STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465143	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Health and Rehabilitation	411 West 1325 North Cedar City, UT 84721

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined for 5 out of 41 sampled residents, that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible; and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, 5 residents had multiple falls without continued attempts at interventions to prevent additional falls. Additionally, one resident had repeated accidents while operating his motorized wheelchair and had been assessed as not safe to operate the motorized wheelchair. Resident identifiers: 1, 39, 43, 53, and 62. Findings included:1. Resident 53 was admitted to the facility on [DATE] with diagnoses which included palliative care, anxiety disorder, and Alzheimer's disease. On 6/23/25 at 8:01 AM, an observation was made of resident 53. Resident 53 was wandering in the dining room and hallway with one non-slip grip sock on her foot and one on her hand. Resident 53's medical record was reviewed 6/22/25 through 6/26/25. A care plan dated 5/18/25 revealed At risk for falls r/t [related to] hx [history] of falls at home, new admit, Dementia The goal was to not sustain a serious injury through the review date. Interventions included the following: a. On 5/28/25, Avoid rearranging furniture; b. On 5/22/25, Bed exchanged for a low bed, bed lowest position; c. On 5/18/25, Bed in lowest position; d. On 5/22/25, Check on resident more frequently; e. On 5/18/25, Ensure resident was wearing appropriate footwear when ambulating or wheeling in wheelchair (w/c); f. On 5/28/25, Invite resident to all activities; g. On 5/18/25, Keep needed items, water, etc, in reach; h. On 5/18/25, Maintain a clear pathway, free of obstacles; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Actual harm Residents Affected - Few	i. On 5/28/25, Needs a safe environment: floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; Side rails as ordered, handrails on walls, personal items within reach; j. On 6/20/25, Provide supervision and assistance with daily activities, especially during mobility; and k. On 5/28/25, Walk with resident when possible when resident was walking in the hallway. Incident reports and progress notes were reviewed and revealed the following falls: a. On 5/18/25 at 12:00 AM, resident 53 was found on the floor next to her recliner. Denied hitting her head but complained of hip pain. The care plan revealed a new intervention to ensure resident 53 was wearing appropriate footwear when ambulating or wheeling in w/c; Keep needed items, water, etc, in reach; bed in lowest position; and Maintain a clear pathway, free of obstacles. b. On 5/21/25 at 8:20 PM, resident 53 was found laying on the ground next to her bed on the fall mat. There were no interventions on the care plan after this fall. c. On 5/22/25 at 12:00 AM, resident 53 was found laying on the ground next to her bed with her head bleeding. Resident 53's husband stated resident 53 rolled off her bed onto the ground. The care plan intervention was bed exchanged for a low bed, bed lowest position and check on resident more frequently. d. On 5/27/25 at 4:25 PM, resident 53 fell in another residents room. There were no new updated care plan interventions. e. On 5/28/25 at 2:45 AM, resident 53 tripped over the standing scale while walking around the memory care unit. Resident 53 hit her left eyebrow, causing a laceration. The care plan interventions included avoid rearranging furniture; invite resident to all activities; needs a safe environment; and walk with resident when possible when resident was walking in the hallway. f. On 5/28/25 at 8:30 AM, resident 53 sat down twice in the memory care unit hallway while wandering around. g. On 6/19/25 at 4:15 PM, resident 53 was found on the floor in the dining room. The care plan intervention included provide supervision and assistance with daily activities, especially during mobility. h. On 6/19/25 at 6:30 PM, resident 53 was sitting on her buttocks at the end of the 200 hallway. An IDT [Interdisciplinary Team] note dated 6/24/25 at 9:59 AM, revealed the resident's care plan was updated to provide supervision and assistance with daily activities, especially during mobility and transfers. There were no interventions on the care plan. i. On 6/25/25 at 7:16 AM, a nurse was alerted that CNA [Certified Nurse Assistant] had heard a noise coming from resident 53’s room. Resident 53 was found lying next to the