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	05/01/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide reasonable accommodations of needs and preferences except when to do so would endanger the health or safety of resident or other residents for 1 of 28 sampled residents. Specifically, a resident was not provided timely appointments to referred specialists for hand contractures and foot drop. Resident identifier: 41. Findings include: On 4/28/25 at 2:27 PM, an interview was conducted with resident 41. Resident 41 stated that she had to ask three different times to get an appointment with a specialist, she just barely got an appointment for the orthopedic hand surgeon. Resident 41 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, type 2 diabetes mellitus, other reduced mobility, and major depressive disorder. Review of resident 41's records was completed on 4/28/25 through 5/1/25. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 41 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. On 2/3/25, an encounter note revealed, resident 41 was seen for hand and feet contractures. Resident 41 states that she is having significant and worsening contractures in her left hand and bilateral feet. She requested to see a specialist to see if there is anything that could be done from their standpoint. A referral requested that resident 41 follow up with an orthopedic hand specialist as well as a podiatrist to see if there are any surgical releases that could be done to help with these contractures. Diagnosis, Assessment and Plan: A referral placed to orthopedic hand as well as podiatry to see if there is any surgical releases that can happen with her contractures. Plan: Referrals placed to orthopedic and as well as podiatry. On 2/10/25, an encounter note revealed, resident 41 was seen for a follow-up for anxiety. Diagnosis, Assessment and Plan: A referral placed to orthopedic hand as well as podiatry to see if there are any surgical releases that can happen with resident 41's contractures. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25, an encounter note for a follow-up visit revealed, resident 41 was seen for a follow-up visit for multiple specialist referral requests. Resident 41 presents today for a follow-up, expressing concerns regarding multiple specialist referral needs. Resident 41 specifically requests referrals to a orthopedic hand surgeon for evaluation of contractures and podiatry for drop foot management. Resident 41 reports these referral requests have been pending for some time. Diagnosis, Assessment and Plan: A referral placed to orthopedic hand as well as podiatry to see if there are any surgical releases that can happen with her contractures. Follow-up Plan: Hand contractures will refer to orthopedic hand surgery for evaluation and management. Pending specialist assessment for potential interventional options. Drop foot, referral to podiatry for comprehensive evaluation and management. On 3/11/25, an encounter note for an acute visit revealed, resident 41 was seen for follow-up visit for multiple specialist referral requests. Resident 41 presents with multiple complaints that have developed over recent weeks. Primary concerns included, hand issues requiring surgical evaluation, and drop foot. Resident 41 also demonstrated difficulty with ambulation due to drop foot, which is significantly impacting mobility. Diagnosis, Assessment and Plan: A referral placed to orthopedic hand as well as podiatry to see if there are any surgical releases that can happen with her contractures. Follow-up Plan: Hand contractures will refer to orthopedic hand surgeon for evaluation and management. Pending specialist assessment for potential interventional options. Drop foot, referral to podiatry for comprehensive evaluation and management. Follow-up Plan: Hand Condition, referral to hand surgeon for evaluation and treatment planning. Will request detailed documentation of specific hand symptoms and functional limitations. Drop foot, referral to podiatrist/orthopedist for evaluation and management. May need assistive devices or orthotics for ambulation safety. Follow-up: Schedule return visit after specialty consultations to coordinate care plan and monitor progression of symptoms. On 3/24/25, an encounter note for an acute visit revealed, resident 41 was seen for foot drop and macular degeneration. Resident 41 requested to see a podiatrist to evaluate her foot drop to see if surgical repair could be done. Resident 41 also requested to see an orthopedic hand surgeon for a finger contracture that she has been developing. Diagnosis, Assessment and Plan: A referral placed to orthopedic hand as well as podiatry to see if there are any surgical releases that can happen with her contractures. Follow-up Plan: A request for ortho and podiatry follow-ups. On 3/24/25 a physician's order was started for a referral to an orthopedic hand surgeon for an evaluation. One time only for finger deformity for 1 Day. On 3/24/25 a physician's order was started for a referral to outside podiatry for an evaluation related to drop foot. One time only for drop foot for 1 Day. On 3/24/25 at 5:20 PM, a nursing progress note revealed new patient orders for resident 41 for orthopedic hand for evaluation related to finger deformity. On 3/24/25 at 5:22 PM, a nursing progress note revealed that resident 41 to refer to outside podiatry for evaluation related to drop foot. On 3/24/25 at 6:00 PM, a nursing progress note revealed that medical doctor assessed resident 41 and wrote referral orders for outside podiatry evaluation related to drop foot. Also orders for orthopedic hand related to finger deformity. