr NOC feeds x 8 hours +120 ml H2O flush q 4 hours. Skin is intact . A/P: significant wt change 90 days in spite of increasing enteral feeds and beginning SLP services. New orders for additional increase of supplemental NOC enteral feedings to 10 hours. This provides TV = 700 ml, 1050 kcals, 48 g protein, 1252 ml free fluid (enteral feed + flush). Will continue weekly wts. Orders updated. Pt education provided. NP and family updated. Resident continues to be seen by ST [Speech Therapist]. A nutrition progress note dated 4/3/24 at 1:29 PM revealed, Discussed in NAR committee meeting with wound nurse, DM, SLP. Wt 96.2 Previous wt: 93.6 Wt change: +2.8% x 1 week, wt is within UBW: 90-100 lbs. BMI: 17.0 Diet order: Regular pureed texture (resident requested down grade per SLP). Intakes: variable. Skin: intact enteral feeds: NOC enteral feedings of Osmolite 1.5 @ 70 ml/hr x 8 hours. Last weeks recommendation to increase to 10 hours was not implemented A/P: Non-significant wt changes x 30, 90, 180 days. Wt is within UBW range. Have enquired with nursing regarding enteral orders. Wt is up from last week but intakes remain poor. Recommend increasing enteral feedings to 10 hours. See previous nutrition note for TV and nutrition information. Will continue to follow weekly at this time. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A nutrition progress note dated 4/24/24 at 1:31 PM revealed, Discussed in NAR committee meeting with wound nurse, SLP, DM. Wt: 94.2 previous wt: 96.6 Wt change: no sig [significant] changes noted. wt is within UBW : 90-100 lbs. Diet order: Regular mech soft, ground, thin liquids, intakes: variable. Skin: intact Enteral NOC feeds per orders. A/P: Resident is nutritionally stable on current POC [Plan of care]. No changes recommended. Monitor weekly. A Nutrition progress note dated 5/1/24 at 1:58 PM revealed, Discussed in NAR committee meeting with ADON [assistant director of nursing]. SLP discussed with RD that resident progression in therapy is minimal and enteral feedings will need to continue and/or be increased. Wt: 94 Previous wt: 94.2 Wt change: no sig changes noted. wt is within UBW: 90-100 lbs. Diet order: Regular mech soft, ground, thin liquids. Intakes: variable. Skin: intact Enteral NOC feeds per orders. A/P: Wt has trended down but remains within UBW range. Will continue current interventions. Consider increasing TF. Monitor weekly. A nutrition progress note dated 5/8/24 at 12:50 PM revealed, Discussed in NAR committee meeting with wound nurse, DM, SLP. Wt: 93 Previous WT: 94 Wt change: no sig wt changes, wt trending down BMI: 16.5 Diet order: Regular pureed texture (resident requested down grade per SLP). Intakes: <50% Skin: intact Enteral feeds: NOC enteral feedings of Osmolite 1.5 @ 70 ml/hr x 10 hours. A/P: Non-significant wt changes x 30, 90, 180 days. Wt is within UBW range but trending down. Recommend increasing enteral feeds to 12 hours. This will provide TV= 840, 1260 kcal, 54g. PO foods will remain pleasure feeds. Will continue to follow weekly at this time. Resident 26's meal intake percentage was reviewed and revealed daily intakes for May 2024 as follows: a. On 5/1/24: 1:53 PM 50% 10:35 PM 10% b. On 5/2/24: 12:00 PM 50% c. On 5/3/24: 12:45 PM 15% d. On 5/4/24: 11:04 AM 20% 5:25 PM 25% e. On 5/5/24: 12:00 PM 50% f. On 5/6/24: 1:41 PM 35% 5:30 PM 15% g. On 5/7/24: 9:37 AM 25% 12:00 PM 25% 5:30 PM 50% (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	h. On 5/8/24: 7:13 PM 70% i. On 5/9/24: 7:14 PM 25% j. On 5/10/24: 1:24 PM 50% 5:30 PM 20% k. On 5/11/24: 1:14 PM 100% l. On 5/12/24: 7:30 AM 25% 1:48 PM 25% 5:55 PM 20% m. On 5/13/24: 12:49 PM 20% 5:30 PM 90% On 5/8/24 at 1:47 PM, an interview was conducted with RN (Registered Nurse) 3. RN 3 stated resident 26 was administered tube feedings at night and had oral intake during the day. RN 3 stated resident 26's tube feeding was turned off before the day shift started. RN 3 stated resident 26 does well eating during the day. RN 3 stated resident 26's weight had been steady for over a year. RN 3 stated there were 2 current tube feeding orders. RN 3 acknowledged one order was for administration for 10 hours, the other stated, On at 1800 and off at 0600. On 5/8/24 at 2:21 PM, a second interview was conducted with RN 3 who stated that she had contacted the RD to verify the tube feeding order. RN 3 stated that the RD confirmed that resident 26's tube feeding order should start at 8:00 PM and finish at 6:00 AM. RN 3 stated she had corrected the orders. On 5/13/24 at 9:02 AM, an interview was conducted with RN 1. RN 1 stated the tube feeding times for administration were a range and could finish at 8:00 AM. RN 1 stated that resident 26 admitted from the hospital with a tube feeding. RN 1 stated when a tube feeding order was received, the nurse put in what time the tube feeding was to be provided, and what the formula was and the rate. RN 1 stated the nurses were required to check to ensure the tube feeding was running correctly. RN 1 stated nurses could adjust the Kangaroo Pumps if needed. RN 1 stated nurses administered whatever was on the MAR every shift. RN 1 stated she checked the MAR and then checked the pump to ensure it was running as ordered. RN 1 stated if there was a problem during the shift with the pump or tube feeding, the nurses would be notified by the CNA's as they had more interaction with the residents. On 5/14/24 at 7:08 AM, a follow-up interview was conducted with resident 26 who stated her tube feed was discontinued a couple of hours ago. Resident 26 stated she thought her weight loss was related to a swallowing issue. Resident 26 stated she did not feel that she was improving. Resident 26 stated her weight was being monitored. Resident 26 stated she did not remember what time her tube feeding was started on the previous evening. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/14/24 at 7:18 AM, an interview was conducted with Medication Technician (MT) 4. MT 4 stated she did not know what time resident 26's tube feeding was discontinued. MT 4 stated the nurses were responsible for hooking up and discontinuing the tube feedings. On 5/14 24 at 7:19 AM, a second interview was conducted with RN 1. RN 1 stated resident 26's tube feed was discontinued at 7:00 AM. RN 1 was observed to look in the medical record to see what time the task was checked off. RN 1 stated the medical record documented the the tube feed was started at 8:15 PM. RN 1 acknowledged that the tube feeding order was to start at 8:00 PM and stop at 8:00 AM. RN 1 stated the reminder in the medical record popped up early, at 7:00 AM. RN 1 stated resident 26 sometimes requested to have the tube feeding taken off at 7:00 AM so she could go to the bathroom. RN 1 stated irregular administration and discontinuation of the tube feeds was the reason why resident 26's weight was being monitored. RN 1 stated if the tube feeding was not administered as ordered, resident 26 would not be getting the intended calories. RN 1 stated resident 26's tube feeding was usually put on when she went to bed and that resident 26 sometimes went out to smoke so the administration times varied. RN 1 stated the MAR was where tube feeding administration was documented. RN 1 stated there was a box to check when the tube feeding was turned on and turned off. RN 1 stated she was not required to document how much formula was infused. RN 1 stated the order would have to specifically state that the volume had to be documented. RN 1 stated the RD would come and speak with the nurses if she had concerns about resident 26. RN 1 stated Certified Nursing Assistants (CNAs) were tracking the amount of food eaten at each meal. On 5/14/24 at 9:30 AM, RN 1 was observed to check resident 26's kangaroo pump for information about the amount of formula that was infused. There was no information in the pump history. RN 1 stated when the pump was turned off the information from the infusion was cleared, but kept the setting that was entered. RN 1 stated the machine was turned all the way off or it would continue to beep all day long. On 5/14/24 at 12:07 PM, an interview was conducted with the RD. The RD stated the DON notified her when a resident with a tube feeding was being admitted . The RD stated after she received the notification from the DON she reviewed the resident's orders and completed an assessment within 7 days. The RD stated resident 26 was followed in the NAR meeting every week and recommendations were based on weight and laboratory results. The RD stated resident 26 had been receiving tube feedings for a long time. The RD stated resident 26's weight went up and down depending on how much oral intake she was able to eat. The RD stated resident 26 had requested a modified texture diet. The RD stated resident 26's weight had always been between 90-100 pounds. The RD stated her weight had been lower based on other circumstances. The RD stated resident 26 had been stable in the past but had been trending down recently. The RD stated resident 26 was unhappy when her weight got up to 100 lbs. The RD stated she had made changes to resident 26's diet based on her preferences. The RD stated stable meant that there were no significant weight changes. The RD stated resident 26 wanted to have NOC feedings. The RD stated pleasure feeding meant that the majority of her nutrition intake was not from oral intake. The RD stated resident 26's estimated needs should be calculated at least annually and documented. The RD stated she had not completed resident 26's estimated needs calculation for her most recent assessments. The RD stated she did not know how much of the tube feeds resident 26 was actually getting. 45490 (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2. Resident 39 was admitted to the facility on [DATE] with diagnosis which included anoxic brain damage, metabolic encephalopathy, aphasia, severe protein calorie malnutrition, dysphagia, cognitive communication deficit, underweight, and lack of coordination. On 5/14/24 at 10:57 AM, an observation was made of resident 39. Resident 39's tube feeding formula container was empty and the pump was turned off. There was a date of 5/13/24 at 3:30 AM on the bottle of formula and the bag of water. The pump was turned on a revealed it was to infuse at 55 millimeters (ml) per hour of formula and 30 mls every hour of water. The pump revealed that the total volume of formula infused was 1123 mls and 624 mls of water over the last 24 hours. The pump further revealed resident 39 was infused 2194 mls of formula and 1284 ml of flush over the previous 48 hours. At 11:12 AM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 was observed to enter resident 39's room. NA 1 stated resident 39's tube feeding was running when she checked on her at 6:00 AM. NA 1 stated she had not checked on her since 6:00 AM. On 5/14/24 at 11:04 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 39's tube feed was shut off because one of her bosses notified her that the feeding pump was alarming and that her boss shut the pump off. RN 1 stated that the feeding pump had been off for about 15 minutes. On 5/14/24 at 11:09 AM, an observation of resident 39 was made. Resident 39 was laying in bed with the head of bed flat. Nurse Aide (NA) 1 was dressing resident 