STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465101	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hurricane Health and Rehabilitation	416 North State Street Hurricane, UT 84737

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 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was defined as any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences. Specifically, for 4 out of 25 sampled residents, blood pressure medications were administered outside of a physician's ordered parameters and one resident required medical intervention. Resident identifiers: 7, 8, 38, and 43. 1. Resident 7 was admitted to the facility on [DATE] with diagnoses which included hypertensive chronic kidney disease, type 2 diabetes, and bladder cancer. Resident 7's medical record was reviewed on 9/22/25 through 9/25/25. On 5/15/25, Lisinopril oral tablet was ordered for hypertension, with the following parameters: Hold if BP [blood pressure] is below 120/80. The Medication Administration Record (MAR) indicated that the administration time for Lisinopril was 7:00 AM. On 5/15/25, Metoprolol Succinate extended release oral tablet was ordered for hypertension, with the following parameters: Hold if BP is below 120/80. The MAR indicated that the administration time for Metoprolol was 7:00 AM. The MAR for the months of July and August 2025 indicated that resident 7 received Lisinopril and Metoprolol 17 times when no morning blood pressure (BP) readings were documented in the resident's medical record. The MAR for the months of July, August, and September 2025 indicated that resident 7 received Lisinopril and Metoprolol 20 times when it should have been held due to a BP below 120/80: On 7/6/25, BP of 115/65 On 7/13/25, BP of 100/68 On 7/15/25, BP of 109/63 On 7/20/25, BP of 104/61 On 7/24/25, BP of 100/60 On 8/4/25, BP of 101/56 (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 0757 Level of Harm - Actual harm Residents Affected - Few	On 8/9/25, BP of 105/57 On 8/11/25, BP of 102/59 On 8/15/25, BP of 106/62 On 8/16/25, BP of 115/80 On 8/21/25, BP of 85/60 On 8/23/25, BP of 100/59 On 8/24/25, BP of 91/51 On 8/28/25, BP of 106/62 On 8/31/25, BP of 105/64 On 9/6/25, BP of 115/62 On 9/7/25, BP of 101/63 On 9/13/25, BP of 101/66 On 9/19/25, BP of 93/50 On 9/21/25, BP of 106/66 On 7/25/25, a Nursing Progress note documented: CNA alerted nurse that resident was unresponsive. Nurse assessed resident. She was responsive to tactile stimuli. She was pale and groaning in pain. Vitals taken BP 84/40, P [pulse] 110, R [respirations] 22, O2 [oxygen saturation] 85@ RA [room air]. EMS [emergency medical services] called and was transferred to [hospital name redacted] for evaluation. Note: The MAR indicated that Lisinopril and Metoprolol was administered on 7/24/25 when it should have been held due to a BP below 120/80. On 8/22/25, a provider Encounter note documented: Today patient being seen regarding a hypotensive episode. Patient's blood pressure has dipped down to 82/51. She did not have a reading above 98/71 yesterday. Patient states that she has been lightheaded, and overall feeling weaker than normal. Patient states she had lost her appetite for a few days, however at this point is rebounding. Patient was eating breakfast when we were speaking. After reviewing patient's medications she is on lisinopril 20 mg [milligram] once daily for treatment of hypertension, and metoprolol 25 mg [milligram] once daily. At this point we will go ahead and hold patient's lisinopril, and metoprolol until patient's blood pressure is back above 120/80. Will also administer 500 cc [cubic centimeters] of lactated Ringer's via IV [intravenous] to aid in supporting her blood pressure. Note: The MAR indicated that both Lisinopril and Metoprolol were administered on 8/21/25 when they should have been held due to a BP below 120/80. (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	On 9/25/25 at 11:21 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that if a resident had a Systolic Blood Pressure (SBP) below 100 she would reposition the resident and obtain a manual BP reading. If the resident's SBP remained under 100, RN 2 stated that she would contact the provider via a phone call and document the notification in the progress notes. RN 2 stated that when she administered a BP medication she verified that