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25, an encounter note for a follow-up visit revealed, resident 41 was seen for a follow-up visit for multiple specialist referral requests. Resident 41 expressed desire for multiple specialty referrals, specifically requesting evaluations from podiatry and orthopedics for assessment of bilateral foot contractures, and orthopedic evaluation for hand contractures. Diagnosis, Assessment and Plan: A referral placed to orthopedic hand as well as podiatry to see if there are any surgical releases that can happen with her contractures. Follow-up Plan: For hand contractures: Orthopedic referral initiated for evaluation and management. Continue the current physical therapy regimen. For foot contractures: Dual specialty approach with podiatry and orthopedic referrals initiated. Continue current physical therapy protocol. For general management: Transportation arrangements in process for specialty appointments. On 4/25/25 at 1:13 PM, an appointment/procedure note revealed that resident 41 was scheduled an appointment on 5/2/25 at 10:00 AM regarding referral for consult hand contractures and possible surgery options. Resident 41 and family notified. On 4/30/25 at 1:32 PM, an interview was conducted with the Director of Transportation (DT). The DT stated that she was the one who scheduled appointments and set up transportation for the residents. The DT stated that when a referral to a specialist was needed, the in-house physician would order it. The nurses would then create the order and print it out for the ordering physician to sign. The DT stated that when she received the signed order, she attempted to schedule an appointment as soon as possible, which could take from 24 to 72 hours. The DT stated that there could be delays during the scheduling process such as no prior relationship with the provider, getting the necessary documents sent over to the referred office, or finding a provider that would take the resident's insurance. The DT stated that she recalled getting the signed order for resident 41's referral to the orthopedic hand surgeon and was able to schedule her an appointment. On 5/1/25 at 9:30 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated the in-house physician would give the floor nurse an order for the referral. RN 2 stated that she could find the orders in the communications tab in the electronic medical record. RN 2 stated she would then enter the order into the resident's medical chart. RN 2 stated that she was unaware if the order needed to be printed out. RN 2 stated that the DT would then look for any entered orders that needed to be scheduled and would schedule the appointment. On 5/1/25 at 11:03 AM, an interview was conducted with RN 1. RN 1 stated the in-house physician would let the floor nurse know that they had a referral request for a resident. RN 1 stated the floor nurse would enter the order and then printed the order out to have physician sign. RN 1 stated the signed order would then go to the transportation department. RN 1 stated that if they were not able to get the physician to sign the order prior to them leaving the building, the DT will follow up with the physician to get the order signed. On 5/1/25 at 11:26 AM, a request was made to Director of Nursing (DON) for the signed order for the referral to the orthopedic hand specialist. The DON provided the signed order dated 3/24/25. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 11:59 AM, an interview was conducted with the DON and Regional Nurse Consultant (RNC). The RNC stated that the DT needed to have a signed order before she could schedule an appointment with an outside provider. The DON stated that the floor nurse got the order from the physician when they were rounding on the residents. The DON stated that the floor nurse would enter the order then print the order to place it into the physician's box. The DON stated the physician would sign any orders that were in their box, once signed it was then placed in the transportation orders box located at the front nursing station. The DON stated that the DT looked in the box at least daily when she was in the facility. The RNC stated that only new appointments or referrals need to have a signed order. The RNC stated that residents that were already established with an outside provider did not need signed orders for any follow-up visits.