39. RN 1 was replacing resident 39's tube feed formula. RN 1 stated that resident 39's tube feed was continuous and they did not keep track the volume infused. RN 1 stated that resident 39's head of bed would be elevated but that she slid down in the bed where her head was no longer elevated. RN 1 stated that they used pillow to try and proper her up. One pillow was observed in the room, when RN 1 was asked if staff only use one pillow she stated that they would get more pillows to sit resident 39 up. RN 1 stated that there was not a way to ensure resident 39 was elevated 30 degrees while the tube feed was running. NA 1 stated that resident 39 moved around a lot in her bed and tended to scoot down in her bed. On 5/14/24 at 1:08 PM, an observation was made of resident 39. Resident 39 was in bed, the head of the bed was elevated. Resident 39's body was down in the bed lying flat with her head turned to the left. Resident 39's Medical record was reviewed from 4/3/24 through 5/14/24. On 3/10/24 a quarterly Minimum Data Set (MDS) assessment documented resident 39 had a Brief Interview for Mental Status (BIMS) of 99, indicating sever cognitive impairment. The MDS documented resident 39's Nutritional Status, that she had a Feeding tube providing 51% or more of total calories received. The MDS documented Other Health Conditions documented resident 39 had vomiting. A care plan dated 11/29/22, documented resident 39 requires gastrojejunostomy tube feeding r/t G-tube [gastric tube] complication . Interventions included, HOB [Head Of Bed] elevated 45 degrees during and thirty minutes after tube feed . Elevate HOB at least 30-45 degrees at all times during feeding. RD to evaluate quarterly and PRN. Monitor caloric intake, estimate needs. Make recommendation for changes to tube feeding as needed. A physician order dated 11/29/22 documented, every shift ELEVATE HOB AT LEAST 30-45 DEGREES AT ALL TIMES DURING FEEDING AND 1 HOUR AFTER. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	A physician order dated 12/6/23 documented, every shift Osmolite 1.5 at 55 ml/hr [hour] + 30 ml q hr H2O continuous feeds. Resident 39's weights were as follows: a. On 11/14/24 was 94.6 pounds, b. On 2/12/24 was 94.0 pounds, c. On 4/15/24 was 97.2 pounds d. On 5/13/24 was 97.3 pounds with a Body Mass Index of 19.0 A Nutrition admission evaluation dated 12/5/22, documented resident 39 was NPO [nothing by mouth] with reliance on enteral feeding for 100% of nutrition needs Estimated nutrition needs: Energy 1200 (30 Kcal/kg [kilocalorie per kilogram]) . is at nutrition risk r/t NPO status reliance on enteral feeding to meet 100% of nutrition needs . will strive for gradual wt [weight] increase . A Nutrition quarterly evaluation dated 8/27/23, documented resident 39 was NPO with reliance on enteral feedings for 100% of nutrition needs. She has a PEG [percutaneous endoscopic gastrostomy] tube . Enteral feeding provides; TV= 1540 2310 kcal (56 kcal/kg) 97 g protein (2.3 g/kg) 1170 ml Free Fluid + water flush of 440 ml today/day= 1610 ml (39 ml/kg) . [Resident 39] is at nutrition risk r/t NPO status, reliance on enteral feeding to meet 100% of nutrition needs, hx [history] protein-calorie malnutrition . A nutrition quarterly evaluation dated 2/26/24, documented resident 39 was NPO with reliance on enteral feedings for 100% of nutrition needs . Based on average run time of 22 hrs TV= 1210 ml . [It should be noted there is no documentation of resident 39's formula intake or number of hours of feeding.] It should be noted that Osmolite 1.5 at 55 ml per hour continuous would provide 1320 mls of formula for 1980 kcals and 82 grams of protein per 24 hours. According to the tube feeding pump resident 39 was provided a total volume of formula of 1123 mls from 24 hours and 1,071 mls the previous 24 hours. On 5/14/24 at 12:44 PM, an interview was conducted with the Registered Dietitian (RD). The RD stated that resident 39's orders for continuous tube feed is based on 22 hours a day and that it was not practical to be based on 24 hours a day because resident 39 was unhooked for showers or nursing cares. The RD stated that the last nutritional needs evaluation was done when she was first admitted in 2022 and that since her weight had not changed her needs would not be significantly different. The RD stated she did not know how much total volume of formula was infused into resident 39 over a 24 hour period. The RD stated she depended on nursing staff to notify her if a resident was not getting tube feedings according to orders. The RD stated she was aware that resident 39 went out with family and did not have her tube feeding running for the full 22 hours. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/14/24 at approximately 1:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that a resident receiving a tube feed should have their upper body elevated at least 30 degrees. The DON stated that the nurses did not document the total volume infused and was not sure if the RD looked at the feeding pump for volume infused. The DON stated that resident 39 was not receiving a continuous tube feeding because of showers, cares and that her family took her out of the facility and so they estimate the total volume of formula. On 5/14/24 at 2:21 PM, a follow-up interview was conducted with the DON and Corporate Resource Nurse (CRN) 1. CRN 1 stated she talked to the facility RD about changing resident 39 to bolus feeding to make sure she maintained an upright position. The DON stated resident 39 was not provided bolus feedings before because she was nauseated, so a smaller amount was better for resident 39.		