the resident's BP had been obtained within the last 40 minutes. RN 2 stated that the electronic charting system showed any ordered parameters associated with a BP medication; required her to acknowledge that she had seen the most recent BP; and gave the option to enter a newly obtained BP before administering BP medication. RN 2 stated that she held BP medication based on provider ordered parameters for the medication. Additionally, RN 2 stated that she would hold BP medication if the most recent SBP was below 115. RN 2 stated that the following were possible outcomes if a resident's BP was below the ordered parameters or the resident did not have BP taken before they received a BP medication: change in cognition; increased weakness and balance issues, a change in the resident's ability to safely ambulate or the resident's BP could bottom out. Resident 7's MAR was reviewed with RN 2. The MAR indicated that RN 2 administered Lisinopril and Metoprolol on 9/19/25 when resident 7 had a documented BP of 93/50. RN 2 stated that it was a documentation error because she was very careful when administering BP medications. RN 2 stated that would not have administered resident 7's BP medications with a BP of 93/50. On 9/25/25 at 2:21 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that when a resident had a low BP the nurse was expected to assess the resident for symptoms of low BP, hold medications with BP parameters, and review the resident's past BP for trends. The DON stated that the nurse was expected to notify the provider if a resident had a low BP and had symptoms or if the resident had a trend of low BPs. Resident 7's MAR was reviewed with the DON. The DON stated that resident 7's Lisinopril and Metoprolol should not have been administered if the BP was below the ordered parameters, and that the provider should have been notified of the trends in resident 7's BPs. 2. Resident 8 was admitted to the facility on [DATE] with diagnoses which included rheumatoid arthritis, type 2 diabetes, unspecified severe protein-calorie malnutrition, and essential hypertension. Resident 8's medical record was reviewed on 9/22/25 through 9/25/25. On 6/10/23, Metoprolol Succinate extended release oral tablet was ordered to be given in the morning for hypertension with the following parameters: Hold if SBP < [is less than] 120 or HR [Heart Rate] < [is less than] 60. The MAR for the months of August and September 2025 indicated that resident 8 received Metoprolol 15 times when it should have been held due to a SBP of less than 120. On 8/5/25, SBP of 101 On 8/7/25, SBP of 114 On 8/9/25, SBP of 112 On 8/12/25, SBP of 111 On 8/24/25, SBP of 113 (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	On 8/25/25, SBP of 117 On 9/1/25, SBP of 101 On 9/4/25, SBP of 118 On 9/6/25, SBP of 106 On 9/8/25, SBP of 106 On 9/10/25, SBP of 117 On 9/11/25, SBP of 117 On 9/15/25, SBP of 108 On 9/16/25, SBP of 107 On 9/18/25, SBP of 110 3. Resident 43 was admitted to the facility on [DATE] with diagnoses which included fracture of right femur, osteoporosis, anxiety disorder, and major depressive disorder. Resident 43's medical record was reviewed on 9/22/25 through 9/25/25. On 3/6/25, Lisinopril oral tablet was ordered one time a day for hypertension with the following parameters: Hold for SBP < [less than] 120 **Hold for SBP is consistently > [greater than] 135/85. The MAR for the months of July, August, and September 2025 indicated that resident 43 received Lisinopril 10 times when it should have been held due to a SBP of less than 120: On 7/6/25, SBP of 105 On 7/12/25, SBP of 111 On 7/23/25, SBP of 108 On 8/5/25, SBP of 115 On 8/7/25, SBP of 118 On 8/17/25, SBP of 104 On 8/18/25, SBP of 106 On 8/24/25, SBP of 103 On 9/13/25, SBP of 118 (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	On 9/16/25, SBP of 119 On 9/25/25 at 11:10 AM, an interview was conducted with RN 1. RN 1 stated that if a resident had a systolic blood pressure in the 80's or 90's she would notify the physician. RN 1 reviewed the parameters of resident 43's Lisinopril order, Hold for SBP [Systolic Blood Pressure] < [less than] 120 **Hold for SBP is consistently > [greater than] 135/85. RN 1 stated that it was confusing and she would get clarification from the physician prior to administering the medication. On 9/25/25 at 11:21 AM, an interview was conducted with RN 2. The parameters of resident 43's Lisinopril order were reviewed with RN 2, who stated that she would contact the provider to clarify what was meant by: Hold for SBP is consistently > [greater than] 135/85. On 9/25/25 at 2:21 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a nurse did not understand the parameters of an order they were expected to call nursing management or the provider for clarification. The DON reviewed the parameters of resident 43's Lisinopril order and stated that she would have called to clarify the order with the provider. 