bed on a fall mat. Resident 53 had a laceration to her left forehead. Resident 53 was sent to the hospital for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/25/25 at 1:31 PM, an interview was conducted with resident 53's family member, who resided in the same room as resident 53. The family member stated resident 53 fell that morning and hit her head. The family member stated resident 53 was transported to the hospital for evaluation of the laceration on her head that required steri-strips. The family member stated resident 53 was in bed and then probably sat at the side of her bed and fell forward. The family member stated resident 53 did not have an alarm but had a low bed and mats next to her bed. The family member stated he waited until resident 53 went to sleep before he was able to go to sleep to make sure she did not get up and fall without staff knowing. The family member stated sometimes night staff were really busy and did not respond quickly to his call light. The family member stated the other night it took staff 30 minutes to respond to the call light. At 1:39 PM, resident 53 was observed to wake-up, stand up out of bed and then walked with an unsteady gate towards the family member. The family member was bed bound and stated to resident 53 to please sit back down. The family member pushed the call light. There were no staff in the hallway available to assist resident 53. At 1:41 PM, CNA 4 was observed in the hallway and was notified that resident 53 was walking. On 6/25/25 at 1:44 PM, an interview was conducted with CNA 4. CNA 4 stated staff had to Keep eyeballs on her [resident 53]. CNA 4 stated resident 53 usually sat with staff in the hallway but resident 53 seemed sleepy so she laid resident 53 down in her bed. CNA 4 stated resident 53 was laying in bed that morning and rolled out of bed hitting her head on the floor. CNA 4 stated sometimes resident 53 sat on the edge of her bed and then fell forward. CNA 4 stated resident 53 did not have a silent alarm on her bed like another resident did. On 6/25/25 at 2:47 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 53 had zero cognition and she wandered all day and whimpered. The DON stated resident 53's family member resided in the same room with her in the secured unit. The DON stated when staff saw resident 53 up wandering, they walked with her. The DON stated resident 53 fell that morning and hit the side of her head. The DON stated he was not sure what happened but resident 53 was sent to the hospital to be evaluated. The DON stated resident 53 was able to get out of bed on her own, sit at the side of the bed, and sometimes fell from there. The DON stated he was not sure if resident 53 had a fall from tripping over a fall mat. The DON stated the Interdisciplinary team had not discussed a larger bed, beveled mattress or a silent alarm for resident 53. The DON stated the criteria for determining if someone needed an alarm would be if someone was in bed a lot. The DON stated resident 53 was fast, so a beveled mattress might not be appropriate. The DON stated resident 53 was discussed in the Quality Assurance meeting regarding falls in the facility. 2. Resident 62 was admitted to the facility on [DATE] with diagnoses which included intracranial injury with loss of consciousness, cerebral infarction, acute resp failure, spinal instabilities, ilium fracture, mandible fracture, and anxiety. On 6/25/25 at 1:00 PM, an observation was made of resident 62 in the dining room. Resident 62 was observed to be wheeled to her room and assisted to bed by CNA 4. Resident 62 was observed to have socks without grippers on and fall mats on both sides of her bed. Resident 62’s bed was observed to be 3 feet from the ground. Resident 62’s medical record was reviewed 6/22/25 though 6/26/25. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note dated 4/4/25 at 10:53 PM revealed, The resident is a [AGE] year-old female who admitted to our facility today with a PMI [past medical information] of a severe TBI [traumatic brain injury] with subdural, subarachnoid, intraparenchymal bleeds, unstable c-spine fracture s/p [status post] fusion, all suffered from MVA [motor vehicle accident] . A care plan dated 4/5/25 revealed resident 62 was “At risk for falls r/t multiple falls at hospital, seizure disorder, weakness”. The goal was “Will be free of minor injury through review date”. Interventions included: a. On 4/24/25, Therapy and resident to communicate prior to transfer to be sure both are ready for transfer; b. On 