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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** 45490 Based on observation, interview, and record review it was determined, for 1 of 38 sampled residents, that the facility did not ensure that a resident who was fed by enteral means received the appropriate treatment. Specifically, a resident's head and torso were not elevated while a tube feeding was infusing. Resident identifier: 39. Findings include: Resident 39 was admitted to the facility on [DATE] with diagnosis which included anoxic brain damage, metabolic encephalopathy, aphasia, severe protein calorie malnutrition, dysphagia, cognitive communication deficit, underweight, and lack of coordination. On 5/14/24 at 11:09 AM, an observation of resident 39 was made. Resident 39 was laying in bed with the head of bed flat. Nurse Aide (NA) 1 was dressing resident 39. RN 1 was replacing resident 39's tube feed formula. RN 1 stated that resident 39's tube feed was continuous and they did not keep track the volume infused. RN 1 stated that resident 39's head of bed needed be elevated but that resident 39 normally slid down in the bed where her head was no longer elevated. RN 1 stated that staff used pillow to try and proper her up. One pillow was observed in the room, when RN 1 was asked if they only use one pillow she stated that they would get more pillows to sit resident 39 up. RN 1 stated that there was not a way to ensure she was up at 30 degrees while the tube feed was running. NA 1 stated that resident 39 moved around a lot in her bed and tended to scoot down in her bed. On 5/14/24 at 1:08 PM, an observation was made of resident 39. Resident 39 was in bed, the head of the bed was elevated. Resident 39's body was down in the bed lying flat with her head turned to the left. Resident 39's Medical record was reviewed from 4/3/24 through 5/14/24. On 3/10/24 a quarterly Minimum Data Set (MDS) assessment documented resident 39 had a Brief Interview for Mental Status (BIMS) of 99, indicating sever cognitive impairment. The MDS documented resident 39's Nutritional Status, that she had a Feeding tube providing 51% or more of total calories received. The MDS documented Other Health Conditions documented resident 39 had vomiting. A care plan dated 11/29/22, documented resident 39 requires gastrojejunostomy tube feeding r/t [related to] G-tube [gastric tube] complication . Interventions included, HOB [Head Of Bed] elevated 45 degrees during and thirty minutes after tube feed . Elevate HOB at least 30-45 degrees at all times during feeding. RD [registered dietitian] to evaluate quarterly and PRN [as needed]. Monitor caloric intake, estimate needs. Make recommendation for changes to tube feeding as needed. A physician order dated 11/29/22 documented, every shift ELEVATE HOB AT LEAST 30-45 DEGREES AT ALL TIMES DURING FEEDING AND 1 HOUR AFTER. A physician order dated 12/6/23 documented, every shift Osmolite . continuous feeds. (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at approximately 1:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that a resident receiving tube feed should be up at least 30 degrees. The DON stated that the nurses did not document the total volume infused and was not sure if the RD looked at the feeding pump for total volume infused. The DON stated that she was not getting continuous feedings because of showers, cares and that her family took her out of the facility and so they estimate the rate for her being taken off the pump.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review, it was determined for 1 of 38 sampled residents, that the facility failed to evaluate the risks versus benefits of an installed side rails for a resident. Specifically, one resident had a half side rail with no evaluation. Resident identifier: 17. Findings include: Resident 17 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular disease, intracranial and intraspinal phebities and thrombophlebitis, diabetes mellitus, adult failure to thrive, and protein-calorie malnutrition. On 5/7/24 at 3:18 PM, an interview and observation were made of resident 17. Resident 17 had a half side rail on the left side of her bed. Resident 17 stated that she would like another half side rail to the right side of her bed but was told that the nurse and doctor had to evaluate her for it. Resident 17 stated she asked the Maintenance Director about three weeks ago for the other half side rail. Resident 17 stated the half side rail would help her to reposition in bed. Resident 17's medical record was reviewed 5/7/24 through 5/14/24. There was no information located in resident 17's medical record regarding an evaluation of a half side rail. A care plan dated 3/14/24 and revised on 5/6/24 revealed, ADL [activities of daily living] Self Care Performance Deficit r/t [related to] CVA [cerebral vascular accident], depression, hx [history] of falls, ., RUE [right upper extremity] tremor, . Contracture management to lle [left lower extremity]. The goal was Will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene with supervision through the review date. Interventions included Explain all procedures/tasks before starting; Promote dignity by ensuring privacy; Wears AFO [ankle-foot orthosis] to lle; Encourage to participate to the fullest extent possible with each interaction; Encourage to use bell to call for assistance and; Monitor/document/report to MD PRN any changes, any potential for improvement,reasons for self-care deficit, expected course, declines in function. On 5/8/24 at 10:26 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated if a resident needed a mobility assistance devise. The Maintenance Director stated he referred the resident to the clinical/nursing department. The Maintenance Director stated he installed the devices and inspected them monthly. The Maintenance Director stated resident 17 had a mobility assistance device on the left side of her bed. The Maintenance Director stated he was not aware resident 17 wanted another half side rail for positioning and would talk to the Director of Nursing (DON) about it. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/8/24 at 10:30 AM, an interview was conducted with Director of Therapy (DOT). The DOT stated therapy did an evaluation and if a resident was having a hard time sitting up without an assistive device. The DOT stated after the evaluation, the Maintenance Director was contacted to install the positioning device. The DOT stated positioning device was also care planned. The DOT stated she was not aware that resident 17 had a half side rail. The DOT stated if the bed was against the wall, then the resident did not need a side rail on that side. The DOT stated she had not heard that resident 17 requested a side rail to the other side of her bed. On 5/13/24 at 11:46 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated if a resident asked for side rail then she would talk to DON and DOT. LPN 1 stated a half side rail would be considered a restraint, so the resident would have to sign a release. LPN 1 stated she did not complete care plans. LPN 1 stated resident 17 had a half side rail on one side of her bed. LPN 1 stated resident 17 pulled herself up in the seated position with it. LPN 1 stated she did not have an evaluation for the side rail because therapy would have it. On 5/14/24 at 8:17 AM, an interview was conducted with the DON. The DON stated if a resident requested a half side rail, then a consent was signed. The DON stated the resident was educated on the risks such as entrapment or hitting head. The DON stated physician's orders were obtained and it was care planned. The DON stated side rail assessment was completed. The DON stated there was not a care plan prior for resident 17's half side rail. The DON stated resident 17 did not have a consent. The DON stated she started a list of residents with side rails and she was going to be talking to therapy about getting evaluations completed.		