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 2 of 28 sample residents, that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, two high fall risk residents did not have interventions put in place after multiple falls. Resident identifiers: 18 and 69. Findings included: Resident 69 was admitted to the facility on [DATE] with diagnoses which included but were not limited to dementia, hypotension, muscle weakness, morbid obesity, unsteadiness on feet, and need for assistance with personal care. Resident 69's medical record was reviewed 4/28/25 through 5/1/25. A Quarterly Minimum Data Set (MDS) dated [DATE] documented resident 69 was a one person physical assist with transfers, toileting and bed mobility. On 12/30/24, resident 69 was documented as a High Fall risk. A care plan focus dated 6/19/21 with a revision date of 2/16/25 revealed, [resident 69] has ADL [Activities of Daily Living] Self Care Performance Deficit r/t [related to]generalized weakness, obesity, confusion, forgetfulness, unspecified lack of coordination, need for assistance with personal care, unsteadiness on feet. ADL assistance level needs vary at times depending on resident behavior and needs. Resident 69's progress notes were reviewed and revealed the following: a. 1/31/25 at 11:40 PM, Pt [patient] was found lying next to bed requesting help to get up at 2320 [11:20 PM] on 01/31/2025. 4 employees assisted Pt back into bed where a skin and neurological assessment was performed. No skin alterations noted at the moment. Pt stated I'm okay when questions about pain. Pt is currently resting in bed with call light and water within reach. Neuros were restarted with current vitals of BP [blood pressure]: 146/77, Pulse: 100, Temp [temperature]: 97.9, Oxygen saturations of 93/3L [liters] and Respirations of 18. Family and Provider notified with no new orders at the moment. b. 2/1/25 at 6:50 PM, CNA [Certified Nursing Assistant] found resident on floor in his room. CNA reported that resident was trying to get from wheelchair to bed. RN [registered nurse] assessed resident, no injuries observed. Resident denies any pain. Helped resident back into bed. Vital sign monitoring started, neuro checks started. AAOx2 [alert and oriented times 2].PERRLA [pupils equal round reactive and accommodating]. VSS [vital signs stable]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. 2/2/25 at 7:11 AM, Resident was yelling out this morning at 0605 [6:05 AM], RN went to assess resident and a second prior to walking in, RN heard a smack and found resident lying on the floor next to his bed. It appeared resident hit his head hard. RN and CNA's quickly helped resident back into bed. No injuries observed. Resident denied any head pain. HR [heart rate] was elevated at 124 and oxygen was 78% [percent] on 2L of O2 [oxygen]. RN increased oxygen to 3L and gave resident 1 dose of albuterol. Oxygen increased to 85%. On call provider [name omitted] notified, given that resident has fallen 4x in the last 40 hours provider wanted resident sent out to the hospital . No new fall prevention interventions were documented in the medical record after each of these falls. On 4/30/25 at 2:41 PM, an interview was conducted with RN 4. RN 4 stated she was the nurse who entered resident 69's room right after he had fallen o 2/1/25. RN 4 stated resident 69 was fighting a cold and was not feeling well. RN 4 stated resident 69 had fallen a couple of times the day before and she was unaware of any new interventions that had been put into place after the falls. RN 4 stated the resident was not on continuous observation. RN 4 stated resident 69 was a full assist at that time during his stay. On 4/30/25 at 2:54 PM, an interview was conducted with the Director of Nursing (DON) and the Corporate Resource Nurse (CRN) who stated neuro checks were done on any resident who fell and hit their head or had an unwitnessed fall. They stated the resident's was already in a low bed and in a room near the nurses station. They stated staff were always in resident 69's room but did not provide any new interventions that were put into place for the falls on 1/31/25 and 2/1/25. Per the resident record, resident 69's was in a room down the hallway from the nurses station. On 5/1/25 at 10:27 AM, a follow up interview as conducted with the DON and the CRN who stated resident 69 was sent to the hospital for a change of condition not for the falls. They stated they just did not have time to update the care plan since his falls happened so closely together. 2. Resident 18 was admitted to the facility on [DATE] with diagnoses which included, epilepsy, other deformity of the brain, unsteadiness on feet, difficulty walking, and muscle weakness. On 5/4/24 a fall risk assessment was completed in resident 18. Resident 18 scored a 12 which indicated a high risk for falls. A review of resident 18's medical records revealed the following falls and interventions: a. On 5/30/24 resident 18 slipped while in the shower and was assisted to the ground. The intervention that was put in place was to apply a non-slip shower mat in shower room. b. On 10/10/24 resident 18 was trying to reach for his electric razor and fell down. The intervention that was put into place was education on using the call light and proper footwear. c. On 11/12/24 resident 18 slipped out of his wheelchair while reaching for something on the ground. The intervention that was put into place was to have occupational therapy (OT) assist resident 18 with dynamic sitting and the use of a reacher. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 12/26/24 resident 18 fell out of his wheelchair while bending over to grab something. The intervention that was put into place was education on the use of the reacher that was previously given to him and to lock the brakes on his wheelchair. It should be noted that the use of the reacher was the intervention for the fall that occurred on 11/12/24. e. On 2/7/25 resident 18 experienced a fall when he ambulated on his own and slipped on the floor. The intervention that was put into place was to provide education on the use of non-skid socks and proper footwear. It should be noted that proper footwear was the intervention for the fall that occurred on 10/10/24. f. On 3/29/25 resident 18 experienced a fall while trying to reach for a garbage bag. The intervention that was put in place was to increase OT to focus on reaching out base of support. g. On 4/16/25 resident 18 experienced a fall he stood up and bent down to reach his activities punch card from under his wheelchair. The intervention that was put into place was to not store his punch care under the wheelchair and to have a rubber band provider for storage to the arm of the chair. On 4/30/25 at 11:09 AM, an interview was conducted with RN 1. RN 1 stated that resident 18 had undergone a brain procedure that caused cognitive delays. RN 1 stated that resident 18 was a fall risk and experienced multiple falls while at the facility. RN 1 stated that the resident often attempted to act independently, had difficulty following instructions, and struggled to retain education. RN 1 stated that resident 18 frequently forgot to use his call light and often fell while trying to bend over. On 5/1/25 at 8:31 AM, an interview was conducted with the DON. The DON stated that resident 18 required frequent prompting and was impulsive, which had contributed to some of his falls. The DON stated that resident 18 was unaware of his physical limitations and would often lean forward and fall. The DON stated that resident 18 liked to get up quickly and valued his independence, but needed constant reminders. On 5/1/25 at 8:42 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that resident 18 had the right to fall, but interventions needed to be done to prevent falls rather than be repeated. The RNC stated that resident 18 needed constant reminders because of his poor impulse control. On 5/1/25 at 10:31 AM, a follow-up interview was conducted with the RNC. The RNC stated that the facility should have implemented different interventions and resident 18's Plan of Care was not enough to prevent falls.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility did not ensure that each resident who needed respiratory care was provided such care consistent with professional standards of practice. Specifically, 1 out of 28 sample residents, did not have an order to change the oxygen tubing and humidifier. Resident identifier: 47 Findings included: Resident 47 was admitted to the facility on [DATE] with diagnoses which included, acute respiratory failure with hypoxia, epilepsy, and subarachnoid hemorrhage. On 4/28/25 at 9:57 AM, a concurrent interview and observation was made with resident 47. Resident 47 was observed in bed with a nasal cannula attached to an oxygen concentrator delivering 3 liters of oxygen. The nasal cannula was undated. Resident 47's portable oxygen tank had a nasal cannula attached that was undated and wrapped around the left wheel of the resident's wheelchair. Resident 47 stated that she did use oxygen. On 4/29/25 at 10:46 AM, an observation was made of resident 47's oxygen cannulas. Resident 47's nasal cannula connected to the concentrator was undated. Resident 47's nasal cannula attached to the portable oxygen tank was undated and placed on the seat of the wheelchair. On 4/30/25 at 8:29 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 47 did use oxygen. RN 1 stated that resident 47 had both an oxygen concentrator and a portable oxygen tank. RN 1 stated that facility nurses were responsible for changing and dating the nasal cannulas. RN 1 stated that the medical record for resident 47 should contain orders for the nurse to change the nasal cannulas; however, RN 1 was unable to locate the order for weekly changes. On 4/30/25 at 12:00 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that CNA's were only permitted to replace oxygen tanks and adjust nasal cannulas that were already in place on the residents. CNA 1 stated that nurses were in charge of changing out the nasal cannulas. On 4/30/25 at 12:03 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that nurses were expected to change out nasal cannulas every Sunday and that there should be a physician's order to support that practice. The RNC stated that she would locate the order for changing the nasal cannulas for resident 47. It should be noted that no order for oxygen supplies was located in the medical record. On 4/30/25 at 12:04 PM, an interview was conducted with the Unit Manager (UM). The UM stated that the nursing night shift changed nasal cannulas on Sundays. The UM stated that all nasal cannulas should be dated. On 5/1/25 at 10:49 AM, a follow-up interview was conducted with the RNC. The RNC stated she had just entered the order for resident 47's nasal cannula to be changed. The RNC stated that the changes had not been occurring because no prior order was in the medical record.