4/7/25, Anticipate and meet needs; c. On 4/5/25, Be sure the call light was within reach and encourage her to use it to call for assistance as needed; d. On 4/11/25, Educate using call light to get assistance prior to transferring; e. On 6/12/25, Ensure resident was wearing appropriate LEFT KNEE BRACE and footwear when ambulating or wheeling in w/c; f. On 4/19/25, Floor mats at both bedsides; g. On 6/16/25, Keep needed items, water, etc, in reach; and h. On 5/8/25, Needs a safe environment: assistive devices as ordered when applicable. Additional care plans after resident 62 fell included the following interventions on 4/7/25 keep needed items, water, etc, in reach; on 4/5/25 be sure the call light is within reach and encourage to use it to call for assistance as needed; on 4/7/25 anticipate and meet needs; on 4/5/25 be sure the call light is within reach and encourage to use it to call for assistance as needed. It should be noted there were no incident reports for falls on 4/5/25 and 4/7/25. Resident 62’s progress notes and incident report revealed the following falls: a. On 4/11/25 at 7:30 AM an incident report and progress notes revealed, CNA found resident 62 sitting on the ground. Resident 62 stated she was trying to use the bathroom when she stumbled and fell. The care plan intervention included education using call light to get assistance prior to transferring; bed in lowest position; check range of motion; continue at risk plan; no apparent acute injury, monitor and document signs and symptoms of pain, change in mental status etc; and vital signs as ordered. A progress note dated 4/11/25 at 11:31 PM, bed in lowest position and education on informing staff. A progress note dated 4/12/25 at 2:27 PM, .Resident reminded to use call light and not transfer self. Education given resident sat back down waiting for help . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note dated 4/13/25 at 11:14 AM, . Resident observed walking to dining room alone today. Resident highly encouraged to call for help . b. On 4/14/25 at 8:40 AM, the incident report revealed resident 62 was found on the floor. Immediate action taken was aides stated she was carrying her meal tray and lost her balance. Resident 62 had complaints of pain to her wrist and right shoulder. There were no interventions located on the care plan after this fall. c. On 4/15/25 at 2:15 AM, the incident report revealed CNA found resident 62 on the floor in her room. Resident 62 stated she hit her head and right elbow. The resident had a little bruise to her right elbow, no other injuries upon assessment. A new care plan was developed which included providing activities that promoted exercise and strength building where possible and therapy consultation for strength and mobility. It should be noted resident 62 was receiving therapy services starting 4/7/25. On 4/17/25 at 1:32 PM, a therapy progress note revealed, “SLP [Speech Language Pathologist] unable to administer the SLUMS [St. Louis University Mental Status] or BIMS [brief interview of mental status] due to significant expressive and receptive aphasia present. On 4/7/25, SLP administered the MAST [Mississippi Aphasia Screening Test] aphasia assessment with an expressive subscale of 10/50 and receptive subscale of 12/50 with a total score of 22/100 with does indicates substantial aphasia impacting both her receptive and expressive communication. The patient also is unable to ambulate independently and shows poor safety awareness. She suffered a severe TBI and subsequent CVA [cerebrovascular accident] which has impacted all areas of her health, and she would not be safe to live in an independent living setting at this time.” On 4/17/25 at 2:56 PM, a fall committee IDT revealed “Resident had fall on the 11th, 14th,15th. with no injury. resident has been educated on using call light, has low bed, working with therapy for strength. Mother is working on getting her new glasses to see if it helps, family reports poor eyesight may be a cause…, interventions in place.” d. On 4/18/25 at 12:00 AM, resident 62 was found on the floor sitting next to her bed, while holding onto the bed bar. Resident 62 had no injuries related to fall. The care plan revealed the same interventions as the fall on 4/15/25. e. On 4/19/25 at 5:45 PM, staff were walking out of resident 62’s room, resident was previously sitting on the bed but was found on the floor between the bed and wall. The care plan included mats to both sides of the bed. A nursing progress note dated 4/21/25 revealed a bed