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 45490 Based on interview and record review, it was determined the facility did not ensure that any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, was competent to provide nursing and nursing related services; and completed a training and competency program, or a competency evaluation program approved by the State. Specifically, a Nurse Aide (NA) was employed at the facility on a full-time basis, for approximately 6 months with out completion of training and competency evaluation program. Findings included: On 5/14/24, a list of NA's with their start date was requested from the facility Administrator. NA 3's employee file was reviewed and documented a start date of 10/31/23. On 5/14/24 at 9:40 AM, an interview was conducted with Human Resources (HR). HR stated that a newly hired NA signed a contract stating they would enroll in a class to become a Certified Nurses Assistant (CNA) within 120 day of hire. HR stated that the process started the first day an NA was hired. When HR was asked about NA 3's CNA documentation HR stated that NA 3 should have completed a CNA course according to her hire date. HR stated that he could not locate documentation that NA 3 was enrolled in a CNA course.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45490 Based on observation, interview and record review it was determined, for 3 of 38 sampled residents, that the facility did not ensure that all drugs and biological's were stored and labeled in accordance with accepted professional principles, under proper temperature controls and cautionary instructions, and the expiration date when applicable. Specifically, the temperature in one medication fridge was not within the required temperature range for medication storage. Resident identifiers: 4, 47 and 157. Findings included: On 5/9/24 at 8:40 AM, an observation was made of the facility medication refrigerators. A mini fridge was located in the medication room. The medication fridge temperature gauge measured 48 degrees Fahrenheit (F). On 5/9/24 at 8:42 AM, an interview was conducted with the Medication Technician (MT) 2. MT 2 stated that the medication fridge needed to be at a certain temperature because the medications needed to maintain a certain temperature in order to be effective. The following items were located in the refrigerator: a. Piperacillin/Tazobactam 3.37 grams (gm)/ 100 ml (milliliter), 3 medicine balls for resident 4. b. Ceftriaxone 2 gm/ 100 ml, 2 medicine balls for resident 47. c. Cefazolin 2 gm/ 100 ml, 2 medication balls for resident 157. d. Acetaminophen suppository 650 mg (milligrams), 3 suppositories. e. Acetic acid 0.25% irrigation solution 500 ml. On 5/9/24 at 9:45 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she observed the fridge temperature at 50 degrees F. The DON stated that the temperature was not within range and that the fridge temperature should be within a certain range and if it is above or below then staff should call the pharmacist. The DON stated that after her observation of the fridge she called the pharmacy and was instructed to dispose of all of the intravenous (IV) medications. The DON stated that she would order a new fridge.		

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F 0779 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep signed and dated reports of x-rays and other diagnostic services in the residents record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45490 Based on interview and record review, it was determined that for 1 or 38 sampled residents, that the facility did not file in the resident's clinical record the signed and dated reports of radiological and other diagnostic services. Specifically, a residents hip x-ray result was not in the medical record. Resident identifier: 20. Findings Included: Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included functional quadriplegia, delusional disorder, bipolar disorder, traumatic brain injury (TBI) and cervical disc disorder. Resident 20's medical record was reviewed from 4/3/24 through 5/14/24. On 5/2/23 at 2:40 PM, a nursing progress note documented, resident 20 came back from his appointment with [a local urology clinic] and told us that he was sitting in his electric wheelchair inside the van but was not seat belted in the van. The van stopped abruptly, and he was thrown from his chair landing his bottom on the footrests of his w/c [wheelchair] and hitting his head and neck on the seat of the w/c. He states he was helped back into the w/c by driver and passersby then brought back to our facility. Pt. [Patient] checked for injuries. None seen at this time. Neuro [neurological] checks started . On 5/2/23, a physician's order documented an X-ray bilateral hips. It should be noted, that no documentation of the x-ray results could be located in resident 20's medical record. On 5/6/24 at 1:37 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she had requested resident 20's hip x-ray from the local mobile x-ray company. The DON stated she could not locate the x-ray in the resident 20's medical record.		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 43212 Based on observation and interview, the facility did not provide meals with no more than 14 hours between the substantial evening meal and the breakfast meal the following day. Specifically, breakfast meals were being served more than 30 minutes beyond the posted time, causing more than 14 hours to elapse between the evening meal and the breakfast meal. Resident identifiers: 7, 9, 30 ,31, 49, 51 and 106. Findings include: 1. On 5/6/24 at 8:41 AM, Dietary Aid (DA) 1 and DA 2 were interviewed and stated the meal times for the facility were: Breakfast at 7:20 AM; Lunch at 12:00 PM; and Dinner at 5:30 PM. DA 1 referenced the meal schedule that was posted to the side of the window area where meals were served in the dining room. 30563 2. The facility provided a form titled Meal Times that revealed the following: a. Breakfast: 0720 AM (7:20 AM) b. Lunch: 12:00 PM c. Dinner: 1730 PM (5:30 PM) On 5/6/24 at 12:00 PM, an observation was made in the dining room. The same form that was provided to surveyors was posted in the dining room. 3. On 5/6/24 at 12:15 PM, an observation was made of the facility dining room. Staff were observed to start serving beverages to residents in the dining room. On 5/6/24 at 12:18 PM, an observation was made of the [NAME] hall. The meal cart was delivered to the hallway. On 5/6/24 at 12:18 PM, an observation was made of the dining room. There were doors that opened from the kitchen to the dining room. On 5/6/24 at 12:22 PM, an observation was made of the first tray being delivered to resident 30. 