4. Resident 38 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included hypertension, congestive heart failure, diabetes mellitus type II, and hepatic failure. Resident 38's medical record was reviewed 9/22/25 through 9/25/25. A physician's order dated 2/26/25 indicated, Metoprolol Tartrate Oral Tablet 25 MG [milligrams] (Metoprolol Tartrate) Give 1 tablet by mouth two times a day for Hold for SBP <100 [less than 100], HR <60 [heart rate less than 60]. related to ESSENTIAL (PRIMARY) HYPERTENSION. The Medication Administration Record for the months of July and September 2025 indicated that resident 38 received Metoprolol two times when it should have been held due to a systolic blood pressure of less than 100: On 7/5/25, resident 38 had a BP of 99/67 and was administered Metoprolol. On 9/3/25, resident 38 had a BP of 96/61 and was administered Metoprolol. On 9/25/25 at 11:10 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated she always checked the blood pressure parameters before administering blood pressure medications. RN 1 stated if the blood pressure was too low and was out of range of the parameters she would hold the blood pressure medications. On 9/25/25 at 2:21 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the nurse should have known what the blood pressure parameters were and that they should have held the metoprolol.

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F 0840 Level of Harm - Actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not arrange services with an outside agency. Specifically, for 1 out of 25 sampled residents, residents had physician's orders to follow up with a specialist and the facility staff did not put the order in for 2 months, which delayed the resident seeing the specialist for over 3 months.Findings included: Resident 18 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included sequelae of cerebral infarction, neuromuscular dysfunction of bladder, benign prostatic hyperplasia with lower urinary tract symptoms, and muscle weakness.Resident 18's medical record was reviewed between 9/22/25 and 9/25/25.Hospital discharge documents dated 4/4/25 indicated resident 18 had a discharge diagnosis of urinary retention and acute kidney injury. Discharge Orders included, Urinary retention: According to nephrology, patient should be discharged with Foley catheter and follow-up with urology as an outpatient; and Follow-up: [Physician's name redacted], Urology; Within 1-2 weeks. Additional instructions were to call for a follow-up appointment.A physician's initial resident Encounter note dated 4/7/25 at 8:38 AM revealed, .The patient remained with an acute kidney injury and nephrology was consulted.However, he remained encephalopathy [sic] with continued worsening kidney function.The patient was followed by nephrology throughout the hospitalization.F/U [follow-up] appointments as ordered.A physician's Encounter note dated 4/13/25 at 11:00 PM revealed, .Today patient being seen regarding his catheter. Catheter has become dislodged. Nursing staff is questioning whether or not to put the catheter back in. He does have an upcoming appointment with urology. Patient has had a catheter in for quite some time at this point. Patient does have pressure wounds on his backside. I believe leaving the catheter in place would help with healing of these wounds. With [sic] will go ahead and replace the catheter today. Patient will follow up with his urologist for further evaluation regarding long-term catheter use.A physician's Encounter note dated 5/2/25 at 1:00 AM indicated, .His only complaint of pain is around the urethra, from the insertion site of the Foley catheter. He states he gets bumped and sometimes pulled and has caused some irritation.A Nursing note