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview and record review, 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, Nurse Aides (NA) were employed at the facility, for over 4 months without completion of training and competency evaluation program. Findings include: On 4/30/25 NA 1's employee record was reviewed. NA 1 was hired on 9/3/24 as a NA. NA 1 was still employed as a NA and the last day worked was on 4/29/25. On 4/30/25 NA 2's employee record was reviewed. NA 2 was hired on 9/9/24 as a NA. NA 2 was still employed as a NA and the last day worked was on 4/11/25. On 4/30/25 NA 3's employee record was reviewed. NA 3 was hired on 5/3/25 and received his certification on 3/18/25. NA 3's last day of work as a NA at the facility was 3/16/25. On 4/30/25 NA 4's employee record was reviewed. NA 4 was hired on 9/4/24. NA 4 was still employed as a NA and the last day worked was on 4/10/25. NA's 1, 2, and 4 were not certified as nursing assistants. On 5/1/25 at 8:23 AM, an interview was conducted with the Administrator (ADM). The ADM stated that the CNA (Certified Nursing Assistant) Coordinator was responsible for scheduling the Certified Nurse Assistants and the NA's. On 5/1/25 at 9:59 AM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that NA's have 120 days from their hire date to become certified. The CNA Coordinator stated that she had to take some of the NA's off the schedule for this week because they were not certified and had worked past their 120 days.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, the facility did not have the nurse staffing information posted. The facility must post the nurse staffing data on a daily basis at the beginning of each shift and maintain the posted daily nurse staffing data for a minimum of 18 months. Specifically, nurse staffing information was out of date and not posted on weekends. Findings include: On 4/28/25 at 8:31 AM, during the initial tour of the facility, the nurse staff posting was dated 4/23/25. On 4/30/25 at 11:52 AM, an interview was conducted with the Administrator (ADM). The ADM stated that the nurse staffing information was posted by the receptionist. On 4/30/25 at 11:55 AM an interview was conducted with the receptionist. The receptionist stated that she was out sick on 4/24/25 and 4/25/25 and no one else posted the daily staffing information during her absence. The receptionist stated that she worked Monday through Friday and that the daily nurse staffing information was not posted on weekends because the weekend receptionist did not know how. On 5/1/25 at 8:15 AM, a follow-up interview was conducted with the receptionist. The receptionist stated that for any weekend censuses or other daily censuses that were not posted, she completed them the following Monday and kept them in a binder.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined for, 1 out of 28 sample residents, that the facility did not file, in the resident's clinical record, laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, a resident's laboratory results were not located in the electronic medical records. Resident identifier: 30 Findings included: Resident 30 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes, congestive heart failure, essential hypertension, schizoaffective disorder, bell's palsy, anxiety disorder, and depression. Resident 30's medical record was reviewed 4/28/25 through 5/1/25. A physician's order, dated 9/9/24, ordered a Complete Blood Count (CBC) every day shift starting on the 10th and ending on the 10th every month for Plavix/Eliquis Use. A physician's order, dated 4/16/25, ordered a CBC one time only related to . possible UTI [urinary tract infection]. No laboratory results could be located on resident 30 ' s electronic medical record for the CBC ordered on 11/10/24, 4/10/25, and 4/16/25. On 4/30/25 at 12:09 PM, an interview was conducted with the Director of Nursing (DON) and Medical Records. The DON stated that the laboratory utilized two electronic health record (EHR) applications. The DON stated the laboratory uploaded the laboratory results to both EHR applications. Medical Records stated that he had access to one of the EHR applications, but not the other EHR application. Medical Records stated he filed the laboratory results on the facility's electronic medical records when the laboratory results were uploaded to the EHR application that he had access to. The DON stated that the missing laboratory results for resident 30 were uploaded by the laboratory to only one of the EHR applications, and it was the EHR application that Medical Records did not have access to.