4. On 5/7/24 at 11:50 AM, an observation was made of the dining room. Staff were observed to start serving beverages in the dining room to residents. The drinks were served to half of the dining room before the beverages ran out on the cart. At 12:09 PM, staff were observed to start serving drinks to the other half of the dining room. (continued on next page)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/7/24 at 12:19 PM, an observation was made. Resident 31 was the first resident to be served lunch. 38031 5. On 5/14/24 at 7:20 AM, a dining observation was made in the main dining room for the breakfast meal service. On 5/14/24 at 7:52 AM, resident 106 asked for and was served coffee from the Director of Therapy (DOT). On 5/14/24 at 7:53 AM, resident 7 stated, Hey all of us want coffee. This was said in response to resident 106 being served coffee. Resident 7 stated I'm just waiting for my coffee. On 5/14/24 at 7:57 AM, the kitchen staff was observed to open the window into the service area for food distribution. The only staff present in the dining room was Licensed Practical Nurse (LPN).1 On 5/14/24 at 8:03 AM, resident 9 was served the first breakfast meal tray by the Dietary Manager (DM). On 5/14/24 at 8:16 AM, the last breakfast meal was served to resident 51 by the DM. On 5/6/24 at 11:55 AM, an interview was conducted with resident 31. Resident 31 stated the food was good but he had to wait a while for food. On 5/7/24 at 8:45 AM, an interview was conducted with resident 47. Resident 47 stated the food is good it just takes along time to receive the food. He stated that the facility is scheduled to serve breakfast at 7:20 AM but they do not start serving until 8:30 AM. On 5/14/24 at 11:09 AM, an interview was conducted with the DM who stated that the posted 7:20 AM mealtime was when the kitchen staff began plating the food. The DM stated kitchen staff had from 7:20 to 8:15 AM to prepare and serve the breakfast meal. The DM stated the food should start coming out from the kitchen in the morning between 7:45 AM and 8:00 AM. The DM stated the hallway trays were served first. The DM stated sometimes residents liked to watch television before breakfast was served. The DM stated if residents wanted a drink while they waited for a meal they should ask a staff member to provide it. The DM stated staff could provide drinks before the beverage cart came out to the dining area. The DM stated as long as there was a staff member in the dining room, the resident could be provided a beverage. The DM stated there usually was a staff member in the dining area when residents started coming down for a meal. The DM stated the 7:20 AM posted meal time could be confusing to residents. The DM stated she attended the resident council regularly when she was invited and the residents had not mentioned anything about having to wait for meals to be served. 45490		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43212 Based on observation and interview, it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the walk-in freezer, walk-in refrigerator, and dry food storage room were open to air, a container in the walk-in refrigerator was not dated, the wall in the dry food storage area had black residue from a water leak, the vent in the dry storage room was not functioning and was rusty with an unknown dried substance on it, there were tiles in the dish room that were cracked and chipped. Findings include: On 5/6/24 at 8:41 AM, an initial tour of the kitchen was conducted. In the walk-in freezer, a box of frozen vegetables was open to air. In the walk-in refrigerator, a box with raw bacon was open to air, and a container of sliced cheese was not dated. In the dry storage room, a box of lasagna noodles was open to air and not sealed, a box of spaghetti noodles was open and not sealed, the floor vent below the food storage racks was rusty, and had a dried substance between the vent slats and around the vent. Additionally, the wall behind another group of food storage shelves was observed to have evidence of a water leak and the black residue went from the ceiling to the floor, and tiles below the dish machine were cracked and chipped. On 5/14/24 at 10:56 AM, a follow-up tour of the kitchen was conducted. In the walk-in freezer, a box of beef patties was open to air, and a box of fish filets was open to air. In the dry storage room, the lasagna noodles and the spaghetti noodles were open to air and not sealed, The vent cover was rusty and had a dried substance between the vent slats and around the vent. The wall in the dry storage room, behind the food storage shelves had a dried black residue running from the ceiling to the floor. In the dish machine room, tiles below the dish machine were cracked and chipped. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at 11:09 AM, an interview was conducted with the Dietary Manager (DM). The DM stated the kitchen was cleaned daily and each dietary staff member had responsibilities to complete. The DM stated cleaning was completed during the day between meals. The DM stated the dry storage area was mopped before the morning cook left for the day, and then before the kitchen closed in the evening. The DM stated the vent in the dry storage room did not work and it was the only vent in the room. The DM stated she did not know what the dried substance was. The DM acknowledged that the vent was rusted. The DM stated she had not notified the maintenance manager about the vent not working and the need for replacement. The DM stated the pasta in the dry storage room did not arrive in a plastic bag within the box. The DM stated she should close up the boxes when the pasta was not being used. The DM stated the staff could use tape to seal the boxes, but had not been doing that. The DM stated the morning cook was responsible for checking the refrigerator and freezer for items that were open to air. The DM stated items in the refrigerator and freezer should be labeled and dated, and sealed up after removing some of the food from the containers. The DM stated the Registered Dietitian (RD) conducted kitchen audits once per month that included cleanliness, food temperatures, testing a food tray, checking food within the refrigerator and freezer. The DM stated, she does everything. The DM stated the RD gave her findings to the Administrator (ADM) and to her for review. The DM stated after she received the results of the audit she would fix what needed to be fixed. The DM stated she did not track the items that required improvement from month to month. The DM stated the RD kept a record of her audits. The DM stated that not even a month ago new tile was installed just outside the walk-in refrigerator due to cracked and chipped tile. The DM stated she had not notified maintenance about the additional tiles in the dish room that required repair. The DM stated it was recently discussed in a meeting, but she did not know what would be done about it. The DM stated the black substance on the wall in the dry storage room was from a leak in the roof that was repaired during the winter time.