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	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Ogden Post-Acute (Cascades at South Ogden)	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 43 sampled residents, the facility did not allow each resident the right to formulate an advance directive. Specifically, a resident did not have a Physician Order for Life Sustaining Treatment (POLST) form. Resident identifier: 76. Resident 76 was admitted to the facility on [DATE] with diagnoses which included moderate protein-calorie malnutrition, adult failure to thrive, and Alzheimer's disease.Resident 76's medical record was reviewed on 8/18/25 through 8/21/25.No orders related to a code status or a POLST form could be located in resident 76's medical records.On 8/19/25 at 10:46 AM, an interview was conducted with Registered Nurse (RN) 1, who stated that she was unable to locate any orders related to resident 76's code status. RN 1 stated that resident 76 was on hospice when she was admitted to the facility and that the hospice company could send a completed POLST form to the facility. RN 1 stated that if orders related to a code status were not in a resident's chart she reacted to situations as if the resident was full code.On 8/19/25 at 11:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that when a resident was admitted to the facility the admitting nurse assisted a resident, or a family member if the resident was not oriented, with filling out a POLST form. The DON stated that if a resident is on hospice the facility obtains a POLST form from the hospice company, but the facility should also fill out a POLST form for themselves. The DON was unable to locate an order related to resident 76's code status. The DON stated that nurse management verified new admissions had a POLST form completed. The DON stated that if code orders cannot be located staff are expected to react to situations as if the resident was a full code.On 8/19/25 at 1:39 PM, an additional interview was conducted with the DON. The DON stated that a POLST form for resident 76 was obtained from the hospice company on 8/19/25.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility did not ensure residents who were continent of bladder received appropriate treatment and services to prevent urinary tract infections (UTI). Specifically, for 1 out of 43 sampled residents, a resident was not started on antibiotics for 11 days after complaining of continued dysuria. Resident identifier: 85. Findings included: Resident 85 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease stage 4, pulmonary hypertension, and chronic diastolic (congestive) heart failure.Resident 85's medical record was reviewed on 8/18/25 through 8/21/25.On 4/30/25 at 7:01 PM, a nurse's note documented, Resident complaining of continued burning with urination. Provider notified. New order to collect UA [urinalysis] with C&S [culture and sensitivity].On 4/30/25, a physician's order documented, UA C&S one time only for Follow up post UTI [urinary tract infection] for 3 days.On 5/2/25 at 5:13PM, a nurse's note documented, resident c/o [complaining of] burning/urination/frequency. ua picked up.On 5/2/25 at 6:12 PM, a nurse's note documented, per provider for urinary frequency and burning with urination; give pyridium 200mg [milligrams] po [by mouth] tid [three times daily] prn [as needed]. encourage fluids.On 5/2/25, a physician's order documented, Pyridium Oral Tablet 200 MG (Phenazopyridine HCl [hydrochloride] Give 200 mg by mouth every 8 hours as needed for voiding pain and frequency for 3 days.On 5/5/25 at 1:31 PM, a nurse's note documented, Provider notified of UA results, waiting for culture results at this time. No new orders.On 5/6/25 at 2:30 PM, a nurse's note documented, Provider notified of UA results, new order to refer to urology.On 5/7/25, a physician's order documented, Pyridium Oral Tablet 100 MG (Phenazopyridine HCl) Give 100 mg by mouth two times a day for Dysuria for 3 DaysOn 5/9/25 at 10:19 AM, an Antimicrobial Stewardship: Molecular Lab Result was reported. On 5/10/25 at 2:22 PM, a nurse's note documented, On call MD [medical doctor] notified of UA and C&S results. New order received for fosfomycin 3 gm [gram] PO X [times] 1 dose for UTI.On 5/10/25, a medication order documented, Fosfomycin Tromethamine Oral Packet 3 GM (Fosfomycin Tromethamine) Give 3 gram by mouth one time only for UTI until 05/10/2025 1600 [4:00 PM].The Medication Administration Record (MAR) was reviewed. On 5/10/25, the Fosfomycin Tromethamine 3 GM was not administered. A MAR note documented at 4:17 PM code 31. Chart code 31 indicated that the medication was held per MD orders. It should be noted that resident 85 never received the one time dose of Fosfomycin Tromethamine.On 5/11/25 at 10:33 AM, a nurse's note documented, Provider ordered to change Augmentin P.O dosing from 500-125 to 875-125 BID X7. RP [responsible party] notified.On 5/11/25, a physician's order documented, Amoxicillin-Pot Clauvulanate Tablet 875-125 MG Give 1 tablet by mouth two times a day for bacterial infection for 7 days.On 5/14/25 at 9:33 AM, a nurse's note documented, NP [Nurse Practitioner] ordered Pyridiumm [sic] 100 mg qd [daily] r/t [related to] dysuria.On 5/14/25 at 3:44 PM, a nurse's note documented, Results for Urinalysis with reflex to PCR [Polymerase Chain Reaction] collected 5/1/25. Negative for infection. Resident continues to report symptoms of uti. Provider would like her seen by urologist. Referral already in. transport to schedule.On 5/15/25, a physician's order documented, Pyridium Oral Tablet 100 MG (Phenazopyridine HCl) Give 100 mg by mouth one time a day for 7 DaysOn 8/21/25 at 9:49 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 85 began to complain of painful urination on 4/14/25 and started on an antibiotic on 4/18/25. The DON stated that urine culture results were received on 4/23/25 and resident 85 was kept on the antibiotic. The DON stated that resident 85 continued to complain of painful urination on 4/30/25 and a new order for a ua and urine culture was ordered and the urine was sent out on 5/2/25. The DON stated that resident 85 was started on pyridium for continued painful urination. The DON stated that on 5/9/25 the results of the urine culture were received and Fosfomycin was ordered for one dose. The DON stated that on 5/11/25 amoxicillin-clauvulanate was restarted. The DON stated she did not (continued on next page)