alarm was placed. It should be noted there was no information on the care plan regarding a bed alarm. A fall committee IDT dated 4/22/25 at 7:33 AM, revealed “The fall committee met on 4/22/25 to discuss the incidents that occurred on 4/18/25 and 4/19/25, the resident was found sitting on the ground next to bed, ., muscle weakness, unsteadiness on feet, and TBI, the resident's interventions include a low bed, floor mats, and medication review by both pharmacy and the provider… “; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A progress note revealed on 4/23/25 at 1:37 PM, the family brought in a left knee brace and prescription glasses for resident 62 to wear. Resident 62 used the knee brace prior to the accident and was able to apply herself. “On while up”. The at risk care plan was updated on 6/12/25 which revealed Ensure resident is wearing appropriate LEFT KNEE BRACE and footwear when ambulating or wheeling in w/c.” It should be noted that this intervention was not added until 6/12/25. f. On 4/24/25 at 12:00 AM, resident 62 had a witnessed fall and hit her head and left hip. Resident 62 was sitting on the floor upon arrival. Resident 62 did not have any injuries noted with fall. Therapy staff mentioned head and left hip was hit during fall. The care plan intervention was therapy and resident to communicate prior to transfer to be sure both were ready for transfer. An additional care plan revealed bed lowest position, check range of motion, continue at risk interventions, monitor for pain, bruises, change in mental status and new onset, and vital signs as ordered. A Fall Committee IDT dated 4/29/25 at 2:38 PM revealed the same information as above and there was no information if resident 62 fell during a transfer with therapy. g. On 5/1/25 at 2:15 AM, the incident report revealed a CNA heard a thug sound and entered the resident's room finding resident 62 on the floor in her bathroom in front of the toilet. The interventions included the same as the fall on 4/24/25 with neuro checks as ordered and no apparent acute injury, determine and address causation factors of the fall and pharmacy consult to evaluate medications. h. On 5/2/25 at 12:55 AM, the incident report revealed resident 62 was observed laying face down on the floor after staff heard a loud noise coming from her room. Resident 62 was assisted off the ground and to her bed. Resident 62 had a large bump on her forehead and reported a headache and a little brain fog. Resident 62 was sent to the hospital for evaluation. The care plan revealed no shunt was needed and Xanax was discontinued. The interventions were the same as the previous ones. i. On 5/4/25 at 10:35 AM, resident 62 was found sitting on her bottom in the bathroom. The care plan interventions included to continue interventions on the at-risk plan, neuro-checks as ordered, and vital signs as ordered. A Fall Committee IDT dated 5/6/25 at 7:54 AM revealed “The fall committee met on 5/6/25 to discuss the incidents that occurred on 5/1/25, 5/2/25, and 5/4/25 the resident was found sitting on the ground in front of the toilet, next to bed, the resident did sustain bruising to the head and face with the 5/2/25 incident, .The resident's care plan was updated with this event.” k. On 5/8/25 at 10:00 AM, a nurse was alerted that during a transfer from bed resident 62 lost balance and CNA was unable to assist resident onto bed or wheelchair. Resident 62 was gently lowered by CNA to her buttocks onto the ground. The care plan intervention was resident 62 needed a safe environment: assistive devices as ordered when applicable. A nursing progress note dated 5/10/25 at 9:53 AM, revealed .Resident had to be reminded to use wheelchair instead of ambulating without assistance. Resident acknowledged reminder, and allowed nurse to help her into wheelchair… (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note dated 5/12/25 at 3:17 PM revealed, “Resident was assessed by NP [Nurse Practitioner] in facility. New orders received to obtain ultrasound of forehead to assess contusion present from previous fall…“ A Fall Committee IDT dated 5/13/25 at 7:56 AM revealed, resident was lowered to the ground on 5/8/25. The resident's interventions included a low bed, floor mats, Therapy and resident to communicate prior to transfer to be sure both are ready for transfer, and medication review by both pharmacy and the provider. The resident's care plan was updated with this event. On 6/25/25 at 12:43 PM, an interview was conducted with the Occupational Therapist (OT) 