dated 5/4/25 at 4:13 PM revealed, Resident with UTI [urinary tract infection] symptoms.UA [urinalysis] sample obtained and sent to lab for testing. Reviewed with primary nurse [name redacted] and in physician log book. Will monitor.A Condition Follow-up note dated 5/7/25 at 8:07 AM revealed, Foul smelling urine.UA still pending.A Nursing Progress note dated 5/7/25 at 9:15 AM revealed, Called to therapy room as resident was ?seizing' per staff. Assessed resident and he was in WC [wheelchair] Diaphoretic., AAOx3 [awake, alert and oriented times 3], visibly uncomfortable.Denied pain, however ?doesn't feel right' .Called [physician] was onsite to assess. He assessed and said to call EMS [emergency medical services] and send to ER [Emergency Room] for evaluation.Resident had focal seizure in chair for about 30seconds [sic] .Hospital discharge documents dated 5/13/25 indicated, Discharge diagnosis: Severe sepsis without septic shock; catheter associated urinary tract infection; and Follow-up: [Physicians name redacted], Urology; Within 1 week. Additional instructions: Referral in [computer program].A physician Encounter note dated 5/23/25 at 1:00 AM indicated, .Chief Complaint/Nature of Presenting Problem: Confusion and paranoid behavior. Fall. Sent to emergency department.During the initial assessment, the patient wanted to know what the kitchen people knew about him. His speech was alittle [sic] garbled.He was not making a lot of sense. UA with reflex CNS [sic: C&S culture and sensitivity] was ordered. His urine is a little hazy. He has a Foley catheter to down drain. Later that day, he had a fall outside in the rocks and hit his head.He was sent to the emergency department for further workup.A Nursing note dated 5/23/25 at 11:51 AM indicated, Resident returned from ER with no significate [sic] finding. No new orders.A Nursing Progress Note dated 6/2/25 at 3:06 PM revealed, Resident sent to [facility redacted] ER via emergency transport for signs/sx [symptoms] of sepsis r/t [related to] UTI dx (continued on next page)

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F 0840 Level of Harm - Actual harm Residents Affected - Few	[diagnosis]. Resident experienced increased confusion and temperature, N/V [nausea and vomiting], unresponsiveness, inability to make self understood, shaking, jerking of movements, and chills. Sent at 1500 [3:00 PM].Note: No documentation of any urology follow up appointments could be located in the medical record. Hospital discharge documents dated 6/5/25 indicated, Discharge diagnosis: Sepsis; Bacteremia due to Klebsiella pneumoniae; Catheter-associated urinary tract infection; Acute kidney injury, POA [present on admission]; and Follow-up: [Physician's name redacted], Urology; within 1 month; and Scheduled Appointments: Wednesday, Jul. 30, 2025 2:30 PM [MDT].A physician order dated 6/6/25 indicated, Urology referral [physicians name redacted] Apt [appointment] 7/30/25.On 9/24/25 at 11:51 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1 who stated if a resident went to the hospital, when they returned, the nurse who was assigned to the room they were returning to would review the paperwork from the hospital and put new discharge orders in. LPN 1 stated the DON [Director of Nursing] or Assistant Director of Nursing [ADON] would review the paperwork to ensure that the orders were put in the resident's medical record. On 9/25/25 at 3:03 PM, an interview was conducted with the DON who stated the old system for making appointments was not putting orders in the resident's medical record. The DON stated a staff member was designated to keep track of resident appointments prior to her tenure as DON. The DON stated the ADON started a tracking system for when a resident came back with new orders for an appointment. The DON stated that transportation staff were notified, and the person making appointments would be notified, and the DON and ADON would be notified so the appointments would be scheduled in a timely manner. The DON stated resident 18's appointment was scheduled after he was seen at the hospital on 6/2/25 and his appointment was scheduled on 7/30/25. The resident was seen on 7/30/25 and physician orders to wean him from the catheter were implemented. The DON stated she did not know why resident 18 did not see the Urologist prior to 7/30/25.