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South Ogden Post-Acute (Cascades at South Ogden)	5540 South 1050 East Ogden, UT 84405

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know why the provider changed the antibiotic to amoxicillin-clauvulanate after the Fosfomycin was administered. On 8/21/25 at 10:08 AM, an interview was conducted with the Assistant Director of Nursing (ADON) 1. ADON 1 stated that she was unsure why the progress note on 5/14/25 stated that resident 85 did not have a urinary tract infection.

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South Ogden Post-Acute (Cascades at South Ogden)	5540 South 1050 East Ogden, UT 84405

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not obtain laboratory (lab) services only when ordered by a physician; physician assistant; nurse practitioner, or clinical nurse specialist. Specifically, for 1 out of 43 sampled residents, a resident had a Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), erythrocyte sedimentation rate (ESR), and C-Reactive Protein (CRP) collected prior to the date the physician's order stated. Resident identifier: 7.Findings included:Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic encephalopathy, paranoid schizophrenia, acute kidney failure, and acquired absence of left leg below knee.Review of resident 7's records was completed on 8/18/25 through 8/21/25.On 7/26/2025 at 10:10 PM, a Nurses Note revealed new orders per house provider were entered. Due to highly elevated ESR and CRP and patient biting hands, internal inflammation may be the cause, steroid to be started on 7/28/25 (Monday). Draw labs on 8/4/25 (Monday) for CBC, CMP, ESR, and CRP.On 7/26/25 a physician's order was entered for labs CBC, CMP, ESR, CRP one time only for Elevated ESR, CRP for 1 Day. This is a Repeat Lab after completion of steroid treatment with a start date of 8/4/25.It should be noted that no laboratory results for 8/4/25 could be located in the medical record.On 8/21/2025 at 9:35 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the lab orders from 8/4/25 for CBC, CMP, ESR, and CRP were received and entered on a weekend, and the lab request form was placed in the lab binder. When lab services came on 7/30/25 the lab request was drawn prior to the completion of the steroid treatment and not on 8/4/25 as the order stated.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined for 2 out of 43 sampled residents, that the facility did not file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, two residents laboratory results were not located in the electronic medical record. Resident identifiers: 5 and 85.Findings included:1. Resident 5 was admitted to the facility on [DATE] with diagnoses which included, obstructive and reflex uropathy, acute kidney failure, and type 2 diabetes.Resident 5's medical record was reviewed 8/18/25 through 8/21/25.A review of resident 5's medical record revealed: a. A physician's order dated 6/23/25 documented, Urinalysis with culture and sensitivity. one time only for Hematuria and increased urine sediments. for 1 day only.There was no urine culture and sensitivity laboratory results located in resident 5's medical record. b. A physician's order dated 8/8/25 documented, UA [urinalysis] with reflex to culture one time only for UTI [urinary tract infection] symptoms for 1 dayThere was no urine culture and sensitivity laboratory results located in resident 5's medical record. 2. Resident 85 was admitted to the facility on [DATE] with diagnoses which included, chronic kidney disease, lymphedema, and pulmonary hypertension.Resident 85's medical record was reviewed 8/18/25 through 8/21/25.A physician's order dated 4/30/25 documented, UA with C&S [culture and sensitivity] one time only for Follow up post UTI for 3 daysThere was no urine culture and sensitivity laboratory results located in resident 85's medical record. On 8/21/25 at 8:43 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the Assistant Director of Nursing (ADON) 1 was the one who handled printing the labs and had the medical provider sign them. The DON stated after the results were reviewed and signed by the medical provider the results would be uploaded into the electronic medical record. The DON stated that medical records was in charge of ensuring the results got uploaded into the resident's chart. On 8/21/25 at 10:33 AM, an interview was conducted with Medical Records. Medical Records stated that he started the position about 4 months ago and at first he did not know that lab results were to be uploaded into the results section of a resident's medical record. Medical Records stated that after the DON and ADON reviewed lab results the results were placed in a folder in the copy room and he got them from there. Medical Records stated that it was hard to concentrate on uploading medical records because he was so busy with other things that he tried to find time to scan them in. Medical Records stated that he was behind on scanning records because he was the only person uploading records and he hadn't been able to keep up.