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 30563 Based on observation, interview, and record review, the facility did not establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. Specifically, multiple areas of harm were identified on the recertification survey and were not identified and corrected through the Quality Assurance and Performance Improvement (QAPI). Resident identifiers: 8, 13, 20, 21, 31, 35, and 257. Findings include: 1. Based on observation, interview and record review it was determined, for 5 of 38 sampled residents, that the facility did not ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident's finger was partially amputated after it became impinged in a tilting wheelchair hinge; a resident sustained multiple falls with one resulting in a hip fracture; a resident sustained multiple falls with two falls resulting in head lacerations; two residents transported in the facility vehicle were not properly secured and sustained falls; and a resident sustained a burn while smoking unsupervised. Resident identifiers: 13, 20, 21, 31, 35, and 257. 2. Based on observation, interview and record review it was determined, for 1 of 38 sampled residents, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choice. Specifically, a resident had skin breakdown that did not have the dressing changed according to orders and was observed to bump another area on the wheelchair. Resident identifier: 8. On 5/14/24 at 2:38 PM, an interview was conducted with the Administrator (ADM). The ADM stated the Quality Assurance and Performance Improvement (QAPI) met at least quarterly. The ADM stated the last QAPI was on 2/9/24. The ADM stated staff met when a problem was identified. The ADM stated the QAPI process included asking the 5 Why's. The ADM stated that he went to the Infection Preventionist, Director of Nursing (DON), Wound Nurse, and business office manager to look for trends and issues to see what could be an issue and then let that staff member know to bring the issues to the QAPI meeting. The ADM stated this created a layout before the QAPI meeting. The ADM stated the incident regarding resident 257 not being secured in the facility van was identified during QAPI on 2/9/24. The ADM stated the QAPI identified there was a issue with the van. The ADM stated a fleet education was completed with the transport staff. The ADM stated he completed spot checks but did not know how to secure the residents in the van. The ADM stated the QAPI team usually re-evaluated the previous QAPI to see if it was successful but did not do that in regards to the van incident. The ADM stated the QAPI team discussed an action plan regarding falls and wounds on 2/9/24 and completed the 5 Whys. The ADM stated there was no follow-up to falls or ulcers. The ADM stated abuse allegations, resident council minutes and grievances were not reviewed for QAPI. The facility Policy and Procedure for Quality Assurance and Performance Improvement dated 9/2017 and updated 1/2022 revealed, Policy (continued on next page)		

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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.			
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility will establish and implement a Quality Assessment and Assurance Committee, develop a written Quality Assurance and Performance Improvement Plan, which will be reviewed and updated annually, and implement Performance Improvement Projects (PIPs) through a data driven and proactive approach. Purpose The purpose of the QAPI Plan and processes is to continually assess the facility's performance in all service areas, so that system and processes achieve the delivery of person-centered care, and which maximizes the individual's highest practicable physical, mental, and social well-being. Procedure 1. Quality Assessment and Assurance Committee (QAA): a. Members of the committee will include: Director of Nursing Services (DNS) Medical Director Administrator Infection Preventionist At least two other members: Staff with responsibilities for direct resident care and services (CNA's [Certified Nursing Assistant], therapists, staff nurse, social workers, activities staff) Staff with responsibilities for the physical plan (maintenance, housekeeping, laundry) b. The committee will meet at least quarterly or more often as the facility deems necessary c. The committee will maintain a record of the dates of all meetings and the names/titles of those attending each meeting d. Committee functions include: QAPI plan, identifying and prioritizing PIPs, implementing actions to correct quality issues, and monitoring to ensure the corrective action implemented is being sustained. 2. QAPI Plan Components: The plan will include a. Design and scope b. Governance and leadership c. Feedback, data systems, and monitoring (continued on next page)		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Performance improvement projects (PIP or QIPs) e. Systemic analysis and systemic action. 