STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465104	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orem Rehabilitation and Nursing Center	575 East 1400 South Orem, UT 84097

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 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 7 sampled residents, that the facility did not ensure that the resident had the right to be free from abuse including involuntary seclusion. Specifically, the resident was seeking egress from a room and was denied the right to exit by facility staff. Resident identifier 2. Findings included: Resident 2 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, congestive heart failure, atrial flutter, type II diabetes mellitus, chronic kidney disease, morbid obesity, chronic pain, difficulty with walking, polyneuropathy, hypertension, obstructive sleep apnea, and thrombocytopenia. Resident 2 was discharged from the facility on 3/30/24. On 12/30/23, resident 2's Minimum Data Set (MDS) assessment documented that the resident had a Brief Interview for Mental Status (BIMS) score of 15, which would indicate that the resident was cognitively intact. The assessment documented that resident 2 required an extensive one-person assist for bed mobility, transfers, and toilet use. Resident 2's progress notes revealed the following: a. On 2/16/24 at 12:08 PM, the social service (SS) note documented, SS followed up with the pt [patient] about the recent self-report that the pt has opened. During this follow up, the pt mentioned that the incident triggered a deeper trauma for her. SS offered a safe space for the pt to share her thoughts and feelings. The pt proceeded to open up to SS about her past traumatic experiences. SS explained that it is standard practice for SS to update a pt's care plans (in PCC) when informed about pt's trauma triggers. The pt then requested that SS not document the trauma in her medical records. The pt stated she did not want to discuss this trauma with anyone else. SS offered the pt mental health counseling services, the pt declined the offer. Pt has not mentioned to SS previously about her trauma, pt has denied having trauma during her quarterly SS assessments. b. On 2/17/24 at 9:58 AM, the SS note documented, SS checked in on [resident 2]. She has been emotional the past few days. Discussed her feelings and her personal healing journey. Pt seems to be improving emotionally. Wants to move forward with forgiveness. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Actual harm Residents Affected - Few	On 2/14/24 at 11:00 AM, the facility reported an incident of mental/verbal abuse had occurred between resident 2 and the Assistant Director of Nursing (ADON). The facility abuse investigation documented that the ADON brought resident 2 into his office on 2/14/24 to address a concern brought up by a Certified Nurse Assistant (CNA). The concern was that [resident 2] was asking staff about a staff member who may have received disciplinary action that is not appropriate to discuss with a resident. [Registered Nurse (RN) 1] was present during the conversation between [ADON] and the resident. During this discussion, [resident 2] voiced she attempted to leave the office. [ADON] stood up and stood in front of the door stating , 'No we need to finish this conversation' [Resident 2] reported feeling distress as a result of this event. On 2/15/24, the Administrator (ADM) documented an interview with resident 2. Resident 2 stated that the ADON asked her to come into his office. He was talking over her and not letting her speak. She told him that if he wasn't going to let her talk then she was leaving. She said she started opening the door and he shut it. He blocked her from leaving. He told her she couldn't leave until they finished their conversation. She brought up her past trauma with her ex-husband and [ADON's] posture and demeanor reminded her of him and it triggered it to resurface. She stated [ADON] called her a 'gossip' and 'busybody.' She stated that [ADON] threatened he would give her a room change if she couldn't stop her gossiping. On 2/15/24, the ADM typed statement from the ADON documented, On 2/14/24 [Certified Nurse Assistant (CNA) 1] came to my office, visibly upset, and stated that the resident [resident 2] had been going around asking staff about an incident she was involved in. She said that another CNA, [CNA 2] had come to her and told her the information that the resident was asking about. [CNA 1] said that the resident was telling others that she should have been fired. I told her that I would speak with the resident. I asked the resident to come to my office. I had also asked [RN 1], another nurse manager, to attend with me. Because of the nature of the conversation, I closed the office door. The resident was in a power wheelchair and was sitting next to the door. [RN1] and I were in office chairs at the desks in the office. I started explaining to the resident that she is a resident here and anything that happens with staff discipline at the facility is not of concern to her. At this point, the resident was trying to interject and tell her side of the story, but I was not finished speaking and she felt that I was not letting her talk. She said she was done talking with us and wanted to leave. Not knowing her history of trauma, I stood up to go to the door to stop her from leaving so we could finish the conversation. I then sat back down, and she informed us that we were 'kidnapping me' and 'holding me against my will.' I told her I just wanted