STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465100	A. Building B. Wing	05/21/2026

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on record review and interview, it was determined for 1 of 25 sampled residents, that the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice. Specifically, one resident was not referred to a urologist or oncologist when it was ordered by the physician. Resident identifier: 48.Findings included: On 5/19/26 at 9:01 AM, an interview was conducted with resident 48 who stated she was supposed to get a mammogram according to a visit she had with the facility's doctor about 2 months ago. Resident 48 stated she tried to schedule it herself, but she needed the order from the doctor.Resident 48's medical record was reviewed 5/18/26 through 5/21/26.Resident 48 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection, overactive bladder, and personal history of malignant neoplasm of breast.A SOAP (Subjective, Objective, Assessment, and Plan) Note dated 3/27/26 indicated, eval [evaluation] secondary to review of MRI [Magnetic Resonance Imaging] as noted on visit 3/12, MRI results with noted abnormalities of thoracic lesions, in presence of noted previous history of breast cancer, reports treatment surgical intervention to left breast,' I have not followed up with oncology for a long time, treatment was stopped '. discussed with patient obtaining mammogram, follow-up with oncology referral.(+) generalized pain, weakness, malaise, fatigue, loose stools. It further indicated, Plan Problem Abnormal MRI results; thoracic lesions in the setting of noted breast cancer history-consult & refer to oncology. A SOAP Note dated 4/20/26 indicated a chief complaint of increased urinary frequency and MRI Imaging; thoracic lesions. It further indicated, eval secondary to nursing reporting patient with complaints of increased urination, previously evaluated discussed with patient use of pelvic floor muscle strengthening conservative measures & continues therapy with OT [Occupational Therapy] with hip significant improvement, discussed medication dose adjustment, follow-up with urology, no other symptomatic manifestations other than polyuria. It further indicated, Plan -consult & refer to urology-consult & refer to oncology.Polyuria continue OT pelvic floor muscle strengthening Change oxybutynin to 10 mg [milligrams] twice a day consult & refer to urology.On 5/21/26 at 9:58 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1 who stated if a physician made an order for a referral the nurse assigned to the resident would be responsible to put the order in. LPN 1 stated the Nurse Practitioner (NP) and the Medical Doctor (MD) would let the nurse know verbally, by text or it was written down and handed to the nurse.On 5/21/26 at 10:11 AM, an interview was conducted with Registered Nurse (RN) 1 who stated resident 48 had no future appointments scheduled. RN 1 stated the MD or NP would let the nurse know if they were going to make a referral for the resident and then the nurse should notify the receptionist who made appointments.On 5/21/26 at 10:15 AM, an interview was conducted with the receptionist who stated she made the appointments for residents and that resident 48 had no appointments scheduled.05/21/2026 at 11:39 AM, an interview was conducted with the Director of Nursing (DON) who stated the providers would usually message staff in the Electronic Medical Record when there was a new order or referral and then the nurse would have to put the order in. The DON stated she was not aware of the oncology and urology referral and that it was not completed.

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 0689 Level of Harm - Minimal harm or potential for 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** Based on observation, interview, and record review, it was determined for 1 of 25 sampled residents, that the facility failed to 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, one resident who required oxygen was observed to be smoking without staff supervision and had not been evaluated for safety while smoking. Resident identifier: 58.Findings included:On 5/18/26 at 10:44 PM, an interview was conducted with resident 58 who stated she started smoking again last week and that she would go out and smoke with friends. Resident 58 was observed to be wearing oxygen via a nasal cannula.On 5/18/26 at 2:43 PM, an observation of resident 58 was made and she was outside in the smoking area with another resident, no staff were outside. Resident 58 was sitting in her wheelchair, she was not wearing her oxygen, and she was smoking a cigarette. Resident 58 stated that she was able to go outside to smoke anytime she wanted and that some residents had to be supervised but she did not.Resident 58's medical record was reviewed 5/18/26 through 5/21/26Resident 58 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, psychoactive substance abuse, insomnia, bipolar disorder, cognitive communication deficit, and unspecified lack of coordination.A smoking list dated 5/18/26 indicated resident 58 was not listed as a smoker.On 5/20/26 at 2:41 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1 who stated there was a smoking book that listed all smokers, they opened the binder and it indicated a date of 5/18/26. CNA 1 stated all staff kept eyes on residents and that they had cameras in the smoking area also. CNA 1 stated they would let the nurse know if he saw a resident who started smoking. CNA 1 stated they were aware that resident 58 smoked and that she had been smoking for 1 to 2 weeks when she started to get more independent. CNA 1 reviewed the smoking book and stated that resident 58 was not listed as a smoker.On 5/20/26 at 3:03 PM, an interview was conducted with Registered Nurse (RN) 2 who stated the nurse who admitted a resident who smoked or the nurse who first identified when a resident started smoking would be responsible to do the smoking assessment to evaluate if they could smoke safely. RN 2 stated she knew resident 58 was smoking and stated she was not smoking when she was admitted and recently she was seen smoking but denied she was smoking when a staff member asked her about it. RN 2 stated the nurse who first observed her smoking should have done the smoking evaluation. RN 2 stated there was a smoking book that was updated weekly that listed independent and supervised smokers.On 5/20/26 at 3:13 PM, an interview was conducted with the Director of Nursing (DON) who stated she had been out for a month and was not sure how long resident 58 had been smoking. The DON stated the nurse should have evaluated each resident who smoked on their first time smoking to determine if they needed supervision and to check their fine motor skills. The DON stated she was pretty sure she was on the smoking list and that she should have had her evaluation done.It should be noted that resident 58 had not had a smoking evaluation completed until 5/20/26 at 3:30 PM.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 25 sampled residents, that the facility did not maintain medical records on each resident that were complete; accurately documented; readily accessible; and systematically organized. Specifically, a resident's radiology report for a possible broken PICC (peripherally inserted central catheter) was not in the medical record. Resident identifier: 54.Findings included:Resident 54 was initiallly admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included spastic hemiplegia of left side, cerebral infarction, type II diabetes, cognitive communication deficit, tachycardia and dysphagia. Resident 54's medical record was reviewed on 5/19/26. A nursing progress note dated 5/9/26 at 4:40 PM documented, Order received to send to ED [emergency department] to be evaluated for suspected broken midline catheter. Paperwork shows on 4/30/26 that [local hospital] placed a 18 gauge X 18 centimeter midline in R [right] arm cephalic vessel. When removed this shift an approximate 4cm [centimeter] cath was removed.No hospital or X-RAY report of the PICC line removal could be located in the medical record. On 5/21/26 at 10:33 AM, an interview was conducted with the Director of Nursing (DON) who stated the nurse would look for new orders and document those in the progress notes. The DON stated that test results from outside facilities were requested by medical records and scanned into the medical record when received. The DON stated that they usually did not get the results of outside testing information unless it was needed for a specific purpose. On 5/21/26 at 11:45 AM, an interview was conducted with Medical Records (MR) who stated that staff placed paperwork requiring scanning in her box, and she scanned it the next business day. MR stated staff would tell us the next day, or she would check the census or progress notes of those that needed records scanned in. MR stated she remembered the PICC line issue and that she may have missed getting that record.