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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. Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, a freezer in the outdoor storage room contained food items open to air, areas in the kitchen were not clean, food items in the reach in refrigerator were not labeled, and dead bugs were found in the outdoor dry storage room. Findings included:On 9/22/25 at 1:55 PM, an initial walk-through of the kitchen was conducted. In the outdoor storage room, a lift-top freezer contained a torn plastic bag with frozen pizza crusts that was open to air, and a large plastic bag containing what appeared to be frozen cookie dough was open to air, and appeared to have freezer burn. There was no thermometer in the freezer. In the kitchen the stove was not clean; there were crumbs, a dipping sauce packet and cheese wrapper under the stove. The ice machine was not clean with rust or water deposits above the ice. In the dry storage room, 2 bulk bins with what appeared to be flour and sugar inside, were not labeled or dated. In the dry storage room, there were also 2 large plastic containers with blue lids that were not labeled. In addition, a box of buttermilk pancake mix was not labeled with an open date, and the bag was not sealed and was open to air.On 9/25/25 at 1:17 PM, a second walk-through was conducted in the kitchen. Three dead roaches and several black bugs of different sizes were observed under the storage shelves and behind the freezer. In the kitchen, the stove was not clean, the steam table had floating food in the bottom of it and the sides had not been wiped clean, the landing under the juice machine was not clean with white powder. The cart next to the juice machine was sticky on the bottom shelf with a white powder. There were crumbs under and behind the stove. In the dry storage room the 2 large bulk storage bins containing flour and sugar were open to air, and were not labeled or dated. The buttermilk pancake mix was open to air, and the floor was not clean. The reach-in refrigerator had a bag of parmesan cheese that was not labeled or dated, and a large bowl of Jell-o salad that was not labeled.On 9/25/25 at 1:44 PM, an interview was conducted with the Dietary Manager (DM) who observed and confirmed that there were bugs in the outside storage room. The DM stated she had been the DM for 2 months and had not seen the pest control company there, but had seen several pest control boxes on the floor of the storage room so she knew a pest control company had been there. The DM stated she and the other staff members swept the storage room frequently to keep the bugs out of the storage room. The DM stated she had seen dead bugs in the storage room before. The DM stated the pizza crust and the dough were thrown into the open top freezer recently when the walk-in freezer went out and they were not properly wrapped or labeled. The DM stated they would have to be thrown away. The DM stated everything placed in a box had to be labeled with a common name, an open date and an expiration date, and if in bags, the item needed to be tied up. The DM stated the bulk bins should be labeled and covered. The DM stated the staff should be closing food items when they were finished with the food item. The DM stated she found the bag of parmesan cheese and Jell-o salad and labeled and dated them, and educated the cook who had put them there. The DM stated each staff member had cleaning duties they were responsible for each day and the cleaning duties were in a binder by the kitchen door. The DM stated she thought putting them in a more visible location would remind the staff about keeping up with them and keeping the kitchen cleaner. The DM stated the consultant Dietitian who came weekly conducted kitchen audits for cleanliness and safety on a regular basis and shared findings with her.On 9/25/25 at 2:06 PM, an interview was conducted with the Administrator (ADM) who stated a pest control company came on a monthly basis to manage pest control needs. The ADM stated for the kitchen, the bug traps were replaced every month.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and observation, for 1 of 25 sampled residents, the facility did not treat residents with respect and dignity and care for each resident in a manner that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, a Certified Nursing Assistant (CNA) was observed standing next to a resident in bed while providing feeding assistance . Resident identifier: 48. Findings included:Resident 48 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included multiple sclerosis, type 2 diabetes, dysphagia, congestive heart failure, and chronic pain.An admission Minimum Data Set (MDS) assessment dated [DATE] revealed resident 48 had a Brief Interview for Mental Status (BIMS) score of 15 indicating she was cognitively intact. The assessment also revealed that resident 48 had upper extremity impairment on one side, and was dependent on staff for eating, oral hygiene, toileting, and bathing.On 9/24/25 at 10:50 AM, an observation was made of Certified Nursing Assistant (CNA) 1 providing feeding assistance to resident 48 in her room. CNA 1 was standing next to resident 48 who was partially sitting up in her bed. On 9/24/25 at 11:09 AM, an interview was conducted with CNA 1 who stated resident 48 was unable to feed herself. CNA 1 stated she was not resident 48's CNA but she just fed her. CNA 1 stated she did not know how much assistance resident 48 needed because she was an agency CNA and was just helping out.