STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation and interview, the facility did not provide a safe, clean, comfortable, and homelike environment. Specifically, resident bathrooms in the memory care unit did not have paper towel dispensers that worked. Findings included: On 3/11/24 at 2:33 PM, an observation was made of the bathroom in room [ROOM NUMBER]. The paper towel dispenser did not work. On 3/11/24 at 2:35 PM, an observation was made of the bathroom in room [ROOM NUMBER]. The paper towel dispenser did not work. On 3/11/24 at 2:39 PM, an observation was made of the bathroom in room [ROOM NUMBER]. The paper towel dispenser did not work. On 3/21/24 at 10:08 AM, an observation was made of the bathroom in room [ROOM NUMBER]. The paper towel dispenser did not work. On 3/21/24 at 10:13 AM, an observation was made of the bathroom in room [ROOM NUMBER]. The paper towel dispenser did not work. On 3/21/24 at 10:18 AM, an observation was made of the bathroom in room [ROOM NUMBER]. The paper towel dispenser did not work. On 3/21/24 at 10:26 AM, an interview was conducted with Housekeeper (HK) 2. HK 2 stated housekeeping refilled the paper towel dispensers. HK 2 stated the maintenance department replaced the batteries in the paper towel dispensers. HK 2 stated maintenance staff provided batteries for housekeeping to replace also. HK 2 was observed to try the paper towel dispenser in room [ROOM NUMBER]'s bathroom. The paper towel dispenser did not work. HK 2 stated the dispenser was not working and she needed batteries from the maintenance staff. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/21/24 at 10:28 AM, an interview was conducted with Certified Nursing Assistant (CNA) 8. CNA 8 stated that housekeeping refilled and made sure the paper towel dispensers were working in resident bathrooms. CNA 8 stated if she noticed a paper towel dispenser was not working, she notified maintenance staff. CNA 8 stated the paper towel dispenser was not working in room [ROOM NUMBER] and the bathroom in 203. On 3/21/24 at 10:36 AM, an interview was conducted with the Maintenance Director (MD). The MD stated staff verbally notified him of things that needed to be fixed and there was an application use. The MD stated there was a laminated form at the nurses station to show agency staff how to use the application system. The MD stated the paper towel dispensers were usually the HK because they replaced the paper towels. The MD stated he provided housekeepers with batteries. The MD stated he had not been notified the paper towel dispensers were not working. On 3/21/24 at 10:40 AM, an interview was conducted with the HK Supervisor. The HK Supervisor stated housekeepers changed paper towels when they were low. The HK Supervisor stated there were batteries in the maintenance office. The HK Supervisor stated sometimes the paper towel dispensers needed to be rest. The HK Supervisor stated HK staff checked the paper towel dispensers daily to see if they were working.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review, the facility failed to prevent an instance of sexual abuse between resident 269 and resident 270, and neglected to provide the supervision necessary to prevent the elopement of resident 17. The facility's failure to prevent the sexual abuse of resident 270 was determined to be noncompliant and constituted immediate jeopardy. Additionally, due to resident 17's assessed impaired cognitive status and known wandering behavior, the facility's lack of a coordinated plan to supervise the resident's whereabouts was also determined to be noncompliant and constituted immediate jeopardy. However, based on the facility's corrective actions and a review of the facility's current compliance in this regulatory area, the deficiency was determined to be past noncompliance. Resident identifiers: 17, 269, and 270. Corrective Action: Elopement: [DATE]: Resident was assessed for injury; no injuries were found. [DATE]: Facility representative spoke with family who reported that she had done this type of thing at home. [DATE]: Resident was determined to be a high risk for further elopements and would need to be moved to the secure unit. Resident was transferred to the secure unit to prevent further elopements. [DATE]: IDT reviewed the elopement Systemic Interventions: A training was conducted on [DATE] for the monthly all staff meeting. Clinical training topics included labs, abuse reporting, and elopement prevention. The training was aimed at helping facility staff understand why residents have behaviors and interventions that they could do to help residents feel more comfortable and minimize behaviors. On [DATE], Facility IDT met to review elopement process. The following interventions were implemented: Elopement binder was created for all high-risk residents on Cambridge. CNA Coordinator was given instructions to create tools for the staff, including a task sheet to alert staff of high-risk behaviors for residents and elopement sheets for the elopement binder. CNA Coordinator was given responsibility to round at least twice daily to verify the unit was running smoothly and that staff had the tools they needed to care for the residents. Monitoring: [DATE]: Administrator/Designee began holding weekly meetings with CNA coordinator regarding the flow of the unit, communication, and the competency of the supervising staff on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	QAPI: On [DATE], the QAPI committee reviewed the events of the month and identified the need for further interventions for elopement/abuse prevention. QAPI committee began creating care kits for memory care residents to decrease boredom, exit seeking, and help residents who were up at night. Corrective Action: Abuse: Immediate Interventions: Immediately, residents were separated, and the abuse investigation was initiated. As part of the immediate actions, the police were notified, CMS [Centers for Medicare & Medicaid Services] was notified. Actions taken to Prevent Recurrence: The resident was placed on 1:1 on [DATE] with the intention to remain until the investigation was complete and interventions could identify how to prevent recurrence. On [DATE], the IDT reviewed the situation and identified that the root cause was that the resident thought (the victim) was his wife. To prevent recurrence, the victim was moved off the unit on [DATE]. On [DATE], As the CMS-Form 359 was nearing completion, an internal meeting was held to review the investigation with the Regional Nurse Consultant, the Director of Clinical Services, the Corporate LCSW [Licensed Clinical Social Worker], the Facility Administrator, and Director of Nursing. The investigation details were reviewed and approved for completion. Systemic Action: On [DATE], the Director of Nursing conducted an in-service with facility staff on Abuse Prevention with a post-test validation. On [DATE], the perpetrator was reviewed weekly by the Behavioral Health Facility Committee to validate interventions were effective and further abuse prevented. On [DATE], Corporate LCSW provided a training with the Social Services Department on Sexual Intimacy in the LTC [Long Term Care] setting, Assessing Capacity to Consent, Care Planning, and appropriate Documentation. Monitoring: A week later, on [DATE] the Corporate LCSW came to the facility and assessed the Perpetrator and reviewed the interventions in place. The resident had been on 1:1 up to that point. Recommendations were made to adjust the interventions as he did not appear to be at high risk to repeat the behavior. CNA Coordinator was given responsibility to round at least twice daily to verify the unit was running smoothly and that staff had the tools they needed to care for the residents. Administrator/Designee held Weekly meetings with CNA Coordinator regarding the flow of the unit, communication, and the competency of the supervising staff on the unit. Camera's were set up to enhance visibility in the unit for staff. Computers in the unit were connected to be able to view halls for when CNA's were busy in rooms. QAPI [Quality Assurance and Performance Improvement]: [DATE]: QAPI Meeting, facility reviewed staffing patterns on the unit to validate that there was proper supervision on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Continued Interventions: An investigation was conducted in [DATE], and found that the abuse program was not being run in accordance with facility policy and procedure. Further investigation identified the administrator was not engaged sufficiently in managing the abuse program. The administrator was terminated. A facility manager took over the facility with significant oversight of the RVP [Regional [NAME] President]/Designee. Determination of Compliance Date: [DATE] Findings included: 1. Resident 269 was admitted to the facility on [DATE] with diagnoses which included dementia, muscle weakness, abnormalities of gait and mobility, adult failure to thrive, cognitive communication deficit, Alzheimer's disease, stage 3 kidney disease, major depressive disorder, anxiety disorder, and insomnia. Resident 269 expired on [DATE]. Resident 270 was admitted to the facility on [DATE] and again on [DATE] with diagnoses which included polyneuropathy, chronic respiratory failure, protein-calorie malnutrition, intracranial injury without loss of consciousness, dementia, major depressive disorder without psychotic features, anxiety disorder, unspecified psychosis, hallucinations, insomnia, fusion of spine, and tendinitis. Resident 270 expired on [DATE]. A form titled Exhibit 358 submitted to the State Survey Agency (SSA) documented on [DATE], there was an allegation of sexual abuse. The alleged victim was identified as resident 270. The alleged perpetrator was identified as resident 269. The allegation details documented, [resident 269] was found in [resident 270's] room naked on top of her. Exhibit 358 documented, Resident were separated by [Speech Therapist (ST)] and [Physical Therapist (PT)]. [Resident 269] redirected back to room. Ethics committee met to discuss room change for [resident 270], specialized unit assessment completed. [Resident 270] moved to rm [room] , d+[DATE] off the the [sic] locked unit. CNA [Certified Nursing Assistant] post moved to hallway to monitor [resident 269] wandering. Monitoring for psychosocial baseline initiated for [resident 270]. Behavior monitoring initated [sic] for [resident 269]. MD [Medical Director] and [resident 270's] hospice notified. Frequent visits from SS [Social Services] for both resident through out durration [sic] of investigation. A witness statement from the initial police report dated [DATE], was reviewed. The witness statement was written by the ST and documented, [The PT] and I began looking for [resident 269] to begin our initial evals [evaluations], he wasn't in his room or the common area so we started looking in empty rooms, then in occupied rooms. I peeked in [resident 270's] room and noticed something was off so I walked in further. I realized [resident 269] was on top of [resident 270] between her legs and was naked from the waist down. I told him to stop and went back to the hallway and told [the PT] and [the occupational therapist (OT)] there was a problem. [The PT] went in next and told [resident 269] to get up. I comforted [resident 270] while [the PT] and [the OT] got [resident 269] dressed and out of the room. [CNA 18] helped to get [resident 270] a new brief and we got her in new clothes. [CNA 18] changed the bedding and we transferred [resident 270] to her wheelchair. I stayed with [resident 270] while admin/DON [Administrator and Director of Nursing] were alerted and arranged for a new room for [resident 270]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A witness statement from [DATE], written by the OT was reviewed. The OT wrote, Therapists were looking for suspect to do therapy. Speech therapist found suspect on top of victim both fully unclothed from waist down. Physical and occupational therapist pulled suspect off of victim. Suspect did not appear erect. Physical and occupational therapist proceeded to help suspect get dressed while speech therapist comforted victim. Suspect kept stating 'is that my wife' Physical therapist proceeded to take suspect out of the room to continue PT evaluation. Speech therapist stayed to help aid [CNA]care for patient. A witness statement from [DATE], written by CNA 18 was reviewed. CNA 18 wrote, I was helping therapy look for [resident 269] for about 15 minutes. We ended up spreading out (4 people including myself). As I was looking I heard a woman yell that they found him and when I went into the room I saw two people talking to [resident 269] and gently pulling him off of her. My first priority was helping [resident 270]. So I helped comfort her while [resident 269] was taken out of the room. Once he left, me and the female therapist put a new brief on her, since her other one was removed and her pants were completely removed when I first entered the room ([resident 269's] clothes from his hips down were completely off and he was still in between [resident 270's] legs when I walked into the room). I did a quick wipe down around her peri area and put on a new brief. I changed all of her clothes and bedding . I sat with [resident 270] while everyone else was making phone calls, her breathing was faster than normal abut other than that I saw no signs of stress. I took her to her new room, talked with the officer, and retrieved all of the bedding and clothes from [resident 269] and [resident 270]. The form titled Exhibit 359, the follow-up investigation report was reviewed. The steps taken to investigate the allegation documented that resident 270 was nonverbal and was alert and oriented to self, and the facility was unable to collect a statement from resident 270. The document reported that resident 270 returned to baseline shortly after separation, and had continued to participate in daily routine such as attending activities and eating in the dining room throughout the duration of the investigation. The summary of the witness interviews was documented as, Per witness statements it is concluded that [resident 269] was in [resident 270's] room on top of [resident 270]. Both of their lower body dressings had been removed. When staff intervened, [resident 269] had expressed that he had believed [resident 270] was his wife. After explaining to [resident 269] that [resident 270] was not his wife, [resident 269] was easily redirected out of the room. Male staff member stayed with [resident 269] in his room. Two females stayed with [resident 270]. DON [Director of Nursing] and Abuse Coordinator notified after it was ensured that both residents were safe. A summary of interview with other residents who may have had contact with the alleged perpetrator documented, Resident interviews were conducted with resident who reside on the locked unit and may have had contact with the perpetrator. Interviews concluded that the residents feel safe at the facility and that no one has made them feel unsafe. Residents expressed that they had not witnessed anything that concerned them . The summary of interviews with staff responsible for oversight and supervision of the location where the alleged victim resides documented, Floor nurse was assisting other residents during the time of the incident and was notified by facilities rehab staff immediately. Nurse informed Abuse Coordinator and DON after ensuring the residents were safe. CNA was informed by rehab staff that [resident 269] was not in room and assisted in locating [resident 269]. Once informed of location of [resident 269], CNA came to [resident 270's] room to assist. [Resident 269] was removed from the room by staff member and CNA stayed with [resident 270]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Exhibit 359 documented that the allegation of sexual abuse was verified by the facility. Exhibit 359 documented the plan for oversight of implementation of corrective action as, [Resident 269] will remain on 1:1 [one on one] with staff member with weekly review to be conducted to assess the effectiveness of current interventions until IDT [interdisciplinary team] finds it appropriate for 1:1 to be weaned off. Interventions planned to assist resident 270 were documented as, no changes in psychosocial baseline was observed per monitoring and frequent visits from social services. [Resident 270] will continue to receive visits from SS as needed. The facility documented steps that have been taken to address the systems as, schedular [sic] notified of need for [resident 269] to have 1:1 with facility staff member. Training being completed as 1:1 comes on shift to re-fresh techniques on de-escalation, re-direction, reporting abuse, and reducing behaviors. Resident 270's medical record was reviewed. Resident 270 started on hospice services on [DATE]. Resident 270's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed that a Brief Interview for Mental Status (BIMS) score was unable to be performed and the resident was noted to be cognitively severely impaired. The MDS for functional status revealed that resident 270 had impairment on both sides for upper and lower extremities. A care plan initiated on [DATE], documented, [resident 270] is at risk for unwanted attention from other residents and has difficulty getting them to go away due to cognitive impairment. The interventions stated, Observe resident's whereabouts closely and encourage resident to be in common areas. Observe whereabouts of any aggressive resident and keep away from at risk resident. Be alert to any changes in resident's mood or attitude which may indicate resident has been subject of aggression. Report any s/sx [signs or symptoms] of abuse including injuries of unknown origin to administrator and/or DON and contact personal representative to update them. Consider a room change to area with better visibility to staff if necessary. On [DATE] at 3:17 PM, an IDT Event Review Note documented, Residents involved in sexually inappropriate conduct .New assessment completed for the need for the specialized unit. Due to decreased mobility and disease progression resident was taken off specialized unit. Ethics committee, hospice and MD agreed to room change. Alert charting initiated for changes from psychosocial baseline, frequent visits from SSW [Social Service Worker] pending investigation. [It should be noted that resident 270 did not have any family or a Power of Attorney to notify of the incident.] On [DATE] at 4:18 PM, a Nurses Note documented, I assessed resident's peri area. There was no redness, swelling or injury noted. On [DATE] at 5:25 PM, a Nurses Note documented, DON called the Medical Director to get orders for the incident. After report of what happened, alert monitoring for changes from psychosocial baseline was initiated. He did not want police to do SAEK [Sexual Assault Evident Kit] d/t [due to] trauma it could cause this resident who is on hospice and no signs of distress or indication of physical incident. Monitor and notify MD of any changes. On [DATE] at 12:00 PM, a Nurses Note documented, I assessed [resident 270] today to see how she is doing in her new room. She has adapted to the change of environment well and staff states there hasn't been any issues at this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident 269's medical record was reviewed. Resident 269's History and Physical Report, dated [DATE], from the hospital prior to being admitted to the facility were reviewed. The document stated, Reportedly he has becoming more and more complicated with his agitation and wandering . Now he is worsening and they [family] have to watch him around-the-clock and concerned about him around little kids due to his agitation and aggression . On [DATE], a BIMS score was completed and resident 269 scored a 0 which indicted severe impairment. Documentation revealed that the facility was aware that resident 269 frequently wandered into other resident rooms prior to the sexual abuse incident. Resident 269's care plan initiated on [DATE], documented, [Resident 269] is an elopement risk/wanderer, r/t [related to] resident tends to wander into other residents rooms. The goal stated, Residents safety will be maintained through the review date. The interventions stated, Assess for fall risk, resident requires a secured unit for safety. Resident 269's care plan initiated [DATE], documented, [Resident 269] is at risk for impaired safety related to Wandering.The goal stated, Will be free from injuries through next review date. The interventions stated, Calmly redirect and cue as needed. Encourage resident to participate in activities of interest as tolerated. Keep environment free from clutter and obstacles to reduce risk of fall or injuries. On [DATE] at 5:17 AM, a 72-Hour Charting Admission Progress Note documented, Pt [patient] needs lots of redirection due to wandering into other pt rooms. A physician's order started on [DATE] at 6:00 PM, stated, Behavior Monitoring: Wandering Document how many episodes of wandering during the shift . It was documented that resident 269 had 10+ episodes on wandering during the night shift on [DATE]. It was documented that resident 269 had 10+ episodes of wandering during the day shift on [DATE]. On [DATE] at 5:15 AM, a 72-Hour Charting Admission Progress Note documented, Pt has been wandering into pt rooms. On [DATE] at 3:17 PM, an IDT Event Review Note documented, Initial IDT to review sexually inappropriate behavior on [DATE]. Residents involved in inappropriate sexual conduct. Residents were separated immediately. The CNA post has been moved to hallway to observe activity in and out of rooms. Behavior tracking has been added. MD notified. SSW to visit resident frequently. Care plan updated. Pending investigation. Resident 269's care plan was updated on [DATE], and documented, [Resident 269] has a history of behaviors that may include: Sexually inappropriate behaviors. The goal stated, Resident will not have sexually inappropriate behaviors . The interventions stated, 1:1 during wake time hours 0600 [6:00 AM]-1800 [6:00 PM] and PRN [as needed] if awake. Administer meds [medications] as ordered, behavior monitor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A physician's order started on [DATE] at 6:15 PM, stated, FLUoxetine HCl [hydrochloride] Capsule 20 MG [milligrams] give 20 mg by mouth one time a day for sexually inappropriate behaviors. The order was discontinued on [DATE]. A physician's order started on [DATE] at 6:00 AM, stated, 1:1 monitoring every day shift. The order was discontinued on [DATE]. On [DATE] at 1:01 PM, an interview with CNA 20 was conducted. CNA 20 stated he was not here during the incident with resident 269 and resident 270. CNA 20 stated that he felt like there were enough staff working on the memory care unit to supervise the residents. CNA 20 stated that there was always someone monitoring the hallways. CNA 20 stated that if the CNAs had to complete a task that would prevent them from watching the hallway, such as a two-person physical assist with transfers or showers, then the CNAs would ask the nurse or pull a CNA from another unit to watch the memory care unit hallway until the CNAs completed their task. On [DATE] at 1:18 PM, an interview with Licensed Practical Nurse (LPN) 2 was conducted. LPN 2 stated she was not here during the incident with resident 269 and resident 270. LPN 2 stated that she believed there were enough staff on the memory care unit to monitor the residents. LPN 2 stated that there was always a CNA watching the hallway. LPN 2 stated that she assisted with watching the hallway if the CNAs had to complete a task that would take them away from watching the hallway. On [DATE] at 9:38 AM, an interview with CNA 18 was conducted. CNA 18 stated that she was working on a different hallway when the incident occurred in the memory care unit with resident 269 and 270. CNA 18 stated that she overheard the therapy team looking for resident 269, and CNA 18 joined the therapy team to search for resident 269. CNA 18 stated the incident occurred between 2:00 PM and 3:00 PM, but could not remember the exact time. CNA 18 stated that one of the therapy employees found resident 269 in resident 270's room. CNA 18 stated that she walked into resident 270's room and saw a staff member helping resident 269 off of the bed. CNA 18 stated that both residents did not have clothes on from the waist down. CNA 18 stated that she helped resident 270 get her clothes back on. CNA 18 stated that she observed resident 270's peri area and did not see any signs of injury or bodily fluid. CNA 18 stated that resident 270 appeared to have some signs of anxiety, which included heavy breathing, slight shaking, and her eyes appeared to be open wide and she looked anxious. CNA 18 stated that resident 269 thought that resident 270 was his wife, and staff helped him get dressed and escorted him out of the room. CNA 18 stated that resident 270 was nonverbal and was unable to walk or transfer out of her bed at the time of the incident. CNA 18 stated that after the incident, resident 269 was on 1:1 monitoring at all times. CNA 18 stated that the memory care unit now has a staff member always monitoring the hallway. CNA 18 stated that the memory care unit would now pull another CNA or staff member to monitor the hallway if the CNAs were too busy to monitor the hallway. CNA 18 stated that she believed there were enough staff to ensure that the memory care unit hallways were being monitored. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 2:58 PM, an interview with CNA 19 was conducted. CNA 19 stated that she was working on the memory care unit when the incident when resident 269 and 270 occurred. CNA 19 stated that at the time there were two CNA's, herself included, and a nurse working on the memory care unit. CNA 19 stated that the incident occurred sometime after lunch, and she, along with the other CNA, were busy cleaning up after lunch, returning items back to the kitchen, and assisting residents into their rooms so they were not monitoring resident 269 when he went into resident 270's room. CNA 19 stated that the last time she observed resident 270 was when he was eating lunch in the memory care unit's dining room, which would have been around 1:00 PM. [It should be noted that resident 269 was found in resident 270's room around 2:30 PM]. CNA 19 stated that when resident 269 arrived at the facility, he would often wander into other resident rooms, including resident 270's room. CNA 19 reported that resident 269 wandered into resident rooms during the day and at night prior to the incident with resident 270. On [DATE], the Administrator (Admin) provided a form with systemic changes completed after the sexual abuse on [DATE]. Immediate Interventions: Immediately, residents were separated, and the abuse investigation was initiated. As part of the immediate actions, the police were notified, CMS [Centers for Medicare & Medicaid Services] was notified. Actions taken to Prevent Recurrence: The resident was placed on 1:1 on [DATE] with the intention to remain until the investigation was complete and interventions could identify how to prevent recurrence. On [DATE], the IDT reviewed the situation and identified that the root cause was that the resident thought (the victim) was his wife. To prevent recurrence, the victim was moved off the unit on [DATE]. On [DATE], As the CMS-Form 359 was nearing completion, an internal meeting was held to review the investigation with the Regional Nurse Consultant, the Director of Clinical Services, the Corporate LCSW [Licensed Clinical Social Worker], the Facility Administrator, and Director of Nursing. The investigation details were reviewed and approved for completion. Systemic Action: On [DATE], the Director of Nursing conducted an in-service with facility staff on Abuse Prevention with a post-test validation. On [DATE], the perpetrator was reviewed weekly by the Behavioral Health Facility Committee to validate interventions were effective and further abuse prevented. On [DATE], Corporate LCSW provided a training with the Social Services Department on Sexual Intimacy in the LTC [Long Term Care] setting, Assessing Capacity to Consent, Care Planning, and appropriate Documentation. Monitoring: A week later, on [DATE] the Corporate LCSW came to the facility and assessed the Perpetrator and reviewed the interventions in place. The resident had been on 1:1 up to that point. Recommendations were made to adjust the interventions as he did not appear to be at high risk to repeat the behavior. CNA Coordinator was given responsibility to round at least twice daily to verify the unit was running smoothly and that staff had the tools they needed to care for the residents. Administrator/Designee held Weekly meetings with CNA Coordinator regarding the flow of the unit, communication, and the competency of the supervising staff on the unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Camera's were set up to enhance visibility in the unit for staff. Computers in the unit were connected to be able to view halls for when CNA's were busy in rooms. QAPI [Quality Assurance and Performance Improvement]: [DATE]: QAPI Meeting, facility reviewed staffing patterns on the unit to validate that there was proper supervision on the unit. Continued Interventions: An investigation was conducted in [DATE], and found that the abuse program was not being run in accordance with facility policy and procedure. Further investigation identified the administrator was not engaged sufficiently in managing the abuse program. The administrator was terminated. A facility manager took over the facility with significant oversight of the RVP [Regional [NAME] President]/Designee. Determination of Compliance Date: The facility believes that substantial compliance from the Sexual Abuse investigation occurred on [DATE] with the completion of the investigation as timely interventions were implemented to prevent recurrence and facility education had been implemented. 30563 2. Resident 17 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance, cognitive communication deficit, unsteadiness on feet, abnormal postures, adult failure to thrive, major depressive disorder, and insomnia. A form 358 was submitted to the SAA revealed on [DATE], there was an allegation of neglect for an elopement. There was no alleged victim's name on the form. A police officer reported to the facility at approximately 11:30 AM, [Initials redacted] was brought back to the facility, full head toe assessment, and resident was moved to the secured unit for wandering, wandering behavior tracking added to electronic medical record as well as 4 x daily safety checks documented on the electronic medical record. Alert monitoring added for changes from psychosocial baseline. The form 359, the follow-up investigation report, revealed resident 17's family was notified on [DATE] at 10:35 AM, of the elopement. The steps taken to investigate the allegation revealed the Assistant Director of Nursing (ADON) interviewed resident 17 and resident 17 did not recall the incident. There were interviews with staff and no one witnessed resident 17 leaving the facility. The receptionist was helping another resident outside and believed that was when resident 17 eloped out the front door. The report further revealed there had been no reports of exit seeking behaviors were noted by staff prior to the event. Resident 17's BIMS score indicated severe cognitive impairment. The conclusion was not verified because there were no indications or reports of elopement, wandering, or exit seeking behaviors prior to the incident that would indicated resident 17 was a risk of eloping from the facility. The systemic changes were facility staff receiving daily education on abuse, specific forms of abuse and extended oversight from management. Resident 17's medical record was reviewed on [DATE] through [DATE]. Resident 17's history and physical prior to admitted d [DATE], revealed that resident had progressively worsening behavioral issues which included frequent wandering, anger outbursts, and today she tried to stab one of her caregivers with a cake icing knife. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	A form titled Admit Report to be completed by Nurse who puts in orders was dated [DATE]. The report details section revealed wandering, every 4 hour checks for 72 hours. An admission MDS assessment dated [DATE], revealed resident 17 had a BIMS score of 7 which indicated severe cognitive impairment. A care plan dated [DATE], revealed [Resident 17] is at risk for impaired safety related to Wandering The goal was [Resident 17] will be free from injuries through next review date. The interventions included Anticipate needs for resident as much as possible; Calmly redirect & cue as needed; Encourage resident to participate in activities of interest as tolerated; Encourage resident to use assistive devices as resident is often noncompliant; Keep environment free from clutter and obstacles to reduce risk of fall or injuries and; Monitor for significant changes in behavior. A physician's order dated [DATE], revealed Resident safety check document yes or no call nursing mngmnt [management] if any issues. four times a day for safety. According to the Treatment Medication Record for [DATE], resident 17 was checked 4 times per day, except at 4:00 PM on [DATE] and [DATE]. It should be noted the admission form revealed to check resident 17 every 4 hours for 72 hours after admission because of wandering. An Admission evaluation for wandering risk scale dated [DATE], revealed resident 17 had a score of 20. The evaluation further revealed resident 17 was able to follow instructions, ambulatory, able to communicate, had a history of wandering, and had medical diagnoses of dementia/cognitive impairment. Resident 17 had wandered within the home without leaving the grounds and had wandered within the past month since admission. Resident 17 was at high risk to wander. Resident 17's nursing progress notes revealed the following: a. On [DATE] at 2:27 AM, Resident is an [AGE] year old female who arrived to facility in a wheelchair via facility transport. Resident was living with grandson and pulled a cake knife on live in caregiver. Resident has had an increase of behaviors recently. Family took resident to hospital for evaluation and treatment. Residents' primary diagnosis for admission is dementia with behaviors. Resident appears to be well dressed and groomed. Bruises noted to BUE [bilateral upper extremities]. A&O [alert and oriented] x1 to self. Resident appears to have sundowning behaviors. She was wandering around nurses' station and hallways. Ambulation with stand by assist- has an unsteady gait. Provided walker and education. Gait improved with walker use. Resident She is very friendly and cooperative with treatment and cares. Resident took HS [at bedtime] trazodone and was able to settle down for bed and sleep well during the night. <b [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, the facility did not develop and implement written policies and procedures that; prohibit and prevent abuse, neglect, and exploitation of residents. In addition, the facility did not established polices and procedures to investigate any such allegations. Specifically, for 4 out of 45 sampled residents, there were residents in the memory care unit that were kissing and did not have a full capacity to consent evaluated. Resident identifiers: 17, 21, 41, and 48. Findings included: The facility provided a form 358 on 2/16/24 at 4:15 PM, to the State Survey Agency (SSA). The form revealed an allegation of sexual abuse. Resident 21 was expressing intimacy with resident 48 with a peck on the lips. The immediate measures were implementing one on one for resident 21 and the physician to assess resident 21 for medication adjustment. The interdisciplinary team (IDT) would establish a new baseline for resident 48 and frequent monitoring from social services. In addition, alert monitoring was implemented for changes in psychosocial baseline. The form 359 was provided to the SSA on 2/23/24 at 10:30 PM. The form revealed the Summary of interviews section that staff concluded resident 21 did not usually approach females in the unit to kiss them. However, resident 17 went up to resident 21 and asked for a kiss. Resident 21 gave her a peck. Resident 41 had sometimes seen this and had requested a kiss from resident 21 as well. Resident 21 had kissed resident 48 occasionally. Staff were able to redirect residents easily. Resident 17 believed that resident 21 was her boyfriend. The allegation was inconclusive Facility is unable to verify or refute the allegation. Throughout the investigation facility did not identify any further physical contact that would raise to the level of inappropriate contact or sexual abuse. Contact between residents consisted of light pecks and very brief contact that did not include sexual activities where one resident indicates that the activity is unwanted through verbal or non-verbal cues. Facility investigation notes no sexual activity, fondling or touching of a persons sexual organs. Facility has intervened as we recognize that this behavior could lead to sexual expression. 1. Resident 17 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance, cognitive communication deficit, unsteadiness on feet, abnormal postures, adult failure to thrive, major depressive disorder, and insomnia. Resident 17's medical record was reviewed on 3/11/24 through 3/21/24. A Minimum Data Set (MDS) assessment titled Other Payment assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A care plan dated 12/13/23, revealed [Resident 17] and a male resident are in a companionship (not married)(hold hands, share a kiss). [Resident 17] has a diagnosis of dementia and been assessed by the MD [Medical Doctor] and IDT to have capacity to consent to holding hands and kissing. The goal was [Resident 17's] psychosocial needs in relation to companionship/holding hands/ kissing will be met safely though review date. Interventions included Reassess resident's capacity for consent to companionship/holding hands/kissing quarterly; Resident at increased risk for potential Abuse related to decreased cognition; Resident will not have unaddressed signs and symptoms of Abuse; Follow Abuse Protocol if Allegations are made; Frequent visits from social services; and Monitor for Behavior Changes. On 12/11/23 at 3:28 PM, Late entry Social Service Note revealed missing part of prog [progress] note MD to assess residents for the ability to consent. Activities informed and requested to provide activities that include meaningful touch. On 12/11/23 at 9:40 AM, a Social Service Note revealed IDT Note In attendance: Admin [Administrator], DON [Director of of Nursing], AIT [Administrator in Training], ADON [Assistant Director of Nursing], WCRN [Wound Care Registered Nurse], RA [Resident Advocate], SSW [Social Service Worker], Activities. IDT met to discuss this resident and another resident kissing. Neither residents were in distress, both residents appeared to engage in the kiss. A Physician's progress note dated 12/12/23 at 4:44 PM, documented Visit type: Acute Visit - . [resident 17] is a [AGE] year old female at [name of facility] . Subjective: Asked to evaluate patient as she has been noted to be mutually kissing another resident recently . Assessment/Plan Disability Weakness Risk of malnutrition Poor memory Wandering . Dementia/Alzheimer's disease with behaviors, . h/o [history of] encephalopathy, PSYCH, Auditory hallucinations, Insomnia .Provider action: I have spoken with the patient to assess her cognition of the situation. He [sic] does have moderate dementia but is able to answer questions appropriately and appears to have a grasp on the situation. She has been friends with the other male resident and it appears he may have a mutual interest. She understands her own moral standards and what she is willing to do. Cognitively she is able to give consent at this time. Will monitor for any change in condition. On 3/13/24 at 10:03 AM, an interview was conducted with Certified Nursing Assistant (CNA) 8. CNA 8 stated resident 17 was independent when she was admitted to the memory care unit. CNA 8 stated weeks later resident 17 needed assistance with cleaning herself. CNA 8 stated resident 17 was a hoarder by picking up stuff and put it into bags. CNA 8 stated resident 17 took food and put it in her clothing. CNA 8 stated resident 17 had a behavioral issue with one of the residents. CNA 8 stated that resident 17 called resident 21 her boyfriend. CNA 8 stated resident 21 did not call resident 17 his girlfriend. CNA 8 stated resident 17 followed resident 21 around. CNA 8 stated resident 17 looked for resident 21 to kiss and she asked resident 21 for kisses. CNA 8 stated resident 21 did not follow her or try to kiss her. CNA 8 stated if resident 21 walked by them, she would follow him and kiss him. CNA 8 stated staff tried to stop resident 17 from kissing resident 21, and then reported it to the nurse. CNA 8 stated she did not feel like they should be doing that. CNA 8 stated the Administrator and DON came and investigated. CNA 8 stated staff were given instruction on how to re-direct resident 17. CNA 8 stated resident 17 was able to ambulate independently. CNA 8 stated If they saw resident 21 heading to the hallway, then they watched her. CNA 8 stated resident 17 was the one that looked for resident 21, resident 21 did not look for resident 17. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 3/13/24 at 10:18 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated resident 17 was pleasant and wandered the secured memory care unit. RN 3 stated resident 17 would stand by the locked doors and pace back and forth because she wanted to get out. RN 3 stated resident 17 was kind of a hoarder, after getting a cup of water, she would put it in a bag and get very upset when staff tried to clean out the bags. RN 3 stated resident 17 took wet briefs and put them inside her bags too. RN 3 stated resident 17 needed verbal cueing for self cares. RN 3 stated resident 17 kissed resident 21 once in a while. RN 3 stated resident 21 didn't mind. RN 3 stated the kiss was on the lips but it was not a romantic kiss it was more like a friend kiss. RN 3 stated staff were educated to deter resident 17 from kissing resident 21. RN 3 stated management was afraid of possible abuse in the future. RN 3 stated she thinks she only saw resident 17 kiss resident 21 once and could not remember what she did after that. RN 3 stated safety checks were initiated and documented on the Medication Administration Record. RN 3 stated the safety checks were for nurses to lay eyes on residents to make sure they were accounted for. On 3/14/24 at 2:24 PM, an interview was conducted with CNA 5. CNA 5 stated the relationship with resident 17 and resident 21 was like a friendship for resident 21. CNA 5 stated there was no instruction to keep the residents apart. 2. Resident 41 was admitted to the facility on [DATE] with diagnoses which included unilateral primary osteoarthritis, type 2 diabetes mellitus, mixed receptive expressive language disorder, unsteadiness on feed, cognitive communication deficit, and Alzheimer's disease with early onset. Resident 41's medical record was reviewed on 3/11/24 through 3/21/24. A quarterly MDS assessment dated [DATE], revealed resident 41 had a BIMS score of 00 which indicated severe cognitive impairment. On 1/31/24 at 7:09 AM, A Physician Progress Note revealed [Resident 41] is a [AGE] year old female at [name of facility redacted] Reason for visit: facility requested evaluation. Subjective: Patient encounter with ADON. Has been observed kissing another resident. Patient mostly focused on some abdominal pain this AM. Does not recall kissing any other residents. Is familiar with the male resident that she was seen kissing. Denies any feelings of being uncomfortable or pressured. States that the abdominal pain is generalized. Passing flatus. Exam: . responds appropriately. H/O [history of] adult sexual abuse.Provider action plan: I have spoken with the patient to assess her cognition of the situation. She has little memory of the events 2/2 dementia but is able to answer questions appropriately and appears to have moral aptitude with the situation. We discussed situations regarding friends, relationships and signs of affection. Cognitively she is able to give consent at this time. Will monitor for any change in condition. 43212 3. Resident 21 was admitted to the facility initially on 8/2/19, and readmitted on [DATE] with diagnoses that included type 2 diabetes with neuropathy, morbid obesity, dementia with behavioral disturbance, and depressive disorder. Resident 21's medical record was reviewed between 3/11/24 and 3/21/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A quarterly MDS assessment dated [DATE], revealed resident 21 had a BIMS score of 8, indicating moderate cognitive impairment. Resident 21's care plan focus area, initiated on 2/16/24, revealed, [resident's name redacted] has expressed a need for physical intimacy, such as kissing other residents. He has a dx [diagnosis] of dementia and does not have the capacity to consent to physical intimacy. The goal was, Residents psychosocial need for physical touch/intimacy will be met safely through review date. Interventions included, Assess resident for unmet needs .Provide resident with physical touch PRN [as needed] from staff by providing gentle hand massage .Involve resident in activities of choice (gather personalized suggestions, items, activities, IDT input .Redirect resident when resident is seeking intimacy/affection from other residents (exercise, pet therapy, hand massage, identify possible unmet need). A physician's order initiated on 2/21/24, included, Behavior monitoring: physical intimacy. Notify Management. On 2/21/24, an IDT: Behavioral Health Review was conducted and revealed that in the past three months resident had been Socially Objectionable by kissing multiple female residents in the unit. The review was marked no to resident 21 having sexually inappropriate behavior. The review is marked yes for resident 21 having a change to medications for behavior health reasons. Additional information included, 1:1 [one on one] with the resident due to abuse allegation. Resident has been taking this well. New interventions included, Meeting with SSW and nurse regarding kissing; 1:1 monitoring; Monitoring on sexually inappropriate behaviors; Med [medication] review; and update care plan on his kissing behavior. Resident 21's progress notes were reviewed and revealed the following: a. On 12/12/23 at 4:43 PM, a physician progress note revealed, Reason for visit: acute; Subjective: Asked to evaluate patient as he has been noted to be mutually kissing another resident recently.Provider action: I have spoken with the patient to assess his cognition of the situation. He does have some mild to moderate dementia but is able to answer questions appropriately and appears to have moral aptitude with the situation. He has been friends with the other female resident and it appears she may have a mutual interest. Cognitively he is able to give consent at this time. Will monitor for any change in condition. b. On 12/13/23 at 3:32 PM, a social service progress note revealed, Note text: IDT Note; In attendance: MD, DON, ADON, LCSW [Licensed Clinical Social Worker], WCRN, SWW [sic], RA . MD has assessed this resident. Rt [resident] is cognitively able to consent at this time. Care plan updated. Will continue to monitor for any changes in condition. c, On 1/26/24 at 5:46 PM, an IDT review note revealed, IDT met to review allegation of sexually inappropriate behavior that occurred on 1/15/24. Other resident was immediately redirected. Resident received frequent visits from social services throughout the investigation. Per the alert charting there were no changes from psychosocial baseline and no lasting effects. Attendees: Administrator, ADON, RA, SSW. [It should be noted that there was no documentation of an event of inappropriate sexual behavior in resident 21's progress notes on 1/15/24.] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	d. On 2/16/24 at 4:37 PM, an IDT review note revealed, IDT to reviewed concern related to Rt and another female resident sharing a peck kiss related to dementia and impaired cognition with inability to safely consent. MD to review medication and adjust appropriately, 1:1 implemented during wake hours. Attendees: ADM, Regional Nurse Consultant, ADON, RA. e. On 2/16/24 at 5:04 PM, a Nurses note revealed, MD ordered to start Depo Provera IM [intramuscular] Q [every] 14 days to help decrease intimate feelings. Family has been notified and approves of the new order. f. On 2/17/24 at 3:32 PM, an Orders-Administration note revealed, Event/alert charting following event, Document every shift until resolved: 1:1 6am-10pm. If resident wakes up during night, staff provide line of site to ensure resident is not seeking physical intimacy, every shift; Resident kissed another resident on the lips. On 3/14/24 at 2:25 PM, an interview was conducted with CNA 8. CNA 8 stated resident 17 was actually the resident who was initiating interactions with resident 21 and he did not reciprocate. CNA 8 stated it was more like a friendship between the two residents and resident 21 was being a gentleman. CNA 8 stated she had not been instructed to keep an eye on any residents or keep any residents apart. On 3/18/24 at 1:00 PM, an interview was conducted with CNA 19. CNA 19 stated resident 17 liked to kiss resident 21 on the lips. CNA 9 stated staff were to do a 1:1 so resident 17 would not kiss resident 21. CNA 19 stated resident 17 was chasing resident 21 and wanted resident 21 to kiss her. CNA 19 stated at first staff thought it was okay. CNA 19 stated since both residents were confused with dementia they were not able to kiss. CNA 19 stated resident 21 and resident 17 had a relationship for about three months. CNA 19 stated she found the residents making out. CNA 19 stated resident 17 and resident 21 kissed on the lips one to two times during her shift. CNA 19 stated resident 17 watched television in resident 21's room. CNA 19 stated resident 21 tried to kiss resident 48 but she refused. CNA 19 stated she tried to re-direct the residents. CNA 19 stated resident 21 had one on one supervision for a couple weeks before resident 17 was discharged . CNA 19 stated resident 41 tried to kiss resident 21. CNA 19 stated resident 41 asked for a kiss from resident 21 and resident 21 would kiss resident 41. CNA 19 stated she re-directed resident 41 when she asked resident 21 to Give me a kiss. CNA 19 stated she re-directed by trying to get the residents minds on other things. CNA 19 stated she saw resident 41 give resident 21 a kiss on the lips a few times. 4. Resident 48 was admitted to the facility initially on 12/21/23, and readmitted on [DATE] with diagnoses that included dementia with agitation, cognitive communication deficit, chronic kidney disease, anxiety disorder, major depressive disorder, Psychotic disorder with delusions, and insomnia. Resident 48's medical record was reviewed between 3/11/24 and 3/21/24. An admission MDS assessment dated [DATE], revealed that resident 48 had a BIMS score of 4, indicating severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Resident 48's care plan included a focus area, initiated on 2/23/24, [resident's name redacted] has expressed a need for physical affection. She has been deemed by the IDT without the capacity to consent to sexual intimacy/expressions r/t [related to] dementia. The goal stated, Residents psychosocial need for physical touch/intimacy will be met safely through review date. Interventions included, Monitor resident's intimacy seeking behaviors to determine a trend, increase or decrease in behavior; Provide resident with physical touch PRN from staff by providing gentle hand massage; Redirect [resident's name redacted] when she is seeking intimacy/affection from other residents (exercise, pet therapy, hand massage, identify possible unmet need). A review of resident 48's progress notes revealed: a. On 1/16/24 at 3:00 PM a physician progress note revealed, Pt was seen by staff kissing another resident. I was asked to evaluate both patients to assess their capacity for safety and awareness, and capacity for such a relationship. While both patients are in our memory care suite, they both appear to understand relationships and have a mutual respect for each other. They do feel safe in their relationship with each other and understand limitations in their relationship at this time. They have the capacity at this time for self determining who they want to be friends with. Both do not feel intimidated or threatened by this relationship and it appears to be a mutual interest. They also understand if they feel any change or feel threatened by the other resident, they can let the staff know for their own safety. Staff will also monitor for any changes and try to maintain safety for each resident. b. On 1/31/24 at 7:08 AM, a Physician Progress Note revealed, Reason for visit: facility requested evaluation .I have spoken with the patient to assess her cognition of the situation. She has poor short term memory due to dementia but is able to answer questions appropriately and appears to have the moral aptitude with the situation. She has been friends with the other male resident. We discussed situations regarding friends and signs of affection. Cognitively she is able to consent at this time. Will monitor for any change in condition. c. On 2/5/24 at 8:48 AM, a Social Service Note revealed, IDT note, in attendance: ADON, WCRN, SSW, RA. MD has assessed this resident on her cognition to be able to consent to kiss another resident. Rt is cognitively able to consent at this time. Care plan updated. Will continue to monitor for any changes. d. On 2/16/24 at 5:41 PM, an IDT event review note revealed, IDT to reviewed concern related to Rt and another male resident sharing a peck kiss related to dementia and impaired cognition with inability to safely consent. Intervention implemented to prevent re-occurrence. Attendees: Admin, Regional nurse consultant, ADON, RA. On 3/13/24 at 12:34 PM, an interview was conducted with RN 3. RN 3 stated she was not aware that there had been any inappropriate interaction between resident 48 and resident 21. RN 3 stated resident 48's behavior was very unpredictable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 3/14/24 at 1:23 PM, an interview was conducted with MD 2. MD 2 stated his process to determine capacity to consent was to talk with the residents. MD 2 stated he tried to gauge the residents orientation and ability to consent using the resident's history and medical background. MD 2 stated his understanding was that the relationship was consensual for both residents. MD 2 stated he did not recall if he asked the nurses if there had been any distressing interactions on the part of either resident. Regarding resident 48, MD 2 stated she had short term memory issues, but was able to talk about having friends and partners, and was able to discuss hypothetical's for the ability to say yes or no. MD 2 stated if the facility staff were made aware of relationships starting, that included touching or signs of affection, he would be contacted to assess the capacity of the residents. MD 2 stated kissing on the lips meant different things to different people. MD 2 stated that capacity also depended on what might be going on with a resident at the time, such as having a urinary tract infection or other medical issues that may affect cognition. MD 2 stated his instructions for staff would be given verbally while at the facility, or an order would be put into the system. On 3/14/24 at 2:30 PM, an interview was conducted with the SSW. The SSW stated the process for determining the ability to consent was that if there were two residents showing affection toward each other, the staff would notify the physician and both residents were assessed. The SSW stated after the MD assessed the residents, the IDT would meet to review the physician assessment and discuss based on staff observation and knowledge. The SSW stated other factors taken into consideration were the resident's cognitive assessment and BIMS score. The SSW stated the physician deemed that resident 17 was able to have the capacity to consent to a sexual relationship. The SSW stated cognitive assessments and BIMS scores were reviewed. The SSW stated resident 17's BIMS score was a 7, which indicated severe cognitive impairment. The SSW stated she did not remember if the IDT reviewed resident 17 and resident 21's capacity to consent to a sexual relationship and was not sure if the residents had the capacity. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 3/14/24 at 3:23 PM, an interview was conducted with the DON and the Regional Nurse Consultant (RNC). The RNC stated capacity to consent was evaluated through assessments and using the BIMS score. The RNC stated that the physician determined if the a resident was able to have the capacity to consent to a sexual relationship. The RNC stated resident 17 was a cute lady and she went up to resident 21 and would give him a peck on the lips. The RNC stated resident 17 gave resident 21 a peck on the cheek like you would give your mom but it was on the lips. The RNC stated neither resident expressed they wanted to be boyfriend and girlfriend. The DON stated that they had talked about the relationship with the previous DON and the physician was going to assess the relationship. The RNC stated the physician approved the capacity to consent, but after talking with the SSA, there was guidance from the regulations that it was not appropriate. The RNC stated initially the facility did what the physician told them to but then re-evaluated the situation and decided to change care plans and manage it differently. The RNC stated resident 17 was from Hawaii and that was part of her culture to kiss on the lips. The RNC stated the IDT felt resident 17 and resident 21 were able to consent to a friendship relation without inappropriate touching or sexual touching. The RNC stated when resident 17 asked for a kiss from resident 21, resident 48 wanted one also. The RNC stated initially the staff thought that resident 21 was the person initiating the interaction, however, after putting resident 21 on 1:1 monitoring, staff found out that he was not the resident initiating, so they swapped the 1:1 monitoring to the female resident. The RNC stated staff would report what was happening. The RNC stated interventions that were put into place included 1:1 monitoring, education with staff as to what was and was not appropriate, education that interactions that were sexual in nature could be considered abuse among residents that have dementia, and encouraging the activities staff to include more meaningful activities that include touch. The DON stated care planning was completed during the IDT meetings. The DON stated during the meeting staff would also brainstorm as to other ways the needs of the residents could be met. On 3/19/24 at 8:39 AM, an interview was conducted with the Administrator. The Administrator stated she was not the Administrator when resident 17 and resident 21's relationship started. The Administrator stated the RNC was with the Administrator when she found the note that residents had kissed. The Administrator stated she provided training about inappropriate behaviors and about how if resident's did not have the capacity to consent it could be abuse. The Administrator stated the clinical team was in charge of determining capacity to consent to a sexual relationship. The Administrator stated the physician was also involved in determining capacity. The Administrator stated if staff were unable to track psychosocial baseline, unable to determine if they could be effected by it then We can't say they have that capacity. On 3/19/24 at 10:10 AM, an interview was conducted with MD 1. MD 1 stated he obtained information about the ability to consent by chatting with the resident to get an idea of what their cognition was like. MD 1 stated he was told there was an issue with residents on the memory care unit kissing other residents. MD 1 stated he wanted to make sure the residents had the ability to consent for something like that. MD 1 stated he was not asked about giving directions if the relationship progressed. MD 1 stated that he asked resident 21 if he felt he was being taken advantage of and resident 21 stated that he did not. MD 1 stated he did not go as far as asking who was initiating the relationship. MD 1 stated he did not feel hallucinations were involved and the residents had no intention of going further than kissing. MD 1 stated he was unaware of any cultural norms that were held by any of the residents regarding kissing. MD 1 stated he did not inquire about time limitation issues from the residents. MD 1 stated he did not have any concerns about resident 48's history of aggression or level of cognition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The facility policy and procedure for Identifying Sexual Abuse and Capacity to Consent dated September 2023 revealed the following: Policy Statement A resident's consent to sexual activity is not valid if obtained from a resident who lacks the capacity to consent, or if consent was obtained through intimidation, fear or coercion. Policy Interpretation and Implementation 1. 'Sexual abuse' is non-consensual sexual contact of any type with a resident, as defined at 42 CFR S483.5. Sexual abuse includes, but is not limited to: a. unwanted intimate touching of any kind especially of breasts or perineal area; b. all types of sexual assault or battery, such as rape, sodomy, and coerced nudity; c. forced observation of masturbation and/or pornography; and d. taking sexually explicit photographs and/or audio/video recordings of a resident(s) and maintaining and/or distributing them (e.g. posting on social media). This would include, but is not limited to, nudity, fondling, and/or intercourse involving a resident. 2. Generally, sexual contact is non-consensual if the resident either: a. appears to want the contact to occur, but lacks the cognitive ability to consent; or b. does not want the contact to occur. 3. Other examples of nonconsensual sexual contact may include, but are not limited to, situations where a resident is sedated, is temporarily unconscious, or is in a coma. 4. Any forced, coerced or extorted sexual activity with a resident, regardless of the existence of a pre -existing or current sexual relationship, is considered to be sexual abuse. 5. The facility will conduct an investigation and protect a resident from non-consensual sexual relations anytime there is reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent. 6. Not all physical contact involving a resident is considered sexual abuse. Residents have the right to engage in consensual sexual activity and to receive non-sexual physical contact consistent with their preferences. 7. Sexual abuse may occur as: a. staff-to-resident sexual abuse; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	b. resident-to-resident sexual abuse; c. spouse-to-resident sexual abuse; or d. visitor-to-resident abuse. 8. Except in the rare situation in which an employee and a resident had a pre -existing sexual relationship (i.e. , spouse or partner) prior to the resident's admission, engaging in a sexual relationship with a resident, (even an apparently willingly engaged and consensual relationship) is not consistent with the staff member's role as a caregiver and is prohibited. 9. Any sexual relationship between a staff member and a resident with or without diminished capacity may constitute sexual abuse in the absence of a sexual relationship that existed before the resident was admitted to the facility, such as a spouse or partner, and will be thoroughly investigated. Indicators of Potential Sexual Abuse 1. Physical indicators of sexual abuse that would prompt an investigation include (but are not limited to): a. bruises around the breasts, genital area, or inner thighs; b. unexplained sexually transmitted disease or genital infections; c. unexplained vaginal or anal bleeding; and/or d. torn, stained, or bloody underclothing. 2. Psychosocial indicators of sexual abuse may include: a. depression; b. anxiety; c. post-traumatic stress disorder; d. sudden or unexplained changes in behaviors and/or activities, such as: (1) fear or avoidance of a person or place; (2) fear of being left alone; (3) fear of the dark; (4) nightmares; and/or (5) disturbed sleep. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Investigating an Allegation of Suspicion of Sexual Abuse 1. For any alleged violation or suspicion of sexual abuse, protective measures and an investigation (pursuant to 42 CFR S483.12 (c)(1)-(4), F609-Reporting of Alleged Violations and F610-Response to Alleged Violations) will begin immediately. These include: a. immediately implementing safeguards to prevent further potential abuse; b. immediately reporting the allegation to appropriate authorities; c. conducting a thorough investigation of the allegation, including the resident's capacity to consent; and d. thoroughly documenting and reporting the result of the investigation of the allegation. 2. During the investigation evidence will be preserved and not tampered with. Examples of tampering include, but are not limited to: a. washing linens or clothing; b. destroying documentation; c. bathing or cleaning the resident until the resident has been examined (including a rape kit, if appropriate); or d. otherwise impeding a law enforcement investigation. 3. The director of nursing services (or designee), in conjunction with the administrator and the QAPI [Quality Assurance and Performance Improvement] committee will determine the facts specific to the case, including: a. whether the resident consented to the sexual activity; and b. whether the resident had the capacity to consent. (1) Determination of capacity is not based on a diagnosis alone. It is evaluated within the context of the situation. (2) Capacity on its most basic level means that a resident has the ability to understand potential consequences and choose a course of action for a given situation. (3) Decisions of capacity to consent to sexual activity balance considerations of safety and resident autonomy, and capacity determinations must be consistent with State law, if applicable. Resident Representatives' Scope of Authority 1. While a legal representative may have been empowered to make some decisions for a resident, it does not mean that the representative is empowered to make all decisions for the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	a. The individual arrangements for legal representative will be reviewed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on observation, interview, and record review, the facility did not provide necessary services to maintain good nutrition for a resident who was unable to carry out activities of daily living. Specifically, for 1 out of 45 sampled residents, a resident that required assistance with eating waited 35 minutes to get assistance by staff after the meal was served to the resident. Resident identifier: 29. Findings included: Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included myasthenia gravis without (acute) exacerbation, displaced fracture of surgical neck of right humerus, moderate dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and type 2 diabetes mellitus with diabetic neuropathy. On 3/14/24 at 11:44 AM, an observation was made of resident 29. Resident 29 was observed to be served their lunch tray. The plate was observed to be placed on the bedside table located to the right side of resident 29 with a dome over plate. At 3/14/24 at 12:04 PM, an observation was made of the Certified Nursing Assistant (CNA) Coordinator and CNA 3 entering resident room [ROOM NUMBER] and asked resident 29, how he was doing, then exited the room. At 3/14/24 at 12:17 PM, an observation was made of the Dietary Manager (DM) entering resident room [ROOM NUMBER]. At 3/14/24 at 12:19 PM, an observation was made of the DM talking to resident 29 stating, I came down here to talk with you and noticed you haven't started eating, so I can talk to you and help you. On 3/14/24 at 12:29 PM, an observation was made of resident 29 stating to the DM, This isn't the first time I have been bypassed for lunch. Resident 29's medical record was reviewed on 3/11/24 through 3/22/24. An Optional State Minimum Data Set (MDS) assessment dated [DATE], revealed that resident 29 had a Brief Interview of Mental Status score of 10 which indicated moderately impaired cognition. The MDS revealed resident 29 needed extensive assistance with one person physical assistance for eating. A care plan initiated on 7/31/22 and revised on 1/3/24, revealed a Focus of [Resident 29] has an ADL [Activities of Daily Living] self -care performance deficit r/t [related to] weakness, impaired mobility, pain, cognitive impairment DX [diagnoses]: Myasthenia Gravis, OA [osteoarthritis], Fx [fracture] R [Right] humerus, Dementia, Carpal tunnel The goal was [Resident 29] will maintain current level of function in ADLS through the review date. One of the interventions revealed EATING: The resident requires supervision to physical 1 staff assistance. On 03/14/24 at 12:51 PM, an interview with the DM was conducted. The DM stated that she came to visit resident 29 and noticed he had not been fed and took the opportunity. The DM stated she was unsure how the CNAs handle the order of the four residents on North and South Rehab halls that require feeding assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/24 at 12:57 PM, an interview with resident 29 was conducted. Resident 29 stated, He is the outlier for the feeders. Resident 29 also stated He often waits for them to find someone to come feed him. On 3/20/24 at 10:45 AM, an interview was conducted with CNA 4. CNA 4 stated that the CNA assigned to the floor was designated to assist residents with feeding. CNA 4 stated he would wait until the end of the hall's meal pass to serve