to finish the conversation so she could understand that disciplinary action of the staff cannot be discussed with the residents. She admitted that she asked the CNA for information. We also asked about her reasoning for asking staff for more information. [Resident 2] expressed that she felt like since she had been with us for so long, we were all like family and that she should be able to know what's going on in the facility. At that point, I got up out of my chair and assisted her in opening the office door. It was not my intention to upset [resident 2], I was only trying to address the concern that was upsetting to the staff member. I did not call her a 'gossip' or 'busybody.' We discussed gossip and the potential negative impact it can have. We discussed a possible room change as she referred to 'hearing nurses talk' if this was something she wanted to do. I did not threaten her with a room change because she gossips. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 2/15/24, the facility investigation documented an interview with RN 1 that was conducted by the Social Services Director (SSD). The interview documented that RN 1 reported, that the conversation was relatively passionate on both sides. She said that [ADON] was being stern and blunt in an attempt to address the above-mentioned staff concern. [Resident 2] responded in a verbally aggressive manner. Defensiveness on both sides was observed, due to both wanted to be heard. When asked about the conversation, contrary to what [resident 2] reported, [RN 1] said that [ADON] gave [resident 2] adequate time to respond and was not talking over her as [resident 2] reported. [Resident 2] felt like she wasn't being listened to and moved to leave out the door. [RN1] confirmed that [ADON] did move to stand in front of the door but reported it wasn't for more than 10 seconds and it wasn't done in a way to trap [resident 2], but to convey that he was hoping for resolution to the concern. She confirmed the door was shut as they entered the office due to the conversation's confidential nature. [RN 1] stated that at no time did she feel [ADON's] intentions were to cause distress to [resident 2]. She denied that [ADON] called [resident 2] a 'gossip' or 'busybody' as per [resident 2's] statement. [RN 1] also denied that [ADON] threatened [resident 2] with a room change if she can't control her gossiping. She stated that [ADON] offered a room change as an option if [resident 2] was concerned about staff conversations at the nurse's station. On 2/14/24, the facility investigation documented an interview with the SSD. The documentation did not specify who was conducting the interview. The interview documented that the Social Services Administrative Assistant (SSAA) was present as a witness. The interview documented, [Resident 2] came in and said she had a grievance. SS asked what was going on. She explained that she had an interaction with [ADON] that was uncomfortable and that she did not like his demeanor. From her report, the conversation got heated (she didn't go into many details during this first meeting), and voices were raised. At one point she tried to leave the conversation and [ADON] went to the door and said something along the lines of, 'No we're going to finish this conversation.' From there, she felt triggered because it reminded her of past trauma she has had with her son and her ex-husband. The posture [ADON] had reminded her of her ex-husband and standing in front of the doorway reminded her of why her son went to prison. The conclusion of the facility abuse investigation was not verified. The actions taken by [ADON] were found to be inappropriate. The investigation did not support, however, that his actions were malicious or that he intended to cause distress to the resident. Further, it is not supported that [ADON] called the residents names or that he threatened the resident with a room change if she cannot stop gossiping. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 5/22/24 at 11:40 AM, an interview was conducted with the SSD. The SSD stated that resident 2 reported the incident with the ADON to her. The SSD stated that the incident with the ADON had triggered resident 2 about an incident in her personal life with her ex-husband. The SSD stated that she offered resident 2 resources such as counseling, a trauma care plan, and informing other staff. The SSD stated that resident 2 mentioned a deeper trauma with her ex-husband, but the SSD refused to disclose what resident 2 stated to her. The SSD stated that the ADM was present when resident 2 reported her past trauma. The SSD stated that the incident with the ADON was when he stood in front of the door blocking her exit, and this action made resident 2 recall her husband's mannerisms. The SSD stated that resident 2 reported that the ADON blocked her from leaving the room. Her interpretation was that she was being held in the room and not allowed to go out. That is what triggered her PTSD [Post Traumatic Stress Disorder] about her husband. The SSD stated she asked resident 2 if she needed counseling services. The SSD stated that resident 2 had never mentioned in past assessments that she had this previous trauma, and she did not have any past mental health services. The SSD stated that she thought resident 2 felt frustrated by the situation and wanted to be able to express her feelings. The SSD stated that resident 2 was tearful when she talked about her ex-husband. The SSD stated that resident 2 reported that the interaction with