3. Identification of, and prioritizing of. PIPs through: a. Open-door policy for staff reporting of quality problems b. Staff meetings c. Resident Council d. Grievances e. Systematic review of facility data, data sources, and comparative data, from market, state, and national sources f. Prioritizing through identification of high-risk, high volume, or problem-prone issues 4. Education and Information Sharing: a. Staff will be educated on QAPI (Committee, Plan, and PIPs) at the time of hire, PRN and annually thereafter b. QAPI plan and activities will be shared through resident council. c. QAPI plan and activities may be shared through staff meetings, bulletin boards, etc. 5. Governance and Leadership: a. The Governing Board and Administrator will promote and create a fair and open culture where staff are comfortable identifying quality problems and opportunities. b. The Administrator will provide support for staff time, space, and resources to carry out QAPI activities c. The Administrator will share QAPI plans and activities periodically to the Governing Board 6. QAPI tools to support Performance Improvement Activities: The facility may utilize the following established Performance Improvement tools/Processes: a. Plan-Do-Study-Act (PDSA cycles) b. The Five Why's to identify root cause c. The Fishbone		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation and interview it was determined, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 1 of 38 sampled residents, a staff member was observed to touch an unknown red/orange substance with gloves. Resident identifiers: 8. Findings include: Resident 8 was admitted to the facility on [DATE] with diagnoses which included other specific joint derangements of left hip, pain in left hip, Alzheimer's, chronic systolic heart failure, visual loss in both eyes and protein-calorie malnutrition. On 5/13/24 at 2:05 PM, an observation was made of resident 8's room. An observation of the wall on the right side of resident 8's was a protruding piece of dry wall, sticking out approximately a half inch from the wall. The dry wall was secured with 7 screws protruding from the drywall. An observation of an orange and red colored substance was on the drywall. On 5/14/24 at 7:35 AM, a second observation was made of resident 8's room. Resident 8 was in bed with his bed in the lowest position. There was a piece of dry wall protruding from the wall on the right side of the bed, sticking out approximately a half inch from the wall. The dry wall was secured with 7 screws protruding from the drywall. An observation of an orange and red colored substance was on the drywall. On 5/14/24 at 9:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she did not know there was drywall sticking out from the wall in resident 8's room. LPN 1 was observed to look at the dry wall. The bed was elevated and over where the drywall that had been attached to the wall. LPN 1 was observed to lower the bed and observed the piece of drywall attached with screws to the wall. There was an orange and red substance on the drywall. LPN 1 stated she did not know what the red and orange colored substance was. LPN 1 was observed to touch the the red and orange colored substance with her finger that was not gloved. There were 7 screws protruding from the piece of drywall. On 5/14/24 at 2:16 PM, a follow up interview was conducted with LPN 1. LPN 1 stated if she suspected blood then she would do a skin assessment and report what was seen. LPN 1 stated she should not touch a possible blood substance with her bare hand. LPN 1 stated she should have used gloves but she did not think it looked like blood. LPN 1 stated the substance had a more orange color verses red for blood. LPN 1 stated she did not know what the substance was and she should not have touch it without gloves.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review it was determined, for 1 of 38 sampled resident, that the facility did not provide an means for contacting nursing staff that was reliable and easily to use. Specifically, a resident did not have their call light within reach. Resident identifier: 36. Findings include: Resident 36 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, seizures, hyperglycemia, diabetes mellitus, protein calorie malnutrition, dysphagia, and personal history of traumatic brain injury. On 5/6/24 from 9:24 AM until 10:22 AM, an observation was made of resident 36. Resident 36 was observed to have his call light around a light fixture by his bed. The call light was out of resident 36's reach. Resident 36's medical record was reviewed 5/6/24 through 5/14/24. A care plan dated 6/1/22 and revised on 2/2/23 revealed Alteration in musculoskeletal status r/t [related to] MVA [motor vehicle accident] w/ [with] Poly Trauma and fractures Fracture to right 4th finger- refused to keep splint in place. The goal was Will remain free of injuries or complications through review date. One of the interventions developed was Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Another care plan dated 6/1/22 and revised on 6/17/22 revealed At risk for a communication problem r/t Head Injury, Hearing deficit, sometimes has difficulty making self understood. The goal revealed, Will be able to make basic needs known on a daily basis through the review date. One intervention included Ensure/provide a safe environment: Call light in reach, Adequate low glare light, Bed in lowest position and wheels locked, Avoid isolation. Another care plan dated 6/1/22 and revised on 4/3/24 revealed At risk for falls r/t actual fall, Hydrocephalus; traumatic brain injury; dysphagia; encephalopathy; bilateral hearing loss; seizure d/o [disorder] Actual fall-11/18/23, 3/13/24, 4/3/24. A goal was Minimize risk of falls through the review date. One of the interventions included Be sure the call light is within reach and encourage to use it to call for assistance as needed. On 5/13/24 at 11:49 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 36 was easily re-directed, but was confused quiet a bit. LPN 1 stated resident 36 had seizures and was confused for a few days after. LPN 1 stated after a seizure his condition changed for the worst but then he came around. LPN 1 stated resident 36 was a little forgetful to use the call light but he might use it sometimes. LPN 1 stated resident 36's call light should be within reach. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 8:07 AM, an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated sometimes resident 36 was able to use his call light. CNA 4 stated resident 36 should have his call light within reach at all times. CNA 4 stated the call light tied to the light fixture would be out of reach of resident 36. On 5/14/24 at 8:27 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 36 was able to use his call light but sometime with his cognition he did not use it. The DON stated she provided education to staff regarding call lights which included making sure the call light was within reach of the resident. The DON stated she provided education because resident council had complained of long wait for call lights. The DON stated call lights within reach was part of the education.		