1. OT 1 stated resident 62 was receiving OT, Physical Therapy (PT) and SLP since 4/7/25 when she was admitted . OT 1 stated resident 62 was discharged from PT on 6/10/25. OT 1 stated resident 62’s cognition was “pretty poor”. OT 1 stated for OT it depended on the day if resident 62 was able to remember tasks. On 6/25/25 at 12:45 PM, an interview was conducted with Physical Therapist Assistant (PTA) 1. PTA 1 stated resident 62 had a TBI from a MVA. PTA 1 stated resident 62 did a lot of balancing exercises because she had right sided weakness. PTA 1 stated all exercises were to reduce her risk for falls because she had fallen multiple times since admission. PTA 1 stated resident 62 was discharged from PT services because she had met her goals. On 6/25/25 at 12:55 PM, an interview was conducted with CNA 4. CNA 4 stated resident 62 was able to understand but struggled to verbally communicate. CNA 4 stated she was able to tell with resident 62’s body language what she wanted. CNA 4 stated resident 62 had routines and depending on the time she was able to understand what CNA 4 wanted. CNA 4 stated resident 62 might remember education to wait for staff assistance before getting up. CNA 4 stated resident 62 had not been getting up lately because she had a routine. CNA 4 stated interventions to prevent falls included a bed that was low to the ground, grippy socks on but she usually had shoes on, glasses on, staff check on her to make sure she was doing alright every 2 hours. CNA 4 stated if there was a new intervention developed, there was communication in an email that managers and shift leaders sent staff. On 6/25/25 at 1:03 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated if there was a new intervention after a fall meeting, the management team informed staff of new interventions verbally and through the care plan. LPN 2 stated for resident 62 she should have proper footwear, gripper socks or shoes, and ask for help before getting into bed to prevent falls. LPN 2 stated gripped socks prevented her from falling and educating her on calling for help and waiting for assistance. LPN 2 stated resident 62 tried to self transfer because of her lack of impulse control. LPN 2 stated when staff laid resident 62 in her bed, they reminded her to call for assistance. LPN 2 stated staff tried to do frequent checks and monitor her. LPN 2 stated there was not a specific time for the checks. LPN 2 was observed to check resident 62’s care plans and stated interventions to prevent falls were to have therapy promote safe transfers, call light and anything she needed within reach, educated on the use of a call light and waiting for assistance, appropriate footwear, left knee brace in place, and floor mats on either side of her bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/25/25 at 1:14 PM, an interview was conducted with CNA 6. CNA 6 stated fall interventions to prevent falls for resident 62 were to make sure her bed was in the lowest position, make sure she had non-slip socks or shoes on and monitor her. CNA 6 stated monitoring resident 62 meant to check on her every 30 minutes to make sure she was okay. An observation was made with CNA 6 of resident 62 in bed. CNA 6 stated the bed was not in the lowest position and confirmed it was about 3 feet from the ground. CNA 6 was observed to lower the bed to the lowest position and stated resident 62’s bed should be at that level. CNA 6 observed resident 62’s footwear and stated they were not non-slip socks. CNA 6 stated she was not aware of a knee brace. On 6/25/25 at 2:12 PM, an interview was conducted with the DON. The DON stated the ADON (Assistant Director of Nursing) and UM (Unit Manager) attended the fall committee meetings and put new interventions on the care plan after a fall. The DON stated the fall committee came up with a new intervention, added it to the care plan and then updated the kardex for the CNA’s. The DON stated resident 62’s cognition was improving but she continued to have fluid on the brain. The DON stated as the fluid increases her cognition changed. The DON stated falls had been discussed in the Quality Assurance meetings in order to get “her to where she isn't falling”. The DON stated some of her falls were related to her cognition, some were because she didn't want to be at the facility, and some were because she was trying to crawl out of bed. The DON stated once her mom and a gentleman friend started coming it had helped to reduce sadness. The DON stated interventions to prevent future falls were on the