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 of 25 sampled residents, that the facility failed to ensure that a resident who was continent of bladder on admission received services and assistance to maintain continence unless his or her clinical condition was or became such that continence was not possible to maintain; and a resident who was incontinent of bladder received appropriate treatment and services to restore continence to the extent possible. Specifically, one resident who was assessed to be continent or a good candidate for bladder retraining was not provided services. Resident identifier: 59. Findings included:On 9/23/25 at 10:37 AM, an interview was conducted with resident 59. Resident 59 stated she wore a brief and was unsure why she needed to wear one because she can tell when she needed to use the bathroom. Resident 59 stated she needed assistance from staff to go to the bathroom. Resident 59 stated she did not need to wear briefs before coming to the facility and that staff just put one [a brief] on me. Resident 59 stated that she had an episode of urinary incontinence this morning because staff did not come quick enough.Resident 59's medical record was reviewed 9/22/25 through 9/25/25.Resident 59 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included subsequent encounter for fracture of right humerus, asthma, congestive heart failure, unspecified injury of head, fibromyalgia, glaucoma, rheumatic heart disease, osteoarthritis of left ankle and foot, and irritable bowel syndrome.An admission Minimum Data Set (MDS) assessment dated [DATE] indicated a Brief Interview for Mental Status (BIMS) score of 14. A BIMS score of 13 to 15 indicated cognition was intact. It further indicated resident 59 had occasional urinary incontinence and did not have a trial of a toileting program, which included scheduled toileting, prompted voiding, or bladder training.An Initial admission Record dated 8/20/25 indicated resident 59 was continent of urine, used the toilet, and did not use pads or briefs.A Daily Skilled document dated 8/22/25 indicated resident 59 was alert and oriented X (times) 3 and sundowns at night. It further indicated, sundowns at night and her memory is not that good at this time, neither is her ability to do ADLs [activities of daily living]. It further indicated, staff changes when needed. She is sometimes able to make it to the bathroom on time. It further indicated, one person assist with transfers and ADLs. uses a wheelchair and walker for ambulation.A Bowel and Bladder Evaluation dated 8/23/25 indicated resident 59 was continent or a Good Candidate for Bladder re-training.A Bowel and Bladder Evaluation dated 9/14/25 indicated resident 59 was incontinent of bladder for an unknown length of time. It further indicated resident 59 was a Possible Candidate for Bladder re-training.A Care Plan Report indicated resident 59 had bowel/bladder incontinence related to Impaired Mobility, which was initiated on 8/22/25. Interventions included, Encourage fluids during the day to promote prompted voiding responses; and Ensure there is an unobstructed path to the bathroom.On 9/24/25 at 9:26 AM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated resident 59 could use her call light to let them know when she had to use the restroom. CNA 3 stated if a resident could not use their call light, then they would offer bathroom use every couple hours.On 9/24/25 at 12:19 PM, an interview was conducted with CNA 4. CNA 4 stated resident 59 wore a brief because when she displayed sundowning cognition changes she would not always be continent. CNA 4 stated she was wearing a brief right now because it was resident 59's preference. CNA 4 stated resident 59 used the call light to get help and that she was continent during the day.On 9/24/25 at 4:36 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated resident 59 was incontinent and wore a brief. LPN 2 stated she was not sure why resident 59 was incontinent but that she was a big fall risk and struggled with her cognition.On 9/25/25 at 10:10 AM, an interview was conducted with CNA 2. CNA 2 stated a bladder program would mean a resident was put into a pull-up brief and then staff would check on the resident every 2 hours to see if they needed to go to the bathroom. CNA 2 stated (continued on next page)