those requiring assistance with feeding. CNA 4 stated once the tray was taken into a resident's room, he would set up the meal and assist the resident with feeding. If a hall does not have any assisted feedings, the CNA was to help any other residents needing assistance. On 3/20/24 at 12:26 PM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that she expected immediate feeding of residents after being serviced their food tray. The CNA Coordinator stated she had trained the CNAs to pass out food trays then go to the rooms to do any assisted feeding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice. Specifically, for 1 out of 45 sampled residents, a resident was admitted to the facility on hospice and was not assessed upon admission, provided the appropriate medications, and was not transferred until the following day to the memory care unit after family requested. Resident identifier: 119. Findings included: Resident 119 was admitted to the facility on [DATE] with diagnoses which included sarcopenia, blindness, hypertension, and cardiovascular disease. On 3/11/24 at 11:18 AM, an interview was conducted with resident 119's family member. Resident 119's family member stated resident 119 did not receive her blood pressure medications because there was some confusion about them when she was admitted . Resident 119's family member stated she asked to have resident 119 moved to the memory care unit and she was not moved till the following day. Resident 119's medical record was reviewed on 3/11/24 through 3/21/24. A form titled Medication Profile dated 2/12/24 through 5/11/24, revealed current medications: a. Abilify Oral Tablet 2 mg (milligram) once daily. b. Promethazine Hydrochloride (HCL) oral tablet 25 mg every 6 hours as needed. c. Acetaminophen Rectal Suppository 650 mg every 6 hours as needed d. Bisacodyl Rectal Suppository 10 mg daily as needed e. Hyoscyamine Sulfate sublingual tablet 0.125 mg every 4 hours as needed f. Lorazepam oral concentrate 2 mg/ml (milliliter) every 2 hours as needed g. Morphine Sulfate 20 mg/ml. Give 1 syringe orally every hour as needed. It should be noted there was no blood pressure medication listed. A form from resident 119's hospice titled Physician telephone order dated 3/1/24, revealed the following medications: a. Losartan Potassium 50 mg once daily b. Metoprolol 100 mg once daily at 7:00 PM c. Calcium 1000 mg once daily at 7:00 PM (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Lorazepam 2 mg/ml (.05 ml) four times a day e. Crush medications as needed It should be noted the Metoprolol did not have the form needed. Resident 119's physician's ordered medications in the medical record were: a. On 3/1/24, Acetaminophen Rectal Suppository 650 mg every 6 hours as needed b. On 3/1/24, Bisacodyl Rectal Suppository 10 mg every 24 hours as needed c. On 3/1/24, Hyoscyamine Sulfate 0.125 mg every 4 hours as needed d. On 3/1/24, Morphine Sulfate 20 mg/ml .25 ml every hours as needed e. On 3/1/24, Promethazine HCL 25 mg every 6 hours as needed. f. On 3/3/24, Metoprolol Tartrate 100 mg at bedtime g. On 3/3/24, Cozaar (Losartan Potassium) 50 mg at bedtime. Nursing progress notes revealed the following: a. On 3/1/24 at 10:25 PM, I received nurse to nurse on [resident 119]. [Resident 119] is a 97 yof [year old female] with vascular dementia confused and delirious. She is DNR [Do Not Resuscitate] with comfort cares. She is minimally responsive and only responds to noxious stimuli she is not eating or drinking. normally she is independent however She had a change in condition today. No recent falls. They have ordered a cxr [chest x-ray], ua [urine analysis] c/s [culture and sensitivity]. Her diet is advance as tolerated. No foley not continent. Normally she walks with a walker but was super weak today, new onset. She does not have any wounds. She is extremely hard of hearing and legally blind. Daughter will bring her meds [medications] and meet her at the facility. b. On 3/3/24 at 6:44 PM, This order is outside of the recommended dose or frequency. Metoprolol Tartrate Oral Tablet 100 MG Give 1 tablet by mouth at bedtime for HTN [hypertension] - The frequency of daily is below the usual frequency of 2 to 4 times per day. c. On 3/3/24 at 6:45 PM, New order received from hospice. 1. Metoprolol 100 mg 1 tablet po [orally] every evening. 2. Losartan 50 mg 1 tablet po every evening. 3. Calcium 600 with Vitamin D po 1 tablet every evening. Resident's daughter brought in medications. d. On 3/4/24 at 6:04 PM, Received order from Hospice for Lorazepam to be PRN [as needed] rather than scheduled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 3/5/24 at 3:17 AM, . Focused Assessment: Resident takes meds whole, incontinent of bowel and bladder, requires extensive 1 person assist with ADLs [activities of daily living] and transfers. Adjustment to Admission: Resident appears to be adjusting well Pain Management: No c/o [complaints of] pain Mental Status/Behavior: Alert and oriented to self, restless at times, especially when brief is wet, staff checks on resident frequently. Improvement/Decline: Stable. f. On 3/8/24 at 2:47 PM, Ra [Resident Advocate], Admission, and Admin [Administrator] met with family to discuss concerns. Family is concerned about the level of care family member requires and the level of care rt [resident] is receiving. After discussing and resolving concerns it was decided that rt may be a good candidate for the specialized unit to provide more structure and support for resident. Daughter was able to tour the unit and expressed that she does believe that it will be a good fit for her loved one. g. On 3/9/24 at 10:30 PM, Resident transferred to Rm. [room] 217-2 'Cambridge' Wing with all personal belongings (Dtr. [daughter] aware) & report given to Nurse on Duty. h. On 3/11/24 at 2:33 AM, Patients medications are not on hand, only medications on hand are pain medications. The March 2024 Medication Administration Record (MAR) was reviewed. Resident 119 was not administered medication on 3/1/24 or 3/2/24. The following was revealed: a. Lorazepam 2 mg/ml, give 0.5 ml by mouth three times a day was refused by resident on 3/2/24, 3/3/24, and 3/4/24, twice daily and was administered once daily those days. b. Metoprolol Tartrate 100 mg by mouth at bedtime was administered 3/3/24, 3/4/24, 3/5/24, 3/7/24, 3/8/24, 3/9/24, and was refused on 3/6/24 and 3/10/24. c. There was no Abilify listed d. Cozaar (Losartan Potassium) 50 mg by mouth at bedtime was administered 3/3/24, 3/4/24, 3/5/24, 3/7/24, 3/8/24, 3/9/24, and was refused on 3/6/24 and 3/10/24. The Admission Assessments were unlocked on 3/5/24, and were blank. On 3/12/24 at 10:26 AM, an interview was conducted with the hospice Registered Nurse (RN). The hospice RN stated when she visited a resident she talked to the facility nurse. The hospice RN stated that she had not provided the facility any paperwork except for a form titled physician's telephone order. The hospice RN stated resident 119's family stated that she brought bottles of Metoprolol and Losartan to the facility nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 2:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated when a resident was admitted , the DON, Assistant Director of Nursing (ADON), or the Regional Nurse Consultant (RNC) received the nurse to nurse report and admission orders. The DON stated the floor nurse completed the admission process. The DON stated the nurse completed an admission note, assessments, and admitting vital signs. The DON stated the nurse managers completed a 48 hour admission check list to make sure it was all done. The DON stated resident 119 was an after hours admission from an Assisted Living Facility. The DON stated she received the nurse to nurse report from the hospice nurse. The DON stated the medications were sent in an e-mail. The DON stated she entered the medications into the resident's medical record on 3/1/24. The DON stated the next day there were medications that were entered and home meds that they wanted her to have later. The DON stated she did not know what the medications were that the family wanted. The DON stated the floor nurse informed her that there were more medications. The DON stated she instructed the floor nurse to call the hospice company and get order clarification. The DON stated I believe I got a hold of the hospice company regarding medications. The DON stated the family wanted to bring in a pill box and the floor nurse told family she needed actual orders from hospice for the medications. On 3/20/24 at 11:48 AM, a follow-up interview was conducted with the DON. The DON stated the telephone orders on 3/1/24, were different from the ones put into the computer and emailed to the facility. The DON stated an email provided on 3/1/24 at 10:15 PM, from the hospice company revealed different physician's orders than were in the medical record. The DON stated if the hospice nurse was onsite, then verbal order could be entered and then orders could be send to the facility. The DON stated facility nurses could call the hospice nurse. The DON stated if a resident did not receive the correct blood pressure medications, then a resident blood pressure could increase. On 3/20/24 at 11:58 AM, an interview was conducted with ADON 1. ADON 1 stated she was e-mailed a medication list. ADON 1 stated the medication was Metoprolol Succinate. On 3/20/24 at 12:04 PM, an interview was conducted with the RNC. The RNC stated she did not know the difference between Metoprolol Tartrate verses Metoprolol Succinate because she was not a physician or pharmacist. The RNC stated after googling the medications the Tartrate was an immediate release or short acting. The RNC stated the Succinate was an extended release. A notice of room change was completed on 3/8/24. Resident with impaired cognition alert and oriented to self. Behaviors identified were nursing services and social services. Resident is a good candidate for resident on special care unit. There was no information regarding a hospice plan of care or what services resident 119 had received from hospice in resident 119's medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 10:26 AM, an interview was conducted with the hospice RN. The hospice RN stated there was no orientation when she entered the facility. The hospice RN stated she was not aware that resident 119 had moved and was looking throughout the facility for her. The hospice RN stated the on-call nurse was notified the facility did not have medications for her in stock. The hospice RN stated hospice nurses left a form titled physician's orders when there was a change to orders. The hospice RN stated she was unable to get Ativan scheduled at specific times because the nurse told her the facility would administer it at 6:00 AM, 10:00 AM, and 8:00 PM. The hospice RN stated she wanted Ativan scheduled at 10:00 PM, 4:00 AM, and 12:00 PM, so resident 119 would not be to tired during meal times if she wanted to eat. The hospice RN stated she usually talked to the nurses but has not provided any paperwork. The hospice RN stated at other facilities there was a book that she was able to sign and put any information regarding the resident when she visited. The hospice RN stated she was not sure if there was a coordination of care completed. On 3/12/24 at 2:48 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated when a resident received hospice services she had a phone number for the nurse. LPN 2 stated the hospice nurse would usually tell the nurse they were at the facility. LPN 2 stated the hospice nurse could leave signed or faxed physician's orders. LPN 2 stated usually hospice would let staff know what days they would provide showers. LPN 2 stated hospice provided the emergency kits and physician's orders. LPN 2 stated she was not aware if hospice staff left paperwork. On 3/20/24 at 10:01 AM, an interview was conducted with the RA. The RA stated resident 119's family member approached the RA because she was concerned about resident 119's level of care. The RA stated resident 119's family member felt there was not enough care and structure. The RA stated she discussed the memory care unit and let her tour it. The RA stated the memory care unit was more structured for residents with dementia. The RA stated resident 119 was upset that resident 119 was in someone else's clothing. The RA stated there was not a grievance completed for resident 119. The RA stated the situation could have been a grievance and should have followed the grievance procedure. On 3/20/24 at 10:10 AM, an interview was conducted with the Administrator. The Administrator stated that resident 119's family member wanted more structure in her day and making sure she was up for every meal and attending activities. The Administrator stated that staff were able to get resident's up for meals better in the memory care unit. The Administrator stated when resident 119 was admitted , she discussed the struggles resident 119 was having with the family member. The Administrator stated resident 119's family member stated that resident 119 was in the wrong clothing and her chest was exposed. The Administrator stated resident 119 was covered with a blanket when she saw her. The Administrator stated there were a few buttons that were buttoned and some that were not under the blanket. The Administrator stated she could not recall if she asked the RA to write a grievance. The Administrator stated it would have been good to have a grievance for a situation like this. The Administrator stated the Social Services came into the facility to move resident 119 to the memory care unit. The Administrator stated that resident 119 was not moved till the following day because they like to give 24 hour notice before moving. The Administrator stated usually when a resident was admitted with hospice services, the hospice staff communicate with the nursing staff. The Administrator stated the hospice company was to provide notes for the residents medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 11:48 AM, an interview was conducted with the DON. The DON stated the hospice company faxed or emailed notes to the facility. The DON stated she was not sure how often notes should be sent to the facility. The DON stated hospice staff verbally communicate with the staff. The DON stated the telephone order on 3/1/24, were different from the ones put into resident 119's medical record. The DON stated the physician's orders matched her comfort medications. The DON stated if the hospice nurse was onsite, verbal physician's orders were entered into the medical record and then orders could be send over. The DON stated nursing staff can call the hospice with concerns. The DON stated if there were newer employees that have not worked with us before. On 3/20/24 at 12:31 PM, a follow-up interview was conducted with the DON. The DON stated that the admission assessments for resident 119 were blank but she remembered completing them on 3/5/24, with the floor nurse. The DON stated she was not sure why they were blank. The DON stated the Admission assessments should have been completed on 3/1/24, when resident 119 was admitted but she was admitted after 10:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 33215 Based on observation, interview, and record review, 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, for 11 out of 45 sampled residents, a resident that had several falls and did not always have preventative interventions in place after each fall sustained a closed head injury, sacral insufficiency fracture, nasal fracture, and a laceration of the nose. The resident had two additional falls and sustained a laceration that required stitches to the head and a laceration that required staples to the back of the head. In addition, a family member found medications in a resident room on the floor and the bathroom and there were hot water temperatures in resident bathrooms. Resident identifiers: 2, 14, 15, 23, 25, 31, 40, 48, 60, 62, and 170. Findings included: 1. Resident 170 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, bilateral primary osteoarthritis of knee, repeated falls, Alzheimer's disease, and dementia with other behavioral disturbance. Resident 170's medical record was reviewed on 3/14/24. A care plan Focus initiated on 11/20/18, documented [Resident 170] is at risk for falls r/t [related to] impaired gait/balance, decreased safety awareness, short term memory deficits related to Alzheimer's dementia. The care plan interventions included: a. Resident needs a safe environment with: adequate, glare-free light; a working and reachable call light, and personal items within reach. Date Initiated: 11/20/18. b. Ensure that resident 170 was wearing appropriate footwear when ambulating or mobilizing in wheelchair. Resident walks hallways in non skid socks per her preference. Date Initiated: 11/20/18. c. Physical Therapy (PT) to evaluate and treat as ordered or as needed (PRN). Date Initiated: 11/20/18. d. Anticipate and meet resident 170's needs. Date Initiated: 4/21/19. e. Follow facility fall protocol. Date Initiated: 4/21/19. f. Be sure resident 170's call light was within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 4/21/19. g. Educate the resident, family, and caregivers about safety reminders and what to do if a fall occurs. Date Initiated: 4/21/19. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	h. Encourage resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Date Initiated: 4/21/19. i. Physical therapy to screen resident for services. Date Initiated: 6/23/20. j. Night light to be placed in resident 170's room to help her see at night. Date Initiated: 7/31/20. k. Make sure resident 170 was not ambulating with sheets in her arms to address her fall risk. Date Initiated: 11/7/22. l. Replace resident 170's non-skid socks weekly on Wednesday and whenever needed. Be sure to throw away the old pair when placing the new pair. Date Initiated: 11/7/22. m. Assist resident in ambulating and maneuvering the halls via walking or wheelchair. Date Initiated: 1/23/23. n. Put on falling star program 3/18/23. Ensure resident 170 was positioned correctly in chair. Date Initiated: 3/12/23. o. Resident is a high fall risk. Staff to increase checks for safety. Date Initiated: 5/5/23. p. Staff to encourage rest periods in bed after meals and activities. Date Initiated: 5/5/23. q. Staff to offer assistance first with this resident in the morning getting up and ready to prevent falls. Date Initiated: 5/5/23. r. Add dycem to wheelchair. Date Initiated: 7/26/23. s. Staff to frequently check on resident and offer assistance as resident allows. Date Initiated: 7/31/23. t. Encourage frequent rest periods to prevent fatigue and falls. Date Initiated: 8/1/23. u. Staff to frequently check on resident to ensure safety. Date Initiated: 8/18/23. v. Ensure resident has non skid socks that are adequate. Date Initiated: 8/21/23. An annual Minimum Data Set (MDS) assessment dated [DATE], documented that resident 170 did not have a Brief Interview for Mental Status (BIMS) score completed due to rarely or never understood. On 9/30/23 at 6:55 AM, a Fall Incident Report documented Nursing Description: Pt [patient] was found lying on her back, tilted slightly to her right, on the floor at the foot of her roommate's bed at 0655 [6:55 AM]. Pt mumbled about going to the bathroom. The Pt was examined for injuries prior to being lifted by the RN [Registered Nurse] and the CNA [Certified Nursing Assistant] into her wheelchair. No injuries, bruising or skin tears were found. Pt was given assistance in the bathroom by the CNA and the RN started vital signs and neuro [neurological] checks immediately. Resident Description: Pt is unable to answer questions or acurately [sic] articulate what happened. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	[Note: No new fall interventions were implemented.] On 9/30/23 at 8:53 PM, a Fall Incident Report documented Nursing Description: Unwitnessed fall. Pt was found lying on the floor of her bedroom at the foot of her roommate's bed. The pt was in her sleeping clothes and bare feet. She mumbled that she was going to the bathroom. She was immediately examined for injuries. No injuries found. Resident Description: Pt is unable to answer questions or acurately [sic] articulate what happened. [Note: No new fall interventions were implemented.] On 9/30/23 at 9:06 PM, a Nurses Note documented Note Text: Pt had an unwitness [sic] fall in her bedroom this morning. No visible injuries were found upon examination. VS [vital signs] and neuro checks were started immediately per protocol. Pt went on to eat breakfast with no s/s [signs or symptoms] injury. On 9/30/23 at 9:13 PM, a Fall Incident Report documented Nursing Description: Pt was sitting in her wheelchair in the Day room watching a movie with the other residents at 1700 [5:00 PM]. The locks were on her wheelchair and she was wearing blue anti-skid socks. The pt suddenly [sic] stood up from her wheelchair and took approx [approximately] 2 steps when she lost her balance and fell . The pt landed on the right side of her body bumping the right side of her head on the tile floor. She did not use her hands or arms to break her fall. The RN was at the nurse's cart and ran over to the pt when she saw her fall. The pt was examined and lifted back into her wheelchair by the RN and the CNA. The pt was further examined and found to have a pink swollen area on the right side of her head about the size of a silver dollar. Ice was promptly applied to the swelling area and neuro checks were started per protocol. The pt was unable to acuratley [sic] articulate what happened or if she had any pain anywhere. Resident Description: Resident Unable to give Description. On 9/30/23 at 9:39 PM, a Nurses Note documented Note Text: Pt was sitting and watching a movie in the Day room with other residents when she decided to get out of her wheelchair and ambulate independently. The RN was at the other side of the room at the nurse's cart and heard the pt. fall. RN immediately ran overto [sic] the pt. Pt was examined and lifted by the RN and the CNA into her wheelchair. THe [sic] RN further examined the pt and found her to have a pink swollen area on the right side of her head where the pt landed on the floor. An ice pack was promptly applied to the swollen area. Vital signs were taken and neuro checks were started promptly per protocol. No other injuries, skin tears or bruising were observed. Pt ate dinner without incident. Close monitoring continued. [Note: No new fall interventions were implemented.] On 10/1/23 at 3:32 PM, a Nurses Note documented Note Text: Resident had a fall near the sink in the day room. she has a severe gash that is bleeding on her nose and is bleeding from the mouth. Sending to [name of hospital redacted]. Notified MD [Medical Director]. On 10/1/23 at 4:02 PM, a Fall Incident Report documented Nursing Description: Resident was found on her stomach near the sink in the lounge. Resident Description: Resident has a gash on her nose and is bleeding from her mouth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/1/23 at 9:33 PM, a Nurses Note documented Note Text: Pt returned from [name of hospital redacted] via EMS [Emergency Medical Services] @2115 [9:15 PM] on a stretcher. Pt was placed in her bed as she was very tired. Vital signs were BP [blood pressure] 156/91, RR [respiratory rate] 16, HR [heart rate] 96, 02 [oxygen] 94% on room air and temp [temperature] was 