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	465104	A. Building B. Wing	05/01/2025

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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility did not provide food that was palatable, attractive, and at a safe and appetizing temperature. Specifically, for 7 out of 28 sampled resident, residents complained of the quality and temperature of the food, food was being fortified with a squirt of cold milk or splash of butter on the already prepared food, a test tray was not palatable and the food was cold. Resident identifiers: 19, 29, 35, 39, 41, 47 and 59. Findings include: 1. On 4/28/25 at 9:57 AM, an interview was conducted with resident 47. Resident 47 stated that she was on a specialized diet of minced and moist food. Resident 47 stated that the food tasted pretty gross. Resident 47 stated that she was given mashed potatoes in the shape of a hot dog that tasted bad and looked awful. 2. On 4/28/25 at 10:00 AM, an interview was conducted with resident 59 who stated the food was usually cold. 3. On 4/28/25 at 10:29 AM, an interview was conducted with resident 39. Resident 39 stated that sometimes the food served at the facility was pretty bad. 4. On 4/28/25 at 10:40 AM, an interview was conducted with resident 35 who stated the food is almost always cold, many times it doesn't have the heated plate underneath it. The chicken and the potatoes are ice cold, anything fried is never, ever warm. For breakfast the toast is not warm and the butter is not put onto the toast. 5. On 4/28/25 at 10:54 AM, an interview was conducted with resident 19. Resident 19 stated that the food was not that great and tasted very bland. 6. On 4/28/25 at 1:48 PM, an interview was conducted with resident 29. Resident 29 stated that the food was often cold. 7. On 4/28/25 at 2:27 PM, an interview was conducted with resident 41. Resident 41 stated that the food that is served is not the best and sometimes comes cold. During tray line service on 4/30/25 at 12:53 PM, [NAME] 1 was observed to squirt cold milk onto the prepared food that was already plated. An immediate interview was conducted with [NAME] 1 who stated a squirt of milk was put on those plates of the residents who needed fortification. [NAME] 1 stated the milk was kept cold in water while waiting to be used. On 5/1/25 at 12:30 PM, the DM was observed to serve the lunch tray line. The DM was observed to drizzle butter on the plates of those residents who needed fortification. On 5/1/25 at 12:22 PM, an observation was made of resident 47 tray. Resident 47 was given couscous, pureed chicken with gravy and pureed broccoli. The DM was observed to use a brush and drizzle butter over the meat two different times. The butter could be observed to pool on the plate around the meat and broccoli. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/25 at 8:09 AM, an interview was conducted with the DM. The DM stated they add butter, milk and sugar for fortification that is added while we are preparing the food. The DM gave the example that they would add a spoonful of butter for a cup of oatmeal. The DM stated for lunch or dinner they would add it over the top of the prepared food because they did not have enough space to add it prior. The DM stated they had a bottle of cold milk that they would squirt a little on the fortified plates. The DM stated it was not measured so they did not know exactly how many calories the residents were receiving. On 5/01/25 at 9:25 AM, a follow up interview was conducted with the DM. The DM stated for pureed diets they processed the chicken in the blender, resident 47 could not have rice so couscous was substituted, the vegetables were also processed in the blender. The DM stated the couscous would have added butter and the chicken will have whole milk added. The DM stated they had a bottle of the milk and they would squirt some milk over the food, the milk was not measured out. On 5/1/25 at 12:56 PM, an observation was made of the hall trays exiting the kitchen. A fortified pureed test tray was requested. At 12:59 PM, the following foods temperatures were obtained [Note: All temperatures were in degrees Fahrenheit.]: a. Chicken - 98.2 b. Couscous - 132.1 c. Broccoli - 100.8 The pureed chicken was cold to the taste and oily from the butter that was used for fortification. The couscous was bland. The broccoli was cool to the taste. On 5/1/25 at 1:25 PM, an interview was conducted with the DM. The DM stated that milk was not used as fortification today, only butter. The DM stated she was unaware that the residents did not like some of the food and that they thought the food was not warm enough.