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	465101	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hurricane Health and Rehabilitation	416 North State Street Hurricane, UT 84737

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was not aware of anyone who was on a bladder program. CNA 2 was not sure if it was documented anywhere when a resident was on a bladder program, but that they just knew the residents.On 9/25/25 at 12:01 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a resident was evaluated to be a possible candidate on the Bowel and Bladder Evaluation, then that resident would need to be further evaluated and it would be on the care plan. The DON stated resident 59 had an impaired cognition, so staff should have been offering for her to attempt to go to the toilet every 2 hours. The DON stated they did not typically do the Bowel and Bladder program. The DON stated she did not think resident 59 would be able to notify staff of needing to go to the bathroom and staff should at least be offering to go to the toilet instead of being incontinent.On 9/25/25 at 2:21 PM, a follow-up interview was conducted with the DON. The DON stated resident 59 had been working with physical therapy to help her with toileting but the CNA should still be working with the resident for her bladder training even if she needed assistance to use the restroom.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 of 25 sampled residents, the facility did not ensure that residents who required dialysis received such services, consistent with professional standards of practice. Specifically, a resident receiving dialysis was not having his pre-dialysis vital signs information documented before leaving for dialysis as was required in the facilities' dialysis communication policy. Resident identifier: 30.Findings included: Resident 30 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included end stage renal disease, dependence on renal dialysis, atrial fibrillation, and muscle wasting and atrophy.On 9/23/25 at 11:48 AM, an interview was conducted with resident 30 who stated he was taken to dialysis on Mondays, Wednesdays, and Fridays by the facility transportation van at 10:00 AM.Resident 30's medical records were reviewed between 9/23/25 and 9/25/25.A review of resident 30's care plan dated 11/2/21 revealed a Focus area, Needs hemodialysis r/t [related to] renal failure (AV[arterio-venous] fistula). [Facility name redacted] on MWF [Monday, Wednesday, Friday] at 10:30 [AM]. Included in the interventions, .Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and BP [blood pressure] immediately. The goal was to have no s/sx [signs or symptoms] of complications from dialysis through the review date. Initiated 11/2/21.A review of resident 30's nursing progress notes revealed:On 9/12/25 at 5:04 PM, Patient came back from dialysis with no concerns noted and a post dry weight of 205.9 [pounds].On 9/1725 at 4:31 PM, Resident returned back to facility from dialysis and is tolerating treatment well. Pre-dialysis weight: 207.6; Post dialysis weight 205.2 [pounds].On 9/19/25 at 6:07 PM, Resident returned from dialysis. Post dialysis wt [weight] 94.1 kg [kilograms]. No new orders at this time. [Note: This is 207 pounds.]On 9/22/25 at 5:09 PM, Resident returned from dialysis. Post dialysis wt 93.6 kg. No new orders at this time. [Note: This is 205.9 pounds.]A review of resident 30's pre-and post-dialysis communication revealed that on 9/12/25, 9/17/25, 9/19/25 and 9/22/25, the resident's name and date were completed at the top of the form, however items not completed were: Cognition status, Vital signs, Fasting Blood sugar (if applicable), Recent falls or trauma (if applicable), Access site assessment, Changes in the past 24-48 hours, the nurse's signature and the date.The facility dialysis policy and procedures were reviewed. The policy titled: Dialysis (Renal), Pre-and Post-Care included the following: PolicyIt is the policy of this facility to:Assist resident in maintaining homeostasis pre-and post-renal dialysis;Assess and maintain patency of the renal dialysis access;Assess resident daily for function related to renal dialysis;Participate in ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.ProcedurePre-dialysis care:Assess resident's blood pressure (in non-fistula arm) prior to being transported to the dialysis unit.Hold any blood pressure medications and/or any other specified medications as ordered by physician.May hold medications scheduled for administration while at dialysis or during dialysis unless otherwise specified by the provider.Any staff concern about resident's condition that may influence the dialysis treatment should be addressed prior to leaving skilled facility as the resident may need to be assessed in an emergency room.Collaboration and Communication of CareThe care of the resident receiving dialysis services will reflect ongoing communication, coordination and collaboration between the nursing home and