97.7 [Fahrenheit]. No concerns to be noted at this time. Pt resumed on neurochecks for head injury and fall and pt current neuro status is at baseline for this pt. On 10/2/23 at 5:30 AM, a Nurses Note documented Note Text: Pt returned from hospital ER [emergency room] 10/1/2023 @2115 with the following diagnosis. Closed Head Injury, Sacral Insufficiency fracture, nasal fracture and a Laceration of nose. Pt has orders to follow up with her regular provider. MD was notified. On 10/2/23 at 9:14 AM, an Interdisciplinary (IDT) Event Review documented IDT Review: IDT to review fall on 9/30/23 at 0655, 2053 [8:53 PM], 2113 [9:13 PM], 10/1/23 at 1602 [4:02 PM]. Falls resulted from failed self-transfers. Interventions-Kardex updated with restlessness when sleepy. Will discuss with MD about appropriateness for hospice. A care plan Focus initiated on 10/2/23, documented [Resident 170] has nasal and sacral fracture r/t Fall. The Interventions initiated on 10/2/23, included: a. Anticipate and meet needs. Be sure call light was within reach and respond promptly to all requests for assistance. [Note: This intervention was a repeat intervention initiated on 4/21/19.] b. Specialty mattress for comfort. [Note: Two of resident 170's falls were located in the Dayroom where the resident would not have had access to a call light or the specialty mattress. No new fall interventions for safety were implemented.] On 10/9/23 at 2:55 PM, an IDT Event Review documented IDT Review: IDT to review fall with major injury on 10/1 [24] at 16:02. After completing investigation, items reviewed that staffing was found to be appropriate. Resident fell due to poor safety awareness and continuing to ambulate without assistive devices. Facility to review appropriateness for hospice. On 10/15/23 at 4:56 PM, a Nurses Note documented Note Text: Resident was found on the floor scooting away from her bed where she was laid in. Transferred to wc [wheelchair] and assessed for pain and injury. It does not appear she was injured. Started neuros. Notified ADON [Assistant Director of Nursing], MD, and family. Left VM [voicemail] for family. The care plan Interventions included: a. Ensure bed is in lowest position. Date Initiated: 10/15/23. [Note: This intervention was a repeat intervention initiated on 4/6/23.] b. Walk to dine with gait belt. Date Initiated: 10/16/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 10/16/23 at 9:23 AM, an IDT Event Review documented IDT Review: IDT to review unwitnessed fall on 10/15 [24] at 1654 [4:54 PM], residence found in her room on floor. Intervention: Continue with OT [Occupational Therapy]. Walk to dine with gait belt. Continue with plan of care. Least restrictive interventions in place. On 10/28/23 at 3:05 PM, a Fall Incident Report documented Nursing Description: Patient sled [sic] off the bed trying to get up. No injury observed, patient denied pain. Vitals [vital signs] within normal limit. MD and family notified. Resident Description: Resident Unable to give Description. On 10/29/23 at 12:13 PM, an Event/Alert Charting documented Type of Event: Unwitnessed fall on 10/28 [24]. Assessment /Observation: Complete neuros for this shift. No bruises/injury or pain noted this shift. Resident participated in watching movies and holding her baby doll in the day room this shift. Resident brief changed q [every] 2-3 hrs [hours]. Interventions: Resident participated in watching movies and holding her baby doll in the day room this shift. Resident brief changed q 2-3 hrs. Resident Reaction to Interventions: Residents reaction to interventions are positive evidence by breathing normal, WNL [within normal limits] for the resident. No outward or verbal expression of pain. Resident participated in watching movies and holding her baby doll in the day room this shift. Pain Management: Used PAINAD [Pain Assessment in Advanced Dementia] for monitoring pain. Frequent repositioning of the resident. Resident tolerated repositioning well evidence by no verbal outward expression of pain noted this shift. Improvement/Decline: Improvement, evidence by no verbal outward expression of pain noted this shift. Resident participated in watching movies and holding her baby doll in the day room. Resident brief changed q 2-3 hrs. Resident tolerated repositioning well evidence by no verbal outward expression of pain noted, resident remained safe this shift. Notifications:. On 10/30/23 at 9:35 AM, an IDT Event Review documented IDT Review: IDT to review unwitnessed fall on 10/28/23 at 1505 [3:05 PM] We have recently seen a decline on [resident 170]. We are unable to educate her due to decreased cognition. She is non-compliant with ambulatory devices. Intervention- Full PAIN-AD assessment by nurse management for possible residual pain from prior falls. The care plan Intervention initiated on 10/30/23, included Nurse management to assess for pain and need for pain modalities. [Note: No new fall interventions were implemented.] On 11/14/23 at 2:38 PM, a Nurses Note documented Note Text: Resident found on the floor next to the bed in her room. CNA reported to nurse. Resident was sitting up on the floor. Resident assessed for injuries. none found. vitals WNL. resident assisted into the wc. resident taken down to day room to nap in the recliner instead of her bed. neuro checks started. MD and DON [Director of Nursing] aware. POA [power of attorney] notified. On 11/15/23 at 9:12 AM, an IDT Event Review documented IDT Review: IDT to review unwitnessed fall 11/14 [24] at 1409 [2:09 PM] She was found sitting next to dresser in her room. Failed self transfer. Intervention- continue with OT, MD to assess for palliative care. The care plan Interventions initiated on 11/15/23, included activities in the day room and MD to assess for palliative care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/20/23 at 8:38 AM, a Nurses Note documented Note Text: Resident found on the floor in her room. Resident was laying in between her bed and roommates bed. Nurse assessed patient for injuries, none were found. vitals WNL. patient assisted into her wc and brought into the dining room for breakfast. neuro checks started. DON and MD aware. Daughter notified. On 11/20/23 at 9:17 AM, an IDT Event Review documented 'IDT Review: IDT to review fall on 11/20/23 at 0700 [7:00 AM] Failed self transfer, unwitnessed fall. Interventions- Continue with OT, assess for appropriateness to continue OT, NSG [nursing] management to asses time she usually gets up. [Note: No new fall interventions were implemented.] On 11/20/23 at 8:17 PM, a Fall Note documented Note Text: At 1930 [7:30 PM] pt was in the television room sitting in her wheelchair at the table. CNA walked into the TV room and pt was on the floor with her head in a pool of blood. Pt was conscious and LOC [level of consciousness] was at baseline. CNA called for this Nurse and I came to assess pt. Pt was on the floor and appeared that pt had hit her head on the metal feet of the table. There was a significant amount of bleeding. We sat pt up and inspected the back of her head and applied pressure with some gauze that I grabbed from the cart that was nearby. Bleeding stopped after about 3 min [minutes] of pressure. CNA held pressure as this nurse assessed pt for further injury. No other injuries were sustained. Pt was lifted back into her wheelchair and vital signs were obtained. Vitals were all WNL But blood sugar was high at 335. Both CNAs took pt to her her [sic] room to change her brief and put clean pants on her while this nurse called EMS. We wanted to ensure pt was clean before transfer. EMS arrived at 2005 [8:05 PM] and left with pt at 2020 [8:20 PM]. Pt is being transferred to [name of hospital redacted] ER and nurse to nurse was given. Two attempts made to call her emergency contact and a message was left to contact this RN for an important update about her mother and current phone number was left. MD, DON and ADON was notified. [Note: No new fall interventions were implemented.] On 11/20/23 at 11:46 PM, a Nurses Note documented Note Text: pt returned from Hospital on stretcher via EMS A2230 [sic] [10:30 PM]. Pt had sutures in her head and CT [computed tomography] of Neck and Head were clear. Vitals were taken and BP was low at 77/41. Will continue on Neuro checks for pt. Pt is awake and orientation is at baseline. On 11/21/23 at 6:57 AM, a Fall Incident Report documented Nursing Description: pt got out of her wheelchair and fell hitting her head on feet of table. CNA came and informed this Nurse of incident. When I arrived to assess pt she was laying on her back and there was a significant amount of bleeding in the back of her head. Pressure was applied with gauze and bleeding stopped. No other injuries sustained with this fall. MD was notified that pt fell and needed stitches and MD gave the OK. Pt was sent to [name of hospital redacted] ER. On 11/21/23 at 9:14 AM, an IDT Event Review documented IDT Review: IDT to review unwitnessed fall on 11/20/21 @ 1930 Unwitnessed fall resulting in staples to back of head. Interventions- Assess for palliative care, silent alarm for bed/chair. The care plan Interventions implemented on 11/21/23, included initiate silent alarm for bed and chair to prevent falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/20/24 at 12:13 PM, an interview was conducted with RN 1. RN 1 stated if a resident had a fall there were fall packets with a checklist. RN 1 stated she would assess the situation to see where the resident was, get vital signs, and get the resident off the floor if the resident was safe. RN 1 stated if the resident was not safe she would call EMS. RN 1 stated a risk assessment in the medical record would be done after the resident was situated and safe. RN 1 stated she would them notify the DON, MD, and the nurse on call. RN 1 stated that any new orders or X-rays from the provider were put in the medical record and the resident would be sent out if the MD requested. RN 1 stated that typically the floor nurse would find out the reason for the fall and come up with an intervention. RN 1 stated It might not be an intervention the management team used but if it was something she could do to prevent a fall she would do it. RN 1 stated the intervention recommendations would go to the IDT which consisted of the ADON, DON, and PT. RN 1 stated the IDT would make the ultimate decision on interventions. RN 1 stated the interventions were put in as an order on the Treatment Administration Record (TAR) for the nurses to check off. RN 1 stated a safety check was a yes or no on the Medication Administration Record. RN 1 stated if the resident had shoes as an intervention that might be a CNA task or on the TAR. On 3/20/24 at 3:18 PM, an interview was conducted with the Director of Physical Therapy (DPT). The DPT stated that he attended the morning meeting daily and the fall IDT. The DPT stated he would check into all options and check into interventions specific to the residents fall. The DPT stated if the resident was appropriate for therapy he would pick them up. The DPT stated that some residents have a hard time following directions or they were combative. The DPT stated he would assess the resident the day of or the day after the recommendation. On 3/21/24 at 9:12 AM, an interview was conducted with RN 2. RN 2 stated that resident 170 was total assistance with all cares. RN 2 stated that resident 170 could feed herself but required a lot of prompting or resident 170 had to fed. RN 2 stated that resident 170 had a lot of falls. RN 2 stated that resident 170 used to walk a lot and then she did not but resident 170 would try to walk at times. RN 2 stated that resident 170 would get tired quickly and would lose her balance right away. RN 2 stated if a resident had a fall the floor nurse would put at least one intervention in place and the IDT might do more interventions. RN 2 stated the floor nurse was not a part of the IDT. RN 2 stated the nurse management team would determine if the interventions were appropriate or not. On 3/21/24 at 10:26 AM, an interview was conducted with CNA 8. CNA 8 stated that resident 170 was a total care with all activities of daily living (ADLs). CNA 8 stated that resident 170 was not ambulatory the last year she had been at the facility. CNA 8 stated the staff would take resident 170 to activities in her wheelchair. CNA 8 stated that resident 170 was a high fall risk. CNA 8 stated that fall interventions for resident 170 included for the CNAs to put shoes or socks on resident 170 and clothes that were resident 170's size. CNA 8 stated she needed to supervise resident 170 a lot. CNA 8 stated a lot meant to always be within eye shot because resident 170 would stand up. CNA 8 stated that resident 170 would refuse cares. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/21/24 at 10:38 AM, an interview was conducted with CNA 5. CNA 5 stated that resident 170 was total assistance with ADLs and required two people for transfers because resident 170 would refuse cares. CNA 5 stated that resident 170 liked to get up and would get up by herself. CNA 5 stated when resident 170 was in her wheelchair resident 170 did not like to be changed. CNA 5 stated that resident 170 did fall a lot. CNA 5 stated that resident 170 liked to walk by herself and she enjoyed walking. CNA 5 stated that resident 170 was not stable the last few months at the facility and resident 170 would try to walk and would fall. CNA 5 stated that resident 170 had dementia and resident 170 would just get up. CNA 5 stated that most of the time staff were close to resident 170. CNA 5 stated there were only two CNAs on the memory care unit and most of the residents on the memory care unit required two staff for cares. CNA 5 stated there really needed to be one more CNA. CNA 5 stated if the staff were not busy they would make sure they had eyes on resident 170. CNA 5 stated that most of resident 170's falls were because no one was watching resident 170. CNA 5 stated when the residents go back to their rooms or if she was showering a resident it was hard to watch the residents. CNA 5 further stated the memory care unit needed another staff member to stay on the unit. On 3/21/24 at 11:01 AM, an interview was conducted with the DON. The DON stated the IDT team would go through the current fall interventions and see what had and had not worked for the resident. The DON stated they had fall meetings every morning and they would bring the fall packet, determine the root cause of the fall, and see what interventions were in place. The DON stated in the fall packet there was a spot to recommend interventions immediately and the IDT would determine if the intervention was appropriate. The DON stated when a resident had a fall the nurse would assess the resident prior to moving. The DON stated the fall packet would be followed and the staff were to notify the nurse manager, doctor, and family. The DON stated the floor nurse would assess the patient and provide any treatment as indicated. The DON stated if the fall was unwitnessed or the resident hit their head the staff would start neuro checks. The DON stated the nurses were to do the immediate interventions and recommendations for any other interventions. The DON stated the IDT would follow up the next day to determine the root cause of the fall and add any other interventions. The DON stated the fall risk assessments were done quarterly. The DON stated we talk as a group and write the IDT note in the chart with the intervention and the risk management which was the incident report. On 3/21/24 at 12:18 PM, an interview was conducted with the Director of Leadership and Development (DLD) and the Administrator (Admin). The DLD stated the day of resident 170's fall there were 15 residents on the memory care unit and staffed with two CNAs and one nurse. The Admin stated if the CNAs were giving cares there were cameras that watch both of the halls on the memory care unit and the nurse would step in. The DLD stated the fall intervention changes were initiated after the initial survey and the facility has had leadership changes. The DLD stated there were holes in the system that were working but not being followed. The DLD stated the fall committee was initiated after the original survey with the plan of correction. The Admin stated the additional information to the fall committee was tracking trends in falls. 03/21/24 at 1:26 PM, an interview was conducted with the Admin. The Admin stated they do track falls but they just started tracking fall trends including the time of day and who was on shift. The Admin stated they would put out training's to staff through the CNA Coordinator. The Admin stated they would continue to track those trends. The Admin stated there were no sign sheets for the training because it was part of the huddle. The Admin stated she would distribute interventions to the staff that day because the CNA coordinator was apart of the IDT. The Admin stated that the IDT team attended the Quality Assurance meetings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility policy Falls and Fall Risk, Managing was reviewed. Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Policy Interpretation and Implementation Definition According to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Challenging a resident's balance and training him/her to recover from loss of balance is an intentional therapeutic intervention. The losses of balance that occur during supervised therapeutic interventions are not considered a fall. Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: a. wet floors; b. poor lighting; c. incorrect bed height or width; d. obstacles in the footpath; e. improperly fitted or maintained wheelchairs; and f. footwear that is unsafe or absent. 2. Resident conditions that may contribute to the risk of falls include: a. fever; g. infection; h. delirium and other cognitive impairment; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	i. pain; j. lower extremity weakness; k. poor grip strength; l. medication side effects; m. orthostatic hypotension; n. functional impairments; o. visual deficits; and p. incontinence. 3. Medical factors that contribute to the risk of falls include: a. arthritis; q. heart failure; r. anemia; s. neurological disorders; and t. balance and gait disorders; etc. Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 4. [sic] Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lighting, etc. 5. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 6. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	7. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. 8. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. 9. Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. 45470 2. Resident 2 was admitted to the facility on [DATE] with diagnoses which include type 2 diabetes mellitus, chronic kidney disease, dementia, bipolar disorder, major depressive disorder, anxiety disorder, insomnia, hypothyroidism, and hyperlipidemia. On 3/12/24 at 12:38 PM, a family member of resident 2 brought a pill and another half pill out of resident 2's room and set it at the nurses' station. Resident 2's family member stated that he found the whole pill on the floor in resident 2's room, and the half pill was found on the floor in resident 2's bathroom. On 3/12/24 at 12:43 PM, RN 1 took the pills off the counter at the nurses' station and discarded them. On 3/12/24 at 12:47 PM, an interview with RN 1 was conducted. RN 1 stated that she identified the pills as being Tylenol and Metformin. RN 1 stated that those were medications that resident 2 received daily. RN 1 explained that nurses were supposed to give resident 2 his medication and stay in the room until resident 2 swallowed the medications. RN 1 stated that she did not know how the pills ended up on the floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident 2's medical record was reviewed. Resident 2's most recent MDS assessment dated [DATE], (State Optional - other) documented that resident 2 had a BIMS score of 7 which suggested severe cognitive impairment. Resident 2's March 2024 Medication Administration Record (MAR) was reviewed. a. The MAR documented that resident 2 had an order of Tylenol Extra Strength Oral Tablet 500 Milligrams (mg) with instructions to give 1000 mg by mouth three times a day for pain. The order was started on 1/30/24. The MAR documented that the o[TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 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** 33215 Based on observation, interview, and record review, the facility did not ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents goals, and preferences. Specifically, for 1 out of 45 sampled residents, a resident that required continuous oxygen therapy was observed without their oxygen nasal cannula on and out of reach. Staff were observed to not apply the oxygen nasal cannula for the resident. Resident identifier: 59. Findings included: Resident 59 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, severe protein-calorie malnutrition, chronic respiratory failure with hypoxia, convulsions, hypertension, and chronic atrial fibrillation. On 3/11/24 at 1:16 PM, an observation was conducted of resident 59's room. Resident 59 was observed in bed and the oxygen nasal cannula was not placed properly on resident 59. The oxygen nasal cannula was observed near resident 59's mouth but the oxygen nasal cannula was not in resident 59's mouth. Resident 59 did not appear to be short of breath. Resident 59's medical record was reviewed on 3/19/24. An admission Minimum Data Set (MDS) assessment dated [DATE], documented that resident 59 did not have a Brief Interview for Mental Status score due to resident was rarely or never understood. The MDS further documented that resident 59 was dependent with all cares and had functional limitation in range of motion with upper and lower extremities. A care plan Focus initiated on 2/12/24, documented [Resident 59] has altered respiratory status/difficulty breathing DX [diagnoses]: Chronic respiratory failure w/ [with] hypoxia Requires O2 [oxygen] therapy and nebulizers PRN [as needed] for management. Interventions initiated on 2/12/24, included a. OXYGEN SETTINGS: Oxygen as ordered, wean as able, Check O2 sats [saturations] as ordered. b. Position resident with proper body alignment for optimal breathing pattern. The February and March 2024 Treatment Administration Record (TAR) were reviewed. The following physician orders were documented: a. On 1/19/24, CHECK O2 SATS EVERY SHIFT every shift. i. On 2/28/24 at Night, O2 sats were documented at 85%. ii. On 2/29/24 at Night, O2 sats were documented at 89%. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 1/29/24, Monitor SOB [shortness of breath] or Difficulty Breathing: (1) SOB with Exertion (2) Sitting at Rest (3) Laying Flat every shift. The March 2024 TAR documented that resident 59 had SOB with exertion on one occasion. c. On 1/29/24, O2 per nc [nasal cannula] at 1-6 L/min [liters per minute] continuous. Check O2 sat [saturation] qshift [every shift]. Goal to maintain O2 sats > [greater than] 90%. every shift. The physician's order was discontinued on 3/1/24. i. 2 L/min of O2 was administered on 17 occasions in February. ii. 3 L/min of O2 was administered on 38 occasions in February. d. On 3/1/24, O2 per nc at 1-6 L/min continuous. Check O2 sat qshift. Goal to maintain O2 sats >90%. every shift. i. 2 L/min of O2 was administered on two occasions in March. ii. 3 L/min of O2 was administered on 27 occasions in March. iii. 4 L/min of O2 was administered on six occasions in March. On 2/27/24 at 6:51 PM, a Nurse Practitioner Note documented Note Text: Resident is residing in a skilled nursing facility due to a recent stroke and inability to care for himself. He is unable to walk or eat independently and can not leave the facility without oxygen and assistance. Resident is unable to serve on a jury due to physical limitations. On 3/19/24 at 1:34 PM, an observation was conducted with Registered Nurse (RN) 1. RN 1 performed a dressing change on resident 59's left hip. Resident 59's oxygen nasal cannula was observed on the floor near the head of the bed. Resident 59 was unable to reach the oxygen nasal cannula. RN 1 completed the dressing change and exited resident 59's room without applying the oxygen nasal cannula for resident 59. A continuous observation was initiated. On 3/19/24 at 2:46 PM, resident 59's oxygen concentrator was observed to be set at 2 L/min. On 3/19/24 at 3:20 PM, an observation was conducted with RN 1. RN 1 obtained an O2 sat on resident 59 at 91% and the heart rate was 113. [Note: The continuous observation was concluded and resident 59 was observed without oxygen for two hours and 46 minutes.] On 3/20/24 at 8:29 AM, an observation was conducted of resident 59. Resident 59 was observed in bed with the oxygen nasal cannula positioned near his cheek. A continuous observation was initiated. On 3/20/24 at 8:41 AM, an observation was conducted of Certified Nursing Assistant (CNA) 11 entering resident 59's room. CNA 11 exited resident 59's room without applying the oxygen nasal cannula for resident 59. Resident 59's oxygen nasal cannula was observed on the floor near the head of the bed. Resident 59 was unable to reach the oxygen nasal cannula. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 9:26 AM, an interview was conducted with RN 1. RN 1 stated that resident 59 would remove the oxygen nasal cannula frequently. RN 1 stated she was not sure how often the CNAs would check on the residents but she was in resident 59's room around 7:30 AM, and RN 1 stated she had to put the oxygen back on resident 59. RN 1 stated that resident 59 would usually sat around 90% with the oxygen off. RN 1 was observed to obtain an O2 sat on resident 59. Resident 59's O2 sat was 95% and the heart rate was 91. An observation of resident 59's back wound was observed with RN 1. RN 1 completed the dressing change and exited resident 59's room without applying the oxygen nasal cannula for resident 59. On 3/20/24 at 9:43 AM, an observation was conducted of the Administrator entering resident 59's room. The Administrator exited resident 59's room and did not apply the oxygen nasal cannula for resident 59. On 3/20/24 at 9:46 AM, an observation was conducted of CNA 4 entering resident 59's room. CNA 4 exited resident 59's room and did not apply the oxygen nasal cannula for resident 59. On 3/20/24 at 10:08 AM, an interview was conducted with CNA 4. CNA 4 stated that he would check on all the residents every two hours as required. CNA 4 stated he liked to check on the residents more frequent like every 30 to 40 minutes. CNA 4 stated if he was in a room cleaning he would check on the residents when he finished. CNA 4 stated the staff had to check on resident 59 often. CNA 4 stated that often meant more frequent than every two hours. CNA 4 stated that resident 59 had to be checked on because he was a fall risk and had a tube feed. CNA 4 stated that he would make sure that resident 59 was not tugging on the tube feed and would ensure that everything was on. CNA 4 stated that resident 59 liked to pull on things so he would check the call light because it would get moved. CNA 4 stated that he would ensure resident 59 was not trying to get out of bed and would wedge him to keep him off of his back. CNA 4 stated that resident 59 would tend to lean a certain way and needed to be readjusted. On 3/20/24 at 10:19 AM, a staff member was observed to enter resident 59's room. The staff member exited resident 59's room with a bag of garbage and did not apply the oxygen nasal cannula for resident 59. On 3/20/24 at 10:26 AM, resident 59 activated the call light. At 10:33 AM, a staff member responded to resident 59's call light. The staff member did not apply the oxygen nasal cannula for resident 59. On 3/20/24 at 11:04 AM, an interview was conducted with RN 1. The State Survey Agency asked RN 1 to obtain an O2 sat on resident 59. RN 1 stated that resident 59's oxygen probably was not on yet and she could guarantee it. Resident 59's O2 sat was 87% and the heart rate was 94. At 11:06 AM, two minutes later resident 59's O2 sat was 93%. [Note: The continuous observation was concluded and resident 59 was observed without oxygen for three hours and 35 minutes.] On 3/20/24 at 12:54 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if a resident required oxygen the nurse would apply the oxygen and call the physician to obtain a physician's order. The DON stated that staff should be checking on the residents every two hours. The DON stated that she had been in resident 59's room when resident 59 had refused oxygen therapy. The facility policy for Oxygen Administration was reviewed and documented, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed. General Guidelines 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. a. The oxygen mask is a device that fits over the resident's nose and mouth. It is held in place by an elastic band placed around the resident's head. b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. c. The nasal catheter is a piece of tubing inserted through the resident's nostrils into the back of his/her mouth. It is held in place by a piece of skin tape attached to the resident's forehead and/or cheek. Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure. 1. Portable oxygen cylinder (strapped to the stand); 2. Nasal cannula, nasal catheter, mask (as ordered); 3. Humidifier bottle; 4. 'No Smoking/Oxygen in Use' signs; 5. Regulator; and 6. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Assessment (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following: 1. Signs or symptoms of cyanosis (i.e., blue tone to the skin and mucous membranes); 2. Signs or symptoms of hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion); 3. Signs or symptoms of oxygen toxicity (i.e., tracheal irritation, difficulty breathing, or slow, shallow rate of breathing); 4. Vital signs; 5. Lung sounds; 6. Arterial blood gases and oxygen saturation, if applicable; and 7. Other laboratory results (hemoglobin, hematocrit, and complete blood count), if applicable. Steps in the Procedure 1. Wash and dry your hands thoroughly. 2. Place an 'Oxygen in Use' sign on the outside of the room entrance door. Close the door. 3. Place an 'Oxygen in Use' sign in a designated place on or over the resident's bed. 4. Remove all potentially flammable items (e.g., lotions, oils, alcohol, smoking articles, etc.) from the immediate area where the oxygen is to be administered. 5. Unless otherwise instructed, unplug and/or relocate all electrical devices (e.g., radios, televisions, electric shavers, etc.) in the immediate area where oxygen is to be administered. 6. Remove any [NAME] blankets, nylon and/or [NAME] clothing, etc., from the immediate area where oxygen is to be administered. 7. Check the tubing connected to the oxygen cylinder to assure that it is free of kinks. 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute. 9. Place appropriate oxygen device on the resident (i.e., mask, nasal cannula and/or nasal catheter). 10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. Securely anchor the tubing so that it does not rub or irritate the resident's nose, behind the resident's ears, etc. 12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. 13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated (see 'Assessment'). 14. Periodically re-check water level in humidifying jar. 15. Discard used supplies into designated containers. 16. Discard personal protective equipment in designated receptacles. Wash and dry your hands thoroughly. 17. Reposition the bed covers. Make the resident comfortable. 18. Place the call light within easy reach of the resident. 19. If the resident desires, return the curtains to the open position and if visitors are waiting, tell them that they may now enter the room. 20. Instruct the resident, his/her family, visitors and roommate (if any) of the oxygen safety precautions. Provide the resident with a written copy of the Oxygen Safety handout. 21. Wash and dry your hands thoroughly. Documentation After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for p.r.n. administration. 6. All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data. Reporting 1. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on observation, interview, and record review, the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 1 out of 45 sampled residents, a resident who sustained a right humerus fracture was not offered a shoulder immobilizer daily as ordered to help mitigate pain. Resident identifier: 58. Findings Included: Resident 58 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include displaced fracture of surgical neck of right humerus, type 2 diabetes mellitus, alcoholic cirrhosis of liver, chronic respiratory failure, infection and inflammatory reaction due to internal left knee prosthesis, pain, hemiplegia and hemiparesis, dysphagia, difficulty in walking, pain in left hip, muscle weakness, unsteadiness on feet, repeated falls, low back pain, essential hypertension, sleep related hypoventilation, glaucoma, hemorrhoids, hyperlipidemia, anxiety disorder, and depression. On 3/11/24 at 1:23 PM, an interview with resident 58 was conducted. Resident 58 stated that she had been in a lot of pain since she broke her right arm from a fall a few months ago. Resident 58 stated that she had asked nurses multiple times for a sling and the nurses responded by telling her that they did not have a sling for her. Resident 58 stated that it was painful to move her arm and a sling would help keep it in place. An observation of resident 58 was made. Resident 58 was lying in bed without a sling on. Resident 58 had a large bruise on her upper right arm. Resident 58 stated that the bruise was from a fall. Resident 58 began to cry and stated that her arm was extremely painful, and she felt forgotten by staff at the facility. Resident 58's medical record was reviewed. On 1/11/24, a quarterly Minimum Data Set (MDS) assessment was completed. The MDS documented that resident 58 had a Brief Interview for Mental Status score of 14, which suggested that cognition was intact. Resident 58's care plan was reviewed. Resident 58 had a care plan initiated on 9/13/23 and revised on 12/18/23, that stated, [Resident 58] is resistant to cares and refuses medications at times; medications, eating, refuses to participate with therapy, refuses her shoulder immobilizer, refuses showers, refuses wound care, refuses supplements, refuses skin checks, refuses splints. The goal, initiated on 9/13/23, stated, [Resident 58] will have less occurrences of refusals of care and medications by the next review. The intervention, initiated on 9/13/23, stated, Allow the resident to make decisions about treatment regime, to provide sense of control. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident 58 had a care plan initiated on 10/1/23, that stated, [Resident 58] has R [right] humoral [sic] fracture r/t [related to] fall. The goal initiated on 10/2/23, stated, The resident will return to prior level of function after wound healing and rehabilitation by review date. The interventions, initiated 10/2/23, stated, Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. Encourage deep breathing and relaxation techniques. Monitor limb for swelling and skin changes. Assess/monitor pedal pulses as needed. Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain. On 9/28/23 at 3:22 PM, a Progress Note documented that resident 58 was found on the floor in the hallway near the front door of the facility. The progress note stated, .Right arm pain unable to move without hurting. Vitals were taken. 911 called at 1528 [3:28 PM] .Resident was sent to [hospital name redacted]. Provider notified. On 10/1/23 at 3:15 PM, a Progress Note documented that resident 58 was returning to the facility with a right arm fracture and had a sling. On 10/4/23 at 3:08 PM, a Progress Note documented, Orthopedics ordered for resident to wear a right shoulder immobilizer at all times. Notes state it's okay to remove for bathing. On 1/17/24 at 12:52 PM, a Social Service Note documented, Rt [resident] came to ra [Resident Advocate] office to express that she would like to be seen by the MD [Medical Director] to get a referral to a surgeon for her shoulder. Rt said that her pain has been getting really bad and that she wanted to die. Ra asked resident to clarify her feelings on wanting todie [sic]. Rt expressed that she thinks about hurting herself due to the pain she is in, but did not have a plan on how she would hurt herself and did not feel that she was going to hurt herself. Rt expressed to the ra that she felt safe at the facility and that she feels very loved. Resident 58's orders were reviewed. Resident 58 had an order that stated, Right shoulder immobilizer at all times. Okay to remove for bathing. Every shift for shoulder fracture. Start date 1/3/24. The order was discontinued on 3/13/24. a. The Treatment Administration Record (TAR) for January 2024 documented that resident 58 wore her right shoulder immobilizer every shift as scheduled. b. The TAR for February 2024 documented that resident 58 wore her right shoulder immobilizer every shift except for the day shift of February 21st and 27th. c. The TAR for March 2024 documented that resident 58 wore her right should immobilizer every shift as scheduled. Resident 58 had an order that stated, Pain Monitoring every shift for pain monitoring. Start date 1/3/24. a. The TAR for January 2024 documented that resident 58 reported a pain level of a 5 out of 10 or higher 36 times. The highest reported score was an 8 out of 10, which was reported ten times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	b. The TAR for February 2024 documented that resident 58 reported a pain level of a 5 out of 10 or higher 29 times. The highest reported score was a 9 out of 10, which was reported three times. c. The TAR for March 2024 was reviewed up to 3/12/24, and documented that resident 58 reported a pain level of a 5 out of 10 or higher 13 times. The highest reported score was a 9 out of 10, which was reported one time. Resident 58's pain medications were reviewed. a. Gabapentin Capsule 300 MG [milligrams] Give 1 capsule by mouth three times a day for Pain. The order was started on 1/3/24. b. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 500 MG by mouth four times a day for pain. The order was started on 1/9/24. c. Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain. The order was started on 1/9/24. On 3/12/24 at 1:30 PM, a follow-up interview was conducted with resident 58. Resident 58 was sitting on the side of her bed and was observed to have a right shoulder immobilizer on. Resident 58 stated that she now had a sling on that helped to keep her arm from moving. Resident 58 was observed smiling and stated that she was excited to go to the activities soon. On 3/12/24 at 2:15 PM, an interview with Certified Nursing Assistant (CNA) 13 was conducted. CNA 13 stated that resident 58 had a fall in September where she broke her arm. CNA 13 stated that resident 58 had a sling on for a few months after the fall, however, resident 58 had not been wearing a sling for the past two or three months, and the sling resident 58 had on today was new. CNA 13 stated that resident 58 often complained of pain in her right arm during transfers, while getting dressed, or while helping resident 58 to the bathroom. CNA 13 stated that resident 58 complained of pain anytime her right arm was moved or touched. CNA 13 stated that this made completing some of resident 13's care difficult, such as helping resident 58 put a shirt on. CNA 13 stated staff were completing these cares for the past few months while resident 58 did not have a sling on. On 3/12/24 at 3:02 PM, an interview with CNA 12 was conducted. CNA 12 stated that she did not work with resident 58 very often. CNA 12 recalled assisting resident 58 out of bed last week. CNA 12 stated that resident 58 did not have a sling on during that transfer. CNA 12 stated that resident 58 did not have a sling on at all last week. On 3/12/24 at 3:08 PM, an interview with the Therapy Recreational Technician (TRT) was conducted. The TRT stated that she was very familiar with resident 58. The TRT stated that resident 58 went to the doctor today and came back with a sling on her right arm. The TRT stated that resident 58 did not have a sling prior to her appointment today. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/19/24 at 2:04 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated that resident 58 was supposed to always wear the right shoulder immobilizer. The DON stated that the right shoulder immobilizer would help with the pain from resident 58's fractured arm. The DON stated that resident 58 almost always refused to wear the right shoulder immobilizer. The DON stated that resident 58 told staff she did not like it and would refuse to wear it. The DON stated that the right shoulder immobilizer was in resident 58's room. The DON stated that nurses and CNA's offered the right shoulder immobilizer to resident 58 daily. The DON stated that it was care planned that resident 58 would refuse to wear the right shoulder immobilizer. Progress notes were reviewed from 9/28/23 to 3/12/24. There were no progress notes reporting resident 58 refusing to wear the right shoulder immobilizer. On 3/20/24 at 10:53 AM, an interview with Registered Nurse (RN) 8 was conducted. RN 8 stated that resident 58 sustained a humeral fracture in September of 2023 and it was inoperable. RN 8 stated that resident 58 had a sling for her right arm, but resident 58 was always losing it. RN 8 stated that resident 58 would ask staff for the sling but nobody knew where it was. RN 8 stated that resident 58 often complained of pain in her right arm. RN 8 stated that she had made a make-shift sling out of ace wrap for resident 58 because she could not find the sling. RN 8 stated that they offer resident 58 a heat pack to help with the pain in her arm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that residents did not receive psychotropic drugs pursuant to an as needed (PRN) order unless the PRN order for psychotropic drugs were limited to 14 days. If the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, they should document their rationale in the resident's medical record and indicate the duration for the PRN order. In addition, PRN orders for anti-psychotic drugs were limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Specifically, for 1 out of 45 sampled residents, a resident had a PRN order for a cream that included Haldol, Benadryl, and Ativan. The cream was not limited to 14 days, and the physician or prescribing practitioner had not evaluated the resident for the appropriateness of the medication. Resident identifier: 2. Findings included: Resident 2 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus, chronic kidney disease stage 2, dementia with other behavioral disturbance, bipolar disorder, major depressive disorder, and anxiety disorder. Resident 2's medical record was reviewed on 3/12/24. A care plan Focus initiated on 1/30/24, documented [Resident 2] has Bipolar Disorder Requires the use of psychotropic medications. The interventions initiated on 1/30/24, included: a. Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT [every shift]. b. Consult with pharmacy, MD [Medical Director] to consider dosage reduction when clinically appropriate at least quarterly. c. Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS [extrapyramidal side effects] (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. On 1/16/24, a physician's order documented ABH- Ativan-Benadryl-Haldol Apply to WRIST topically every 12 hours as needed for BIPOLAR WITH AGITATION for 30 Days 1ML [milliliter] TO WRIST. The physician's order was discontinued on 2/7/24. On 2/7/24 at 12:45 PM, a Nurses Note documented Note Text: Daughter met with ADON [Assistant Director of Nursing] and requested that his ABH cream is to be PRN instead of scheduled. Order approved by in house MD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 2/7/24, a physician's order documented ABH- Ativan-Benadryl-Haldol Apply to WRIST topically every 12 hours as needed for BIPOLAR WITH AGITATION for 30 Days 1ML TO WRIST- PRN BID [twice daily]. Max [maximum] dose of 3 syringes given a day. The physician's order was discontinued on 2/11/24. On 2/8/24 at 3:22 PM, a Nurses Note documented Note Text: MD spoke with resident's daughter about medication changes. New orders to discontinue sertraline and aripiprazole. Change tramadol to BID. DC [discontinue] PRN clonazepam and maintain current scheduled clonazepam order. ABH cream is PRN and only to be given if anxious/agitated per daughter's request. Orders have been updated accordingly. On 2/11/24 at 4:52 PM, an Event/Alert Charting documented Type of Event: Verbal and physical aggression Assessment /Observation: Rt. [resident] combative and verbally aggressive toward staff when assisting with ambulation, transfers, ADLs [activities of daily living], and toileting. Observed Rt. punch and scratch staff during transfers and while assisting with ambulation. Interventions: Notified ADON, family and physician. Physician ordered prn ABH cream to be applied QID [four times a day]. Applied cream with effective results. Family notified about frequency change. Resident Reaction to Interventions:Cooperative. Pain Management: No c/o [complaints of] pain or discomfort Improvement/Decline: Stable Notifications: On 2/11/24, a physician's order documented ABH- Ativan-Benadryl-Haldol Apply to Wrist topically every 6 hours as needed for Bipolar and Agitation. The physician's order was discontinued on 2/16/24. On 2/11/24 at 11:37 PM, an Event/Alert Charting documented Type of Event: Verbal and physical aggression Assessment /Observation: Resident combative and verbally aggressive with staff during cares. Attempting to kick and punch staff. Med [medication] pass nurse reported resident punched her in the face. Interventions: Redirection, calm environment, PRN ABH cream, scheduled meds. Resident Reaction to Interventions: Resident was able to be redirected and calmed down after a while. Pain Management: Scheduled Tramadol Improvement/Decline: No changes. Notifications: ADON, MD and daughter were notified. On 2/15/24 at 6:43 PM, a Physician Progress Notes documented Note Text: Visit type: Reg [regular] . Reason for visit: Regulatory visit Subjective: Reviewed plan of care with patient and daughter (via phone). Addressed all concerns. Reviewed full list of medications. Trying to minimize medications. Discussed difficult situation of over medicating him but keeping him safe. Patient to see psychiatrist at outpatient clinic for further evaluation/management of his psychiatric medications. On 2/16/24, a physician's order documented ABH- Ativan Benadryl-Haldol Apply to Wrist topically every 6 hours as needed for Bipolar and Agitation NOTIFY ON CALL NURSE MANAGEMENT IF ABH MUST BE GIVEN. The January, February, and March 2024 Medication Administration Record was reviewed. a. ABH was administered two times in January. One dose was documented as ineffective. b. ABH was administered 23 times in February. One dose was documented as ineffective and on one dose the effectiveness was documented undetermined. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	c. ABH was administered one time in March and the dose effectiveness was documented as undetermined. On 2/28/24 at 4:52 PM, a Behavioral Health Clinic Note documented Chief Complaint Client presents to follow-up with his dementia with behavioral disturbance and bipolar disorder. He suffers from dementia and is on a memory unit. She relates that he was given a notice to vacate after going to the hospital ER [emergency room] for behavioral issues felt to be secondary to his dementia. [Doctor name redacted] at that time switched him over to Haldol [to] help minimize exposure from multiple antipsychotics since he was already getting a compounded cream with a combination of Haldol, Benadryl and Ativan in it. Daughter relates that she did not want her dad on Haldol and he was not functioning on it, could not walk, so the oral form has been discontinued. He continues to take Seroquel 25 mg [milligrams] at night and his clonazepam has been reduced now he is on 0.5 mg in the morning and milligram at night. Reportedly he get [sic] agitated at times, sometimes thinks people are stealing things from his room. Daughter still wanting client to be off Haldol completely, but reportedly he has gotten this compounded cream a few times for agitation. Today, client continues to not seem depressed or manic, his bipolar does seem to be well-controlled. He does have episodic issues with behavioral outburst from his dementia. I do agree with going down on his clonazepam, hopefully that will decrease his chances of falls and also help hopefully with less confusion. Discussed that we should not have 2 different providers prescribing for the same condition. Daughter wants to talk it over with her brother on exactly what to do, since the provider at the facility seems to like the compounded cream. Perhaps they could take the Haldol out of the compounded cream. PLAN: Plan was made with regards to the psychiatric medications to continue the medications unchanged. It was felt the potential benefits of changing the medications did not outweigh the potential risk and side effects of changing the medication at this time. FOLLOW UP: It was recommended the patient follow up in 1 or 2 months or she can transfer care to the facility provider. [Note: The PRN ABH physician's order was not limited to 14 days and an evaluation every 14 days by the attending physician or prescribing practitioner to evaluate resident 2 for the appropriateness of the medication was unable to be located in the medical record.] On 3/19/24 at 1:03 PM, an interview was conducted with the Director of Nursing (DON). The DON stated an evaluation would depend on the medication. The DON stated the facility had behavior tracking for the psychotropic medications. The DON stated that during the psychotropic meetings the team would pull the behavior tracking and review how much the resident expressed behaviors. The DON stated the team would also review the PRN medication usage and review if the resident still needed the medication. The DON stated the team tried not to use as many PRN antipsychotics. The DON stated the facility MD did not like to use PRN Seroquel. The DON stated that resident 2 was seen by an out patient psychologist doctor and that doctor recommended not changing any medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, the facility did not ensure each resident was free of any significant medication errors. Specifically, for 1 out of 45 sampled residents, a resident was not administered the correct blood pressure medication. Resident identifiers: 119. Findings included: Resident 119 was admitted to the facility on [DATE] with diagnoses which included sarcopenia, blindness, hypertension, and cardiovascular disease. On 3/11/24 at 11:18 AM, an interview was conducted with resident 119's family member. Resident 119's family member stated resident 119 did not receive her blood pressure medications because there was some confusion about them when she was admitted . Resident 119's medical record was reviewed on 3/11/24 through 3/21/24. A form titled Medication Profile dated 2/12/24 through 5/11/24 revealed current medications: a. Abilify Oral Tablet 2 mg (milligram) once daily. b. Promethazine Hydrochloride (HCL) oral tablet 25 mg every 6 hours as needed. c. Acetaminophen Rectal Suppository 650 mg every 6 hours as needed d. Bisacodyl Rectal Suppository 10 mg daily as needed e. Hyoscyamine Sulfate sublingual tablet 0.125 mg every 4 hours as needed f. Lorazepam oral concentrate 2 mg/ml (milliliter) every 2 hours as needed g. Morphine Sulfate 20 mg/ml. Give 1 syringe orally every hour as needed. It should be noted there was no order for blood pressure medication. A form from resident 119's hospice titled Physician telephone order dated 3/1/24, revealed the following medications: a. Losartan Potassium 50 mg once daily for hypertension b. Metoprolol 100 mg once daily at 7:00 PM, for hypertension c. Calcium 1000 mg once daily at 7:00 PM d. Lorazepam 2mg/ml (.05 ml) four times a day (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	e. Crush medications as needed It should be noted there was no specification on what type of Metoprolol was to be administered. Resident 119's physician ordered medications entered into the medical record at the facility were: a. On 3/1/24, Acetaminophen Rectal Suppository 650 mg every 6 hours as needed b. On 3/1/24, Bisacodyl Rectal Suppository 10 mg every 24 hours as needed c. On 3/1/24, Hyoscyamine Sulfate 0.125 mg every 4 hours as needed d. On 3/1/24, Morphine Sulfate 20 mg/ml .25 ml every hours as needed e. On 3/1/24, Promethazine HCL 25 mg every 6 hours as needed. f. On 3/3/24, Metoprolol Tartrate 100 mg at bedtime g. On 3/3/24, Cozaar (Losartan Potassium) 50 mg at bedtime. Nursing progress notes revealed the following: a. On 3/1/24 at 10:25 PM, I received nurse to nurse on [resident 119]. [Resident 119] is a 97 yof [year old female] with vascular dementia confused and delirious. She is minimally responsive and only responds to noxious stimuli she is not eating or drinking. Normally she is independent however She had a change in condition today. No recent falls. They have ordered a cxr [chest x-ray], ua [urine analysis] c/s [culture and sensitivity] Her diet is advance as tolerated. No foley not continent. Normally she walks with a walker but was super weak today, new onset. She does not have any wounds. She is extremely hard of hearing and legally blind. Daughter will bring her meds [medications] and meet her at the facility. b. On 3/3/24 at 6:45 PM, New order received from hospice. 1. Metoprolol 100 mg 1 tablet po [by mouth] every evening. 2. Losartan 50 mg 1 tablet po every evening. 3. Calcium 600 with Vitamin D po 1 tablet every evening. Resident's daughter brought in medications. c. On 3/3/24 at 6:44 PM, This order is outside of the recommended dose or frequency. Metoprolol Tartrate Oral Tablet 100 MG Give 1 tablet by mouth at bedtime for HTN [hypertension]- The frequency of daily is below the usual frequency of 2 to 4 times per day. The March 2024 Medication Administration Record (MAR) was reviewed. Resident 119 was not administered medication on 3/1/24 or 3/2/24. The following was revealed: a. Lorazepam 2 mg/ml, give 0.5 ml by mouth three times a day was refused by resident on 3/2/24, 3/3/24, and 3/4/24, twice daily and was administered once daily on those days. b. Metoprolol Tartrate 100 mg by mouth at bedtime was administered 3/3/24, 3/4/24, 3/5/24, 3/7/24, 3/8/24, 3/9/24, and was refused on 3/6/24 and 3/10/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 3/12/24 at 10:26 AM, an interview was conducted with the hospice Registered Nurse (RN). The hospice RN stated when she visited a resident she talked to the facility nurse. The hospice RN stated that she had not provided the facility any paperwork except for a form titled physician's telephone order. The hospice RN stated resident 119's family stated that she brought bottles of Metoprolol and Losartan to the facility nurse. The hospice RN stated there was a mix up regarding resident 119's blood pressure medication and it was not administered for a few days after admission. On 3/12/24 at 2:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated when a resident was admitted , the DON, Assistant Director of Nursing (ADON) or the Regional Nurse Consultant (RNC) received the nurse to nurse report and admission orders. The DON stated the floor nurse completed the admission process. The DON stated the nurse completed an admission note, assessments, and admitting vital signs. The DON stated the nurse managers completed a 48 hour admission check list to make sure it was all done. The DON stated resident 119 was an after hours admission from an Assisted Living Faintly. The DON stated she received the nurse to nurse report from the hospice nurse. The DON stated the ordered medications were sent in an e-mail. The DON stated she entered the medications into the resident's medical record on 3/1/24. The DON stated the next day the family had home medications that they wanted resident 119 to have later. The DON stated she did not know what the medications were that the family wanted. The DON stated the floor nurse informed her that there were more medications. The DON stated she instructed the floor nurse to call the hospice company and get order clarification. The DON stated I believe I got a hold of the hospice company regarding medications. The DON stated the family wanted to bring in a pill box and the floor nurse told the family she needed actual orders from hospice for the medications. On 3/20/24 at 11:48 AM, a follow-up interview was conducted with the DON. The DON stated the telephone orders on 3/1/24, were different from the ones entered into resident 119's medical record and they were different from the list emailed to the facility. The DON stated an email provided on 3/1/24 at 10:15 PM, from the hospice company revealed different physician orders than were in the medical record. The DON stated if the hospice nurse was onsite, then verbal orders could be entered and then orders could be sent to the facility. The DON stated facility nurses could call the hospice nurse. The DON stated if a resident did not receive the correct blood pressure medications, then a resident blood pressure could increase. On 3/20/24 at 11:58 AM, an interview was conducted with ADON 1. ADON 1 stated she was e-mailed a medication list for resident 119. ADON 1 stated the medication was Metoprolol Succinate. On 3/20/24 at 12:04 PM, an interview was conducted with the RNC. The RNC stated she did not know the difference between Metoprolol Tartrate verses Metoprolol Succinate because she was not a physician or pharmacist. The RNC stated after googling the medications the Tartrate was an immediate release or short acting. The RNC stated the Succinate was and extended release.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0811 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are assessed for appropriateness for a feeding assistant program, receive services as per their plan of care, and feeding assistants are trained and supervised. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on observation, interview, and record review, the facility did not ensure that a feeding assistant had completed a state-approved training course before providing feeding assistance to residents. Specifically, for 1 out of 45 sampled residents, the Dietary Manager (DM) was providing feeding assistance to a resident without having completed a state-approved training course. Resident identifier: 29. Findings included: Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included myasthenia gravis without (acute) exacerbation, displaced fracture of surgical neck of right humerus, moderate dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and type 2 diabetes mellitus with diabetic neuropathy. On 3/14/24 at 12:19 PM, an observation of resident 29 was made. Resident 29 was observed to be assisted with feeding by the DM. The DM was observed talking to resident 29 stating, I came down here to talk with you and noticed you haven't started eating, so I can talk to you and help you. Resident 29's medical record was reviewed on 3/11/24 through 3/22/24. An Optional State Minimum Data Set (MDS) assessment dated [DATE], revealed resident 29 had a Brief Interview of Mental Status score of 10 which indicated moderately impaired cognition. The MDS revealed resident 29 needed extensive assistance with 1 person physical assistance for eating. A care plan initiated on 7/31/22 and revised on 1/3/24, revealed a focus of [Resident 29] has an ADL [Activities of Daily Living] self -care performance deficit r/t [related to] weakness, impaired mobility, pain, cognitive impairment DX [diagnose]: Myasthenia Gravis, OA [osteoarthritis], Fx [fracture] R [Right] humerus, Dementia, Carpal tunnel The goal was [Resident 29] will maintain current level of function in ADLS through the review date. One of the interventions revealed EATING: The resident requires supervision to physical 1 staff assistance. On 3/20/24 at 12:26 PM, an interview was conducted with the Certified Nursing Assistant (CNA) Coordinator. The CNA Coordinator stated only the nurses and CNAs were qualified to assist with resident feeding. On 3/20/24 at 12:28 PM, an interview was conducted with the DM. The DM stated that as far as she was aware the facility did not have extra paid feeding assistants. The DM stated that feeding assistants must have a certification and the CNAs were certified to help with resident feeding assistance. The DM stated that she previously had training in that regard, but she did not hold a CNA certificate, her current certifications were in the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 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, food and drinks were observed to be uncovered when being delivered to resident rooms. Findings included: 1. On 3/11/24 at 11:45 AM, an observation was made of the lunch meal cart on the North Rehab hallway. The lunch meal cart was parked next to resident room [ROOM NUMBER]. a. At 11:47 AM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. b. At 11:47 AM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. c. At 11:48 AM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. d. At 11:49 AM, a meal tray was delivered to room [ROOM NUMBER]. The drinks were uncovered. e. At 11:50 AM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. 2. On 3/11/24 at 12:07 PM, an observation was made of the lunch meal cart on the South Rehab hallway. The lunch meal cart was parked next between resident room [ROOM NUMBER] and 152. a. At 12:08 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. b. At 12:08 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert and drink were uncovered. c. At 12:09 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert and drink were uncovered. d. At 12:10 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert and drinks were uncovered. e. At 12:11 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert and drinks were uncovered. f. At 12:12 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert and drink were uncovered. 3. On 3/11/24 at 12:15 PM, an observation was made of the lunch meal cart on the [NAME] Rehab hallway. The lunch meal cart was parked next to resident room [ROOM NUMBER]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465117	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. At 12:17 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert and drink were uncovered. 4. On 3/12/24 at 11:50 AM, an observation was made of Certified Nursing Assistant (CNA) 12 passing trays on the South Rehab hallway. a. At 11:50 AM, a meal tray was delivered to room [ROOM NUMBER]. The drink was uncovered. b. At 12:12 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. c. At 12:13 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. d. At 12:15 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. e. At 12:21 PM, an observation was made of CNA 15. CNA 15 was observed transporting a meal tray through the nursing station the full length of the South Rehab hallway with the dessert uncovered and delivered to room [ROOM NUMBER]. f. At 12:22 PM, an observation was made of CNA 16. CNA 16 was observed transporting a meal tray through the nursing station the full length of South Rehab hallway with the dessert uncovered and delivered to room [ROOM NUMBER]. 5. On 3/12/24 at 12:14 PM, an observation was made of CNA 1 passing trays on the Colonial hallway during the lunch meal. The meal cart was parked between resident room [ROOM NUMBER] and 249. a. At 12:14 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. b. At 12:15 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. c. At 12:16 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. d. At 12:17 PM, a drink was delivered to room [ROOM NUMBER] uncovered. e. At 12:19 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. f. At 12:21 PM, a meal tray was delivered to room [ROOM NUMBER]. The dessert was uncovered. 6. On 3/13/24 at 7:43 AM, an observation was made of CNA 12 passing trays during the breakfast meal. The meal cart was parked next to resident room [ROOM NUMBER]. a. At 7:44 AM, a meal tray was delivered to room [ROOM NUMBER]. The drink was uncovered. b. At 7:46 AM, a meal tray was delivered to room [ROOM NUMBER]. The drink was uncovered. c. At 7:47 AM, a meal tray was delivered to room [ROOM NUMBER]. The drink was uncovered. d. At 7:49 AM, a meal tray was delivered to room [ROOM NUMBER], which was in a different hallway from where the meal cart was parked. The drink was uncovered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 3/13/23 at 8:03 AM, an observation was made the breakfast meal cart on the Colonial hallway. The meal cart was parked between resident room [ROOM NUMBER] and 243. a. At 8:16 AM, a meal tray was delivered to room [ROOM NUMBER]. The fruit cup on the tray was uncovered On 3/20/24 at 12:28, an interview with the Dietary Manager (DM) was conducted. The DM stated that her expectation for delivering food to resident rooms was to have all the food covered. The DM stated that the main meal was covered with a heavy-duty cover, and all desserts and fruits should be covered. The DM stated there was a drink cart where staff should either be pouring drinks right outside a resident's room and then delivered to that room, or, have the drinks covered if staff were walking throughout the hallway with the drinks. The DM stated that if condiments were not already in a prepared packet, then the condiments must be in a contained lid. 33215 43212 47431

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, the facility did not maintain medical records on each resident that were accurately documented. Specifically, for 2 out of 45 sampled residents, a resident's medical record contained another resident's fall report and a resident's care plan was found in another resident's medical record. Resident identifiers: 17 and 56. Findings included: 1. Resident 56 was admitted to the facility initially on 3/3/23 and was readmitted on [DATE] with diagnoses that included hereditary and idiopathic neuropathy, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, bipolar disorder, major depressive disorder, and anxiety disorder. Resident 56's medical record was reviewed between 3/11/24 and 3/21/24. A review of resident 56's medical record revealed an unwitnessed fall documentation belonging to resident 2. 30563 2. Resident 17 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia with other behavioral disturbance, cognitive communication deficit, unsteadiness on feet, abnormal postures, adult failure to thrive, major depressive disorder, and insomnia. Resident 17's medical record was reviewed on 3/11/24 through 3/21/24. A care plan dated 2/23/24, revealed [Resident 48] has expressed a need for physical affection . On 3/20/24 at 12:30 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that residents information should be in the correct medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review, the facility did not ensure that the hospice services met professional standards and principles that applied to individuals providing services in the facility, and to the timeliness of those services. Specifically, for 1 out of 45 sampled residents, the facility did not obtain from the hospice provider the nursing notes, coordination of care notes, and the correct physician's orders. Resident identifier: 119. Findings included: Resident 119 was admitted to the facility on [DATE] with diagnoses which included sarcopenia, blindness, hypertension (HTN), and cardiovascular disease. On 3/11/24 at 10:55 AM, a phone interview was conducted with resident 119's family member. Resident 119's family member stated that the facility lost resident 119's medications that were provided to the nurse. Resident 119's family member stated the facility offered to move resident to the memory care unit to provide her more care but resident 119 was not moved until the following day. Resident 119's family member stated the communication with hospice and the facility was not good. Resident 119's medical record was reviewed on 3/11/24 through 3/21/24. Progress notes revealed the following entries: a. On 3/1/24 at 10:25 PM, I received nurse to nurse on [resident 119]. [Resident 119] is a 97 yof [year old female] with vascular dementia confused and delirious. She is DNR [Do Not Resuscitate] with comfort cares. She is minimally responsive and only responds to noxious stimuli she is not eating or drinking. normally she is independent however She had a change in condition today. No recent falls. They have ordered a cxr [chest x-ray], ua [urine analysis] c/s [culture and sensitivity]. Her diet is advance as tolerated. No foley not continent. Normally she walks with a walker but was super weak today, new onset. She does not have any wounds. She is extremely hard of hearing and legally blind. Daughter will bring her meds [medications] and meet her at the facility. b. On 3/3/24 at 6:44 PM, This order is outside of the recommended dose or frequency. Metoprolol Tartrate Oral Tablet 100 MG [milligrams] Give 1 tablet by mouth at bedtime for HTN - The frequency of daily is below the usual frequency of 2 to 4 times per day. c. On 3/3/24 at 6:45 PM, New order received from hospice. 1. Metoprolol 100 mg 1 tablet po [by mouth] every evening. 2. Losartan 50 mg 1 tablet po every evening. 3. Calcium 600 with Vitamin D po 1 tablet every evening. Resident's daughter brought in medications. d. On 3/4/24 at 6:04 PM, Received order from Hospice for Lorazepam to be PRN [as needed] rather than scheduled. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 3/5/24 at 3:17 AM, . Focused Assessment: Resident takes meds whole, incontinent of bowel and bladder, requires extensive 1 person assist with ADLs [activities of daily living] and transfers. Adjustment to Admission: Resident appears to be adjusting well Pain Management: No c/o [complaints of] pain Mental Status/Behavior: Alert and oriented to self, restless at times, especially when brief is wet, staff checks on resident frequently. Improvement/Decline: Stable. f. On 3/8/24 at 2:47 PM, Ra [Resident Advocate], Admission, and Admin [Administrator] met with family to discuss concerns. Family is concerned about the level of care family member requires and the level of care rt [resident] is receiving. After discussing and resolving concerns it was decided that rt may be a good candidate for the specialized unit to provide more structure and support for resident. Daughter was able to tour the unit and expressed that she does believe that it will be a good fit for her loved one. g. On 3/9/24 at 10:30 PM, Resident transferred to Rm. [room] 217-2 'Cambridge' Wing with all personal belongings (Dtr. [daughter] aware) & report given to Nurse on Duty. h. On 3/11/24 at 2:33 AM, Patients medications are not on hand, only medications on hand are pain medications. A form titled Medication Profile dated 2/12/24 through 5/11/24, revealed current medications: a. Abilify Oral Tablet 2 mg once daily. b. Promethazine Hydrochloride (HCL) oral tablet 25 mg every 6 hours as needed. c. Acetaminophen Rectal Suppository 650 mg every 6 hours as needed. d. Bisacodyl Rectal Suppository 10 mg daily as needed. e. Hyoscyamine Sulfate sublingual tablet 0.125 mg every 4 hours as needed. f. Lorazepam oral concentrate 2 mg/ml (milliliter) every 2 hours as needed. g. Morphine Sulfate 20 mg/ml. Give 1 syringe orally every hour as needed. It should be noted there were no orders for blood pressure medication. A form from resident 119's hospice titled Physician telephone order dated 3/1/24, revealed the following medications: a. Losartan Potassium 50 mg once daily for hypertension b. Metoprolol 100 mg once daily at 7:00 PM, for hypertension c. Calcium 1000 mg once daily at 7:00 PM d. Lorazepam 2mg/ml (.05 ml) four times a day (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Crush medications as needed Resident 119's physician ordered medications entered into the medical record at the facility were: a. On 3/1/24, Acetaminophen Rectal Suppository 650 mg every 6 hours as needed b. On 3/1/24, Bisacodyl Rectal Suppository 10 mg every 24 hours as needed c. On 3/1/24, Hyoscyamine Sulfate 0.125 mg every 4 hours as needed d. On 3/1/24, Morphine Sulfate 20 mg/ml .25 ml every hours as needed e. On 3/1/24, Promethazine HCL 25 mg every 6 hours as needed. f. On 3/3/24, Metoprolol Tartrate 100 mg at bedtime g. On 3/3/24, Cozaar (Losartan Potassium) 50 mg at bedtime. The March 2024 Medication Administration Record (MAR) was reviewed. Resident 119 was not administered medication on 3/1/24 or 3/2/24. The following was revealed: a. Lorazepam 2 mg/ml, give 0.5 ml by mouth three times a day was refused by resident on 3/2/24, 3/3/24 and 3/4/24, twice daily and was administered once daily on those days. b. Metoprolol Tartrate 100 mg by mouth at bedtime was administered 3/3/24, 3/4/24, 3/5/24, 3/7/24, 3/8/24, 3/9/24, and was refused on 3/6/24 and 3/10/24. c. Cozaar (Losartan Potassium) 50 mg by mouth at bed time was administered on 3/3/24, 3/4/24, 3/5/24, 3/7/24, 3/8/24, 3/9/24, and refused on 3/6/24 and 3/10/24. d. Abilify was not on the MAR. A notice of room change was completed on 3/8/24. Resident with impaired cognition alert and oriented to self. Behaviors identified were nursing services and social services. Resident was a good candidate for resident on special care unit. There was no information regarding a hospice plan of care or what services resident 119 had received from hospice in resident 119's medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/24 at 10:26 AM, an interview was conducted with the Hospice Registered Nurse (RN). The Hospice RN stated there was no orientation when she entered the facility. The Hospice RN stated she was not aware that resident 119 had moved and was looking throughout the facility for her. The Hospice RN stated the on-call nurse was notified by the facility and did not have medications for her in stock. The Hospice RN stated hospice nurses left a form titled physician's orders when there was a change to orders. The Hospice RN stated she was unable to get Ativan scheduled at specific times because the nurse told her the facility would administer it at 6:00 AM, 10:00 AM, and 8:00 PM. The hospice RN stated she wanted Ativan scheduled at 10:00 PM, 4:00 AM, and 12:00 PM, so resident 119 would not be to tired during meal times if she wanted to eat. The Hospice RN stated she usually talked to the nurses but had not provided any paperwork. The Hospice RN stated at other facilities there was a book that she was able to sign and put any information regarding the resident when she visited. The Hospice RN stated she was not sure if there was a coordination of care completed. On 3/12/24 at 2:48 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated when a resident received hospice services she had a phone number for the nurse. LPN 2 stated the hospice nurse would usually tell the nurse when they were at the facility. LPN 2 stated the hospice nurse could leave signed or fax physician orders. LPN 2 stated usually hospice would let staff know what days they would provide showers. LPN 2 stated hospice provided the emergency kit and physician's orders. LPN 2 stated she was not aware if hospice staff left paperwork. On 3/20/24 at 10:01 AM, an interview was conducted with the RA. The RA stated resident 119's family member approached the RA because she was concerned about resident 119's level of care. The RA stated resident 119's family member felt there was not enough care and structure. The RA stated she discussed the memory care unit and let her tour it. The RA stated the memory care unit was more structured for residents with dementia. The RA stated resident 119's family member was upset that resident 119 was in someone else's clothing. The RA stated there was not a grievance completed for resident 119. The RA stated the situation could have been a grievance and should have followed the grievance procedure. On 3/20/24 at 10:10 AM, an interview was conducted with the Administrator. The Administrator stated that resident 119's family member wanted more structure in her day and making sure she was up for every meal and attending activities. The Administrator stated that staff were able to get resident's up for meals better in the memory care unit. The Administrator stated when resident 119 was admitted , she discussed the struggles resident 119 was having with the family member. The Administrator stated resident 119's family member stated that resident 119 was in the wrong clothing and her chest was exposed. The Administrator stated resident 119 was covered with a blanket when she saw her. The Administrator stated there were a few buttons that were buttoned and some that were not under the blanket. The Administrator stated she could not recall if she asked the RA to write a grievance. The Administrator stated it would have been good to have a grievance for a situation like this. The Administrator stated the Social Services came into the facility to move resident 119 to the memory care unit. The Administrator stated that resident 119 was not moved till the following day because they like to give a 24 hour notice before moving. The Administrator stated usually when a resident was admitted with hospice services, the hospice staff communicate with the nursing staff. The Administrator stated the hospice company was to provide notes for the residents medical record. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/24 at 11:48 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the hospice company faxed or emailed notes to the facility. The DON stated she was not sure how often notes should be sent to the facility. The DON stated hospice staff verbally communicate with the staff. The DON stated the telephone order on 3/1/24, was different from the ones put into resident 119's medical record. The DON stated the physician orders matched her comfort medications. The DON stated if the hospice nurse was onsite, verbal physician orders were entered into the medical record and then orders could be send over. The DON stated nursing staff could call the hospice with concerns. The DON stated there were newer employees that had not worked with us before. On 3/20/24 at 12:31 PM, a follow-up interview was conducted with the DON. The DON stated that the admission assessments for resident 119 were blank but she remembered completing them on 3/5/24, with the floor nurse. The DON stated she was not sure why they were blank. The DON stated the Admission assessments should have been completed on 3/1/24, when resident 119 was admitted but she was admitted after 10:00 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, including Coronavirus 2019 (COVID-19). Specifically, observations were made of staff members in the facility without Personal Protective Equipment (PPE). Additionally, a staff member was observed transporting dirty linens in the facility without proper coverings. Resident identifier: 58. Findings included: 1. On 3/19/24 at 2:49 PM, an interview was conducted with Certified Nursing Assistant (CNA) 12. CNA 12 stated that the CNA Coordinator went home sick with COVID-19. On 3/19/24 at 6:31 PM, the State Survey Agency received a phone call from the Administrator (Admin). The Admin stated a resident had tested positive in the facility. Resident 58 was admitted on [DATE] and again on 10/8/23 with diagnoses which include displaced fracture of surgical neck of right humerus, type 2 diabetes mellitus, alcoholic cirrhosis of liver, chronic respiratory failure, infection and inflammatory reaction due to internal left knee prosthesis, pain, hemiplegia and hemiparesis, dysphagia, difficulty in walking, pain in left hip, muscle weakness, unsteadiness on feet, repeated falls, low back pain, essential hypertension, sleep related hypoventilation, glaucoma, hemorrhoids, hyperlipidemia, anxiety disorder, and depression. Resident 58's medical record was reviewed on 3/11/24 through 3/22/24. On 3/19/24 at 6:14 PM, a Nurses Progress Note for resident 58 revealed the following: Due to resident possible exposure to Covid, she was tested . Result was positive. Resident placed in isolation. On 3/20/24 at 7:55 AM, an observation was made of the facility entrance. There was no signage informing the public that COVID-19 was in the facility. There was no PPE available for the public when entering the facility. At 10:00 AM, an observation was made of the facility entrance. There was a sign that revealed there was a COVID-19 positive case in the facility. On 3/20/24 at 1:18 PM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated she started getting a runny nose on 3/17/24. The CNA Coordinator stated she was not worried about a runny nose, thinking it was allergies, and came to work at the facility. The CNA Coordinator stated she did not wear a mask while in the facility. The CNA Coordinator stated she did not believe she needed to test for COVID-19 it was the Admin that instructed the need for COVID-19 testing. The CNA Coordinator stated she shared an office with the Minimum Data Set (MDS) Coordinator, and the Admin informed her that the MDS Coordinator tested positive for COVID-19. The CNA Coordinator stated she tested positive for COVID-19 on 3/19/24 at approximately 10:00 AM. The CNA Coordinator stated that she was in contact with the Admin providing a list of residents she had contact with for more than 15 minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 3/20/24 at 1:20 PM, Registered Nurse (RN) 2 and Housekeeper (HK) 1 were observed in the Colonial hallway not wearing a surgical mask. On 3/20/24 at 1:26 PM, Licensed Practical Nurse 1, CNA 5, CNA 6, and the Social Services Worker (SSW) were observed in the memory care unit not wearing surgical mask. On 3/20/24 at 1:31 PM, CNA 2 and CNA 7 were observed in the Colonial hallway not wearing surgical mask. On 3/20/24 at 1:37 PM, an observation was made of CNA 8 carrying a meal tray through the hallway between the two sides of the facility and not wearing a surgical mask. On 3/20/24 at 1:56 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated she was working in the facility on 3/14/24, after she had left for the day she started experiencing symptoms of illness. The MDS Coordinator stated on 3/15/24 at approximately 9:00 AM, she self-tested positive for COVID-19. The MDS Coordinator stated that she was not scheduled to work on 3/15/24, and did not come into the facility after experiencing symptoms of COVID-19. On 3/20/24 at 2:08 PM, an observation was made of room [ROOM NUMBER] assigned to resident 58. room [ROOM NUMBER] was observed to have PPE outside of the room with a Droplet Precautions sign posted on the door. On 3/20/24 at 2:11 PM, RN 1, CNA 4, and RN 6 were observed at the Rehab nursing station not wearing a surgical mask. On 3/20/24 at 2:27 PM, an observation was made of the Activities Director (AD) walking through the hallway between the two sides of the facility and not wearing a surgical mask. On 3/21/24 at 07:56 AM, an observation was made of the facility entrance. A sign was posted on the outside informing the public that COVID-19 was in the facility. Another observation was made that PPE was not available at the main door or at the reception desk. At 1:55 PM, an observation was made of the reception area. There was a box of surgical masks located on the front desk. On 3/21/24 at 8:19 AM, an observation was made of CNA 10. CNA 10 was observed in the main dining room delivering food trays not wearing a surgical mask. On 3/21/24 at 8:20 AM, an observation was made of RN 6. RN 6 was observed at the Rehab nursing station near the medication cart not wearing a surgical mask. On 3/21/24 at 8:23 AM, an observation was made of the Resident Advocate (RA). The RA was observed delivering food trays in the Heritage hallway not wearing a surgical mask. On 3/21/24 at 8:30 AM, an observation was made of RN 7. RN 7 was observed on the Heritage hallway passing medication not wearing a surgical mask. On 3/21/24 at 8:38 AM, an interview was conducted with RN 7. RN 7 stated that the facility did make her aware of an outbreak of COVID-19 in the facility. RN 7 stated that resident 58 was assigned to her, resident 58 was COVID-19 positive, and was instructed to don PPE prior to entering the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 3/21/24 at 9:33 AM, an observation was made of RN 2. RN 2 was observed on the Colonial hallway near the medication cart not wearing a surgical mask. On 3/21/24 at 9:38 AM, an observation was made of the Maintenance Director. The Maintenance Director was observed at the Colonial nurses station not wearing a surgical mask. The Maintenance Director was observed to answer resident call lights. On 3/21/24 at 9:43 AM, an observation was made of CNA 3. CNA 3 was observed in the North Rehab hallway not wearing a surgical mask. On 3/21/24 at 9:43 AM, RN 2, CNA 9, and CNA 10 were observed in the Colonial hallway not wearing a surgical mask. On 3/21/24 at 9:51 AM, CNA 5, RN 3, RN 4, CNA 8, and HK 2 were observed in the memory care unit not wearing a surgical mask. On 3/21/24 at 9:57 AM, an observation was made of the Director of Nursing (DON). The DON was observed walking the main hallway not wearing a surgical mask. On 3/21/24 at 10:00 AM, the SSW and the Admission and Marketing Director were observed in the memory care unit not wearing a surgical mask. On 3/21/24 at 10:01 AM. an observation was made of the Housekeeping Supervisor (HKS). The HKS was observed loading dirty laundry into the washing machine without wearing a surgical mask. On 3/21/24 at 10:10 AM, the Receptionist and Laundry Staff 1 were observed in the hallway between the two sides of the facility not wearing a surgical mask. On 3/21/24 at 10:31 AM, an observation was made of the AD and Therapy Recreational Tech (TRT). The AD and TRT were observed walking the main hallway not wearing a surgical mask. On 3/21/24 at 10:31 AM, an interview with the AD and TRT was conducted. Both the AD and TRT stated that they received a group text on the evening of 3/19/24, from the facility letting them know they would need to be tested for COVID-19. The AD and TRT stated on 3/20/24 at 7:46 AM, they received another text message informing them a resident test COVID-19 positive in the facility. The AD stated, that resident 58 was the resident that tested positive for COVID-19. The AD stated, resident 58 was in attendance of activities on 3/19/24, with 17 other residents. The AD stated, that she had heard of two staff members who also tested positive for COVID-19. The AD and TRT stated the only instructions given regarding COVID-19 by the facility was full PPE was needed to go into resident 58's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 3/21/24 at 10:44 AM, an interview was conducted with RN 2. RN 2 stated the facility policy for residents exposed to COVID-19, start with precautions and testing. RN 2 stated until further results from exposed residents, N95 masks should be worn when residents were out of their room or until the DON cleared the resident. RN 2 stated he would notify the DON or Administrator regarding COVID-19 status and the DON would contact the provider to determine the length of precautions. RN 2 stated if a resident tested positive for COVID-19, the facility would put the resident in isolation. RN 2 stated if a staff member was exposed to COVID-19, the staff member would inform the DON of possible exposer. RN 2 stated the DON would want to know the status of COVID-19 testing, a positive test staff member should stay away from the facility for 7 to 10 days. If staff tested negative but was still exposed, the management might tell the staff to wear a mask for a determined number of days. On 3/21/24 at 11:01 AM, an observation was made of CNA 3. CNA 3 was observed in the North Rehab hallway not wearing a surgical mask. CNA 3 was observed answering call lights and talking with residents in the hallway. On 3/21/24 11:02 AM, an observation of the AD and the TRT was made. The AD and the TRT were observed in the North Rehab hallway not wearing a surgical mask. The AD and the TRT were observed entering residents rooms to drop off the daily activities packet. On 3/21/24 at 12:58 PM, an interview was conducted with the Infection Preventionist (IP). The IP stated she was assigned to the facility to be the IP and was overseen by the DON, who has completed the IP certification. The IP stated when the CNA Coordinator tested positive for COVID-19 on 3/17/24, it was determined that anyone she had close contact with would get tested for COVID-19. The IP stated close contact was defined as, within six feet and spent 15 minutes or longer with a person who tested positive for COVID-19. The IP stated resident 58 was identified to have had close contact with the CNA Coordinator, resident 58 tested positive for COVID-19. The IP stated resident 58 was placed in isolation, placed signs on her door, placed PPE outside of the room for staff, and the physician was contacted. The IP stated the facility had been following their policy and the most recent guidelines from the Center of Disease Control (CDC) regarding COVID-19. The IP stated the regional nurses follow any updates from the CDC and would forward the information to the facilities. The IP stated the protocol for anyone exposed to COVID-19 would be tested on the first, third, and fifth day of exposure. The IP stated currently only those that had close contact with COVID-19 positive staff or residents would be tested not the whole facility. The IP stated any staff exposed to COVID-19 that tested negative or was asymptomatic would not need to wear a mask. The IP stated the Admin would be the one to contact the County Health Department when an outbreak of COVID-19 occurred. The IP stated the Admin had not contacted the County Health Department at that moment. The IP stated COVID-19 acknowledgment was not placed on the facility's entrance until the morning of 3/20/24, and reaffirmed resident 58 tested positive the evening of 3/19/24. On 3/21/24 at approximately 2:00 PM a follow-up interview was conducted with the IP. The IP stated the Admin was contacting the local Health Department right now. The IP stated when discussing with management it was determined any COVID-19 outbreak should be reported within 24 hours. A review of the Infection Prevention and Control Program revised February 2024 revealed the following: Outbreak management is a process that consists of: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Determining the presence of an outbreak; Managing the affected residents; Preventing the spread to other residents; Documenting information about the outbreak; Reporting the information to appropriate public health authorities; Educating the staff and the public; Monitoring for recurrences; Reviewing the care after the outbreak has subsided; Recommending new or revised policies to handle similar events in the future. Important facets of infection prevention include: Identifying possible infections or potential complications of existing infections; Instituting measures to avoid complications or dissemination; Educating staff and ensuring that they adhere to proper techniques and procedures; Communicating the importance of standard precautions and cough etiquette to visitors and family members; Enhancing screening for possible significant pathogens; Immunizing residents and staff to try to prevent illness; Implementing appropriate isolation precautions when necessary; Following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). According to the Center for Disease Control updated 9/23/22, the Return to Work Criteria for HCP [Healthcare Professional] Who Were Exposed to Individuals with Confirmed SARS-CoV-2 [COVID-19] Infection. Higher-risk exposures are classified as HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 infection and: HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask) HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465117	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post Acute	5540 South 1050 East Ogden, UT 84405

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure Following a higher-risk exposure, HCP should: Have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Follow all recommended infection prevention and control practices, including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection. Any HCP who develop fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html 2. On 3/21/24 at 9:43 AM an observation was made of CNA 3. CNA 3 was observed walking the North Rehab hallway through the common area near the television to the soiled linen closet with linens that wear uncovered. On 3/21/24 at 10:03 AM an interview was conducted with the HKS. The HKS stated when transporting any type of laundry, the laundry needed to be covered or bagged. The HKS stated for example if a CNA came down to the laundry area and requested sheets the laundry staff would put the sheets in a bag for the CNA and hand them to the CNA. On 3/21/24 at 10:10 AM, an interview was conducted with CNA 3. CNA 3 stated the policy for transporting linens throughout the facility was to have all laundry bagged for clean and dirty linens. CNA 3 stated with dirty laundry you want to make sure it was bagged as not to containment and not to have other residents to see the dirty laundry as it was transported. 43212 30563 45470