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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, it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, there were unlabeled and undated food items stored in the kitchen, there was food stored on the floor in the kitchen, meat was improperly stored in the walk-in refrigerator, staff cellphones and beverages were stored in food preparation areas, and staff did not serve food in a hygienic manner. Findings Include: On 4/28/25 at 8:41 AM, an initial observation of the kitchen was conducted. On 4/28/25 at 8:47 AM, an observation was made of the walk in refrigerator. There was an undated, unlabeled liquid in a 22 quart container. There was an opened box of bacon stored on a shelf above open boxes of bananas and oranges. There were multiplied carafes of juice that were not labeled or dated on the top shelf of the refrigerator. On 4/28/25 at 8:50 AM, an observation was made of the kitchen's dry storage room. There was a #10 can of beets sitting on the floor of the dry storage. There was a large rolling storage bin full of dry rice. The bin was not labeled or dated. On 4/28/25 at 8:52 AM, an observation was made of the food preparation area of the kitchen. There were 5 plastic bins full of cereal. The bins were labeled, cherios [sic], mini wheat, raisin brand, corn flakes, and rice crispy. None of the 5 bins were labeled with dates. There was a cellphone stored on top of a food preparation table. There were also two staff drink cups with no lids stored on a food preparation table. On 4/30/25 at 11:51 AM, a follow up observation of the kitchen was conducted. There was a cellphone and two staff drink cups stored on a food preparation table. There were cleaning supplies stored in the same room as potatoes, onions, and sweet potatoes. On 4/20/25 at 12:07 PM, an observation was made of staff plating meals for the lunch time meal service. [NAME] 1 was observed touching plates used to serve meals to residents with dirty gloves that had touched other surfaces. [NAME] 1 was observed touching food on the plates, the plate covers, meal tickets, and the faces of the plates. On 4/30/25 at 12:09 PM, water was observed dripping from a ceiling vent onto the plate warmer. On 4/30/25 at 12:25 PM, [NAME] 1 was observed touching a shelf that scoops were stored on, then touched the faces of several plates. [NAME] 1 then touched an electrical cord that was plugged into the ceiling and then touched the faces of several plates. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/25 at 8:01 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that when food is delivered to the facility, a staff member will date and label items with the received date. The DM stated that kitchen staff should not have drinks or personal items in cooking or preparation areas of the kitchen. The DM stated that food should not be stored on the floor of the kitchen. The DM stated that that meat should never be stored above produce in the refrigerator and that it should always be stored below everything. The DM stated that bins of rice or cereal should be dated and labeled. The DM stated that staff should not touch other surfaces before touching food or surfaces of plates.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined, for 2 or 28 sampled residents, the facility failed to keep an antibiotic stewardship program that included antibiotics use protocols and a system to monitor all antibiotic use for all residents. Specifically, residents with orders for prophylaxis antibiotics were not monitored for their antibiotic use. Resident identifier: 23 and 28. Findings include: 1. Resident 23 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included acquired deformity of left lower leg, type 2 diabetes mellitus, bipolar disorder, and personal history of urinary tract infections (UTI). Review of resident 23's records was completed on 4/29/25 through 5/1/25. A physician's order dated 10/20/24 documented, Keflex Oral Capsule 500 milligrams (mg) (Cephalexin) Give 1 capsule by mouth at bedtime for Prophylaxis for UTI. 2. Resident 28 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included borderline personality disorder, generalized anxiety disorder, major depressive disorder, and long term use of antibiotics. Review of resident 28's records was completed on 4/29/25 through 5/1/25. A physician's order dated 3/29/23 documented, Cephalexin Oral Capsule 250 mg. Give 250 mg by mouth one time a day for prophylaxis for history (hx) of chronic UTI related to long term use of antibiotics. On 5/01/25 at 12:35 PM, an interview was conducted with the Infection Preventionist (IP). The IP stated that he did an antibiotic review for resident 28 about a year ago. The IP stated that resident 23 was recently put on prophylaxis antibiotics but unsure of when that was. The IP stated that when a resident was placed on a prophylaxis antibiotic he placed them on the infection tracking sheet for that month and that he did not carry the tracking over to future months. The IP stated that he did not have a tracking system for residents that are on long term antibiotics use. On 5/01/25 at 12:19 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she did not do any of the infection control monitoring. The DON stated the IP took care of all of the antibiotic stewardship.