the ADON made her feel trapped and she was being forced to stay in the room. The SSD stated that the deeper problem was that the incident triggered her past history of trauma and abuse. On 5/22/24 at 1:13 PM, an interview was conducted with RN 1. RN 1 stated that the ADON pulled her into the office to be a witness to the conversation with resident 2. RN 1 stated that the ADON shut the door to the office during the discussion with resident 2. RN 1 stated that resident 2 was asking about a staff member, and resident 2 wanted to get an aide fired because of an incident. RN 1 stated that the ADON told resident 2 that it was none of her business and why was she asking about it. RN 1 stated that resident 2 stated she was leaving, and the ADON stood in the doorway and said you're not leaving until we talk about this. RN 1 stated that the ADON stood in the doorway blocking resident 2 for maybe 3 seconds and then he sat back down. RN 1 stated that resident 2 and the ADON were both upset and talking loudly. RN 1 stated that they were not yelling but talked in raised voices. RN 1 stated that resident 2 seemed upset, she was uneasy and frustrated. RN 1 stated that at the end of the conversation resident 2 asked if she could go and the ADON opened the door for her to exit. RN 1 stated that in her opinion the ADON prevented resident 2 from leaving when she wanted to leave. RN 1 stated that the whole thing made her feel uncomfortable, and she did not like how either of them were talking to each other. RN 1 stated that the ADON meant business, but it was inappropriate for him to talk to her in that manner. RN 1 stated that she was not sure if resident 2 felt threatened but maybe intimidated. RN 1 stated that the ADON was trying to get his point across very seriously that it was not the resident's business to dig around in other people's business. RN 1 stated that resident 2 seemed upset. RN 1 stated that later that same day she asked resident 2 how she was and the resident replied by calling the ADON an expletive. RN 1 stated that resident 2's room was across from the nurse's station, and she was nosey and would ask about what she heard said. RN 1 stated that the ADON did call resident 2 a busybody. RN 1 stated that resident 2 responded with something like I want to know what's going on with the people taking care of me, and that it was her home. RN 1 stated that resident 2's excuse was that she knows things because her room was across from the nurse's station and he said okay we'll move your room. RN 1 stated that she did not think resident 2 would have wanted to move rooms, and it was possible that resident 2 could have interpreted that as a form of punishment. RN 1 stated that resident 2 had lived there for a while, and it would have been an inconvenience to move rooms. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 5/22/24 at 2:09 PM, an interview was conducted with the ADM. The ADM stated that it was reported that resident 2 was asking staff about situations with other residents and another staff, and she was trying to gossip. She liked to go around and know what was going on. The ADM stated that the ADON pulled resident 2 aside with RN 1 to address it. The ADM stated that the ADON reported he explained that he was addressing the situation with the resident to understand privacy and how it impacted other people. The ADM stated that the ADON basically stated what had happened, stood up and redirected resident 2, and sat back down and they talked. The ADM stated that resident 2 went to SSD to file a grievance against the ADON. The ADM stated that resident 2 told him about her ex-husband and how the ADON's posture reminded her of him. It resurfaced some past trauma. The ADM stated that resident 2 reported that the ADON had called her a gossip and busybody, and he threatened to move rooms if she did not stop gossiping. The ADM stated that resident 2 reported that the ADON had blocked her from leaving the room. The ADM stated, I don't believe they were yelling but there were raised voices. It was a conversation with some emotion. The ADM stated that the ADON's demeanor and how he was communicating with resident 2 triggered some past trauma responses of verbal abuse. The ADM stated that resident 2 had said that they were kidnapping her and this was in response to him blocking her exit and standing in front the door. The ADM stated that RN 1 reported that the ADON did step in front of the door to stop the resident from leaving but it was no more than 10 seconds. The ADM stated that he spoke with resident 2 afterwards and she wanted to know that it was being handled and investigated. The ADM stated that he told resident 2 that the ADON was suspended, and they were providing education based on the situation. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	On 5/22/24 at 2:36 PM, an interview was conducted with the ADON. The ADON stated that he had heard that resident 2 was going around talking about an incident that she was not involved in. The ADON stated that a staff member came to him upset and crying, she had heard on the floor that resident 2 was talking about her. The ADON stated that he brought resident 2 into the office to talk to her and it did not go well. The ADON stated that he had learned after the fact that resident 2 had been in an abusive relationship. The ADON stated that during his conversation with resident 2 he had the door shut and the resident felt trapped with the door closed. The ADON stated that resident 2 had said it was entrapment. She knew it because her son was in prison for it. The ADON stated that resident 2 did not want to stay, she wanted to go. The ADON stated that when he got up to go to the door resident 2 thought he was blocking her. The ADON stated he should have stopped the conversation and let her out. The ADON stated that resident 2 was name calling, and called him an asshole. The ADON stated that at the time he did not think to stop the conversation. The ADON stated that the conversation appeared to bother resident 2. The residents demeanor was fine when she entered, it changed when they told her what they were talking about. The ADON stated that he did not recall calling resident 2 a busybody. The ADON stated that resident 2's room was across from the nurse's station, and they talked about a room change so she would not be close to the nurses station. The ADON stated he did not tell her he would move her room if she did not stop gossiping, no I don't believe so. The ADON stated that while he spoke to resident 2 the tone of his voice was stern, and it could have been taken the wrong way. The ADON stated that he did not think his voice was threatening. The ADON stated that he should have left it for someone else to talk to her, and probably should not have done it in a closed area. The ADON stated that when resident 2 said she felt entrapped they should have ended the conversation and let her out. The ADON stated that he did not end the conversation because it was a problem they had with her since she had been there, the gossiping and wanting to know everything. The ADON stated that this situation had nothing to do with resident 2. I didn't feel like it was none of her business (sic). The ADON stated that resident 2 was probably not receptive to the conversation after she said that she was entrapped, stating I should have let her go. The ADON stated that resident 2 went and talked to SSD about it, and they came and talked to him. The ADON stated that the SSD told him that resident 2 had a previous history of an abusive relationship. The ADON stated that he was suspended the day of the incident and returned to work 3 to 5 days later. The ADON stated that he had training on the types of abuse and it covered involuntary seclusion. The ADON stated that involuntary seclusion was if you put someone in their room or locked them in a room but nothing covered a resident being held against their will. The ADON stated that management suggested that he write a letter of apology to resident 2, and he explained where he was coming from and why it may have gone the way it did. Review of the facility Policy and Procedure on Reporting Alleged Violations of Abuse, Neglect, Exploitation or Mistreatment documented It is the policy of the Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, exploitation and mistreatment. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The policy further defined involuntary seclusion as Separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's representative. The policy was last revised on 11/28/17.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38031 Based on interview and record review it was determined, for 1 of 7 sampled residents, that the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later than 2 hours after the allegation was made if the events that cause the allegation involved abuse to the administrator of the facility, the State Survey Agency (SSA) and Adult Protective Services (APS). Specifically, an allegation of abuse was not reported to the SSA or APS within 2 hours of the allegation being made. Resident identifier 2. Findings included: Resident 2 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, congestive heart failure, atrial flutter, type II diabetes mellitus, chronic kidney disease, morbid obesity, chronic pain, difficulty with walking, polyneuropathy, hypertension, obstructive sleep apnea, and thrombocytopenia. Resident 2 was discharged from the facility on 3/30/24. On 2/14/24 at 11:00 AM, the facility reported an incident of mental/verbal abuse had occurred between resident 2 and the Assistant Director of Nursing (ADON). The facility abuse investigation documented that the ADON brought resident 2 into his office on 2/14/24 to address a concern brought up by a Certified Nurse Assistant (CNA). The concern was that [resident 2] was asking staff about a staff member who may have received disciplinary action that is not appropriate to discuss with a resident. [Registered Nurse (RN) 1] was present during the conversation between [ADON] and the resident. During this discussion, [resident 2] voiced she attempted to leave the office. [ADON] stood up and stood in front of the door stating , 'No we need to finish this conversation' [Resident 2] reported feeling distress as a result of this event. On 2/15/24 at 2:30 PM, the SSA was notified of the allegation of abuse on form 358 Facility Reported Incidents. It should be noted that the incident was reported to the SSA 27.5 hours after the allegation was made. On 2/22/24 at 1:11 PM, APS was notified of the allegation of Suspected Dependent Adult/Elder Abuse. It should be noted that the incident was reported to APS eight days after the allegation was made. On 5/22/24 at 2:09 PM, an interview was conducted with the Administrator (ADM). The ADM stated that he believed that he submitted the initial report to the SSA timely according to regulations. The ADM stated that he thought he had 24 hours to report because the allegation did not result in serious bodily injury. [Cross-refer F603]