dialysis staff.Staff will immediately contact and communicate with the attending physician/practitioner, resident/resident representative, and designated dialysis staff (i.e. nephrologist, registered nurse) regarding any significant changes in the resident's status related to clinical complications or emergent situations that may impact the dialysis portion of the care plan.DocumentationDocumentation related to pre- and post-dialysis care will be placed in the clinical record and include:Resident assessments, interventions, and any provided education.Assessment of renal dialysis access site, to include presence or absence and quality of a bruit and thrill for residents with an arteriovenous fistula.Communication between facility and dialysis staff or medical (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider.On 9/24/25 at 2:06 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated the night staff filled out the form the night before the resident's appointment. LPN 1 stated in the morning, the CNA obtained the resident's vital signs and the nurse took the vital signs from the sheet at the nurses station and put it on the form before the resident left the facility. LPN 1 stated after the resident returned from the dialysis appointment with the communication form, the information that was documented from the dialysis nurse was put into a progress note in the resident's medical record. LPN 1 stated resident 30 usually returned from his appointment around dinner time and had never told her that he was feeling ill after his appointment. LPN 1 stated the nurses assessed the resident's shunt each day as part of the resident's assessment. LPN 1 stated she looked at it in the morning when providing his morning medications, but did not look at it when he returned from his dialysis appointment because he had a bandage on his arm. LPN 1 stated there was not a physician's order to assess the shunt when the resident returned from dialysis which was why it was likely forgotten. LPN 1 stated it probably should be done after the bandage was removed. On 9/24/25 at 4:21 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the resident took a face sheet, a medication list and a dialysis communication form to the dialysis appointment. The DON stated the physician order said to check the shunt daily but did not indicate a time. The DON stated the resident came back with a pressure dressing after dialysis and the nurses should be looking at the port when they removed the dressing 2 hours after he returned. The DON stated blood pressures were documented on the communication form, but were not being put in the resident's progress note. The DON stated she was unaware that the communication forms were being sent to the dialysis center without being completed by the nurses.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 of 25 sample residents, the facility did not ensure that the monthly drug regimen recommendations by a licensed pharmacist were implemented in a timely manner. Specifically, a recommendation made by the pharmacist to separate administration of a medication and a supplement due to interaction was not acknowledged by the physician or implemented. Resident identifier: 3. Findings included:Resident 3 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included ataxia, repeated falls, chronic kidney disease, encephalopathy, and memory deficit following nontraumatic subarachnoid hemorrhage. Resident 3's medical record was reviewed between 9/22/25 and 9/25/25.No documentation of the monthly pharmacy reviews were found in the progress notes. There was no documentation of the pharmacy reviews found in the resident's miscellaneous documents.The facility 2025 monthly pharmacy review binder was reviewed. In March 2025, a pharmacy recommendation for resident 3 revealed, Levothyroxine and Ferrous Sulfate 7 am orders-consider separating administration times (one an hour earlier or in the PM) Drug interaction-binding may occur. There was no acceptance of the recommendation or decline of the recommendation, and no signature indicating the physician had reviewed or acknowledged the recommendation.Resident 3's Medication Administration Records (MARs) from March 2025 through September 2025 were reviewed. Both Levothyroxine and Ferrous Sulfate were documented as administered together at 7:00 AM throughout the MARs. On 9/25/25 at 11:49 AM, an interview was conducted with the Director of Nursing (DON) who stated the pharmacist reviewed all resident medications monthly. The DON stated the pharmacist emailed his reviews to her and she gave them to the physician for review. The DON stated once the physician went over the medication reviews, they were given back to her so she could implement any medication order changes that had been approved by the provider. The DON stated the form should then be uploaded into the resident's chart. The DON stated it looked like the form for resident 3 had been completely missed.