

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465104	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/01/2025
NAME OF PROVIDER OR SUPPLIER  Orem Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, it was determined that the facility did not prevent misappropriation of a resident's medications for 1 of 28 sampled residents. Specifically, a resident had a nurse tell him he was getting his pain medication but was replacing it with another medication on multiple occasions. Resident identifier: 170.</p> <p>Findings included:</p> <p>Resident 170 was admitted to the facility on [DATE] and discharged on 9/27/24 with diagnoses which included cerebral infarction due to embolism, acute and chronic respiratory failure, and chronic pain syndrome.</p> <p>Review of resident 170's records was completed on 4/28/25 through 5/1/25.</p> <p>A comprehensive Minimum Data Set (MDS) dated [DATE] revealed that resident 170 had a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition.</p> <p>A grievance placed on 9/9/24, by resident 170 to the Director of Social Services (DSS) revealed, [Resident 170] states that he has some concerns about his medications, he feels that he is being given the wrong medications from a particular nurse, [Registered Nurse (RN) 3]. The grievance was resolved on 9/10/24, by the Director of Nursing (DON), the DSS and the Administrator (ADM). After further investigation, it was determined that this grievance will be a self-report.</p> <p>On 9/13/24 at 6:06 PM, the ADM submitted Form 358 to the State Agency (SA) which revealed the following. On 9/13/24 at 4:15 PM, During a scheduled Care Conference with [resident 170] and his Daughters, [sic] they alleged that [RN 3] had given a different colored pill when requesting his narcotic. The alleged incident happened on 8/31/24 at 12:30 PM. Adult Protective Services (APS) was notified on 9/13/24 at 6:08 PM.</p> <p>On 5/6/24, a physician's order for oxycodone hydrochloride (HCl) Tablet 20 milligram (mg), give 20 mg by mouth every 4 hours as needed (PRN) for pain related to chronic pain syndrome was started.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/20/24 at 4:55 PM, the ADM submitted Form 359 - Follow-Up Investigation Report to the SA which revealed the following: Resident 170 was interviewed and claimed that on 8/31/24, he was getting ready to go out with his family and ask for his pain pill. What RN 3 gave him was not the correct color of his oxycodone, it was a tiny white pill. Resident 170 said That's not my Oxy. RN 3 said Yes it was. RN 3 made a comment about not needing these, they are bad for you. Resident 170 stated that he did not report the first incident on 8/31/24, to anyone because he did not want to get the nurse in trouble. Resident 170 just thought it was off and did not realize at that time that it could be foul play. When a second incident happened on 9/9/24, he talked to his daughter over the phone. Resident 170 and his daughter requested a care conference. On 9/13/24, resident 170 reported the two incidents to the facility. On 9/17/24, resident 170 stated that he would notice an upset stomach when RN 3 worked and he had forgotten to ask for the PRN oxycodone. Resident 170 denied any uncontrollable or increased pain during the reported incidents. Resident 170's daughter claimed she had witnessed RN 3 giving resident 170 a white pill on 8/31/24, when he asked for his pain meds. Resident 170's daughter thought it was weird but did not think much about it until resident 170 claimed it happened again on 9/9/24. Resident 170's daughter then asked for a meeting. On 9/13/24, resident 170's daughter made the concern known to the Interdisciplinary team (IDT).</p> <p>An interview with the suspected perpetrator on 9/20/24 documented the following, RN 3 stated she was instructed to put the medications into separated pill packs and label when to take them and put his pain medication into a separate pack with six pills that would last for the requested 24 hours. RN 3 stated she did as was instructed and had another nurse sign to verify the pain pills and the number she was sending, and we both signed for them, I explained the medication to resident 170's daughter, who seemed confused as to why I was not just sending cards of meds. RN 3 stated she explained to resident 170's daughter that it was just easier to keep track of what resident 170 was taking. RN 3 stated that resident 170's daughter seemed upset but finished signing out Resident 170's daughter went to resident 170 room to get him, and they left. RN 3 stated I believe I only took care of resident 170 one more time after that and did not have any interactions with resident 170's daughter. That day, resident 170 did not express any concerns, confusion or have questions about the medications given throughout the shift. RN 3 stated the next time she worked, I was approached by several staff telling me that resident 170's daughter was filling a complaint about his pain medication, saying that I had been giving him heart medication and not his pain medication, and that resident 170's daughter had witnessed this. RN 3 stated that I was also told that resident 170's daughter and resident 170 were telling other staff they were out to get my license. RN 3 stated that on these days, I do not recall resident 170's daughter ever being present when medications were administered.</p> <p>The facility verified the allegation of misappropriation of resident 170's medications. During the investigation, camera footage was reviewed by the DON and CNA (Certified Nursing Assistant) coordinator. It was determined that it is probable that Resident 170 was not administered his narcotic as alleged. RN 3 was observed accessing the narcotic drawer, withdrawing a bubble pack of medication, placing medication into her hand and then placing her hand in her pocket.</p> <p>On 9/13/24 RN 3 was placed on suspension pending investigation.</p> <p>On 9/17/24, RN 3 was reported to Division of Professional Licensing (DOPL).</p> <p>On 9/18/24, RN 3 was involuntary terminated due to a Code of Conduct Violation for Drug Diversion.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/24/25, APS submitted a completed investigation to SA which revealed the following: The facility the [sic] [resident 170] is at, gave him the wrong medications. He was told by the nurse she was getting pain meds, but she was just giving him more of his heart medications. The bottle of pills went empty before it should have, His doctor stated that overdose of heart medication was messing with his heart rate. They said they were giving him pain meds. She [sic] gave him something else. It [sic] is messing with his heart rate a lot. [Resident 170] has also been on pain meds for 20 years and has been experiencing withdrawals, he is not being given his pain meds. Closure Statement Narrative: The allegation of financial exploitation is being supported. [Resident 170] is a vulnerable adult who at the time of the visit has full capacity as it relates to the allegation .</p> <p>On 5/01/25 at 12:11 PM, an interview with the DON was conducted. The DON stated that resident 170 and his daughter had an IDT meeting about resident 170's missing his medications. The DON stated that as soon as the allegations were known they placed RN 3 on suspension pending an investigation. The DON stated that her and the CNA coordinator reviewed hours of video footage to see if they were able to see any suspicious activity. The DON stated that there was video footage showing RN 3 accessing the locked narcotic drawer, pulling out a blister pack, placing medication in her hand, then placing her hand in her pocket. The DON stated that they reported RN 3 to DOPL, and they came and did an investigation. The DON stated that the incident was also reported to APS and the Police Department, they both came and did an investigation. The DON stated that once the investigation was completed it was decided that RN 3 needed their employment terminated and that was done on 9/18/25.</p>		