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	465117	A. Building B. Wing	08/21/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, it was determined that the facility did not store, prepare, distribute, and serve food in accordance with professionals standards for food safety. Specifically, there were observations of numerous flies making contact with food preparation surfaces and utensils in the kitchen, observations of kitchen staff not properly wearing hairnets, observations of staff not washing their hands after leaving the kitchen and returning, and observations of dirty ceiling tiles above food preparation areas of the kitchen. Findings Included:On 8/20/25 at 11:37 AM, an observation was made of the facility kitchen while lunch was being plated and served. There were multiple flies in the kitchen. The flies were landing on hotel pans and food preparation tables. The ceiling above the tray line area of the kitchen was dirty. On 8/20/25 at 11:44 AM, Dietary Aide (DA) 1 was observed to be wearing a hairnet. The hairnet only covered the bun on the back of her head, and not the face framing pieces of her hair. DA 1 was observed to touch her hair, then touch a resident's meal plate that was being prepared without washing her hands. On 8/20/25 at 12:12 PM, DA 2 was observed to leave the kitchen and then return. DA 2 did not wash her hands upon returning to the kitchen. DA 2 started handling food without washing her hands. On 8/21/25 at 9:24 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that the kitchen does not handle pest control and that maintenance is responsible for pest control. The DM stated that all staff in the kitchen should be wearing a hairnet. The DM stated that kitchen staff should wash their hands when starting shifts, when changing gloves, when changing tasks, when using the restroom, when they leave the kitchen, and when switching between handling clean and dirty dishes.

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	465117	A. Building B. Wing	08/21/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Based on interview and record review, it was determined for 1 of 43 sampled residents, the facility failed to maintain medical records on each resident that was complete, accurately documented, readily accessible, and systematically organized. Specifically, a resident had no documentation regarding an incident. Resident identifier: 36.Findings included:Resident 36 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction, heart failure, and chronic respiratory failure.Resident 36's medical record was reviewed on 8/18/25 through 8/21/25.On 8/19/25 at 8:12 AM, resident 36 stated that her eyebrows were singed when a staff member was assisting her in lighting her cigarette.An email from Licensed Practical Nurse (LPN) 1 was time stamped at 8/20/25 at 12:39 PM. LPN 1 stated that on 8/5/25 at approximately 6:30 PM she assisted resident 36 with lighting a cigarette with a lighter. LPN 1 stated that as resident 36 leaned in to light the cigarette a few strands of hair were singed, and LPN 1 immediately extinguished the lighter. LPN 1 stated that she conducted an immediate assessment of resident 36 and no evidence of burns or injury to the skin was found. LPN 1 stated that resident 36 was lighthearted and in good spirits after the incident.No documentation of this incident was located in resident 36's medical record.On 8/20/2025 at 2:37 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that if there was an incident where a resident could have been injured the nursing staff was required to notify nurse management, the administrator, and the resident's provider. The DON stated that nursing staff was encouraged to make a progress note about the incident. The DON stated that the incident with resident 36 was a gray area because resident 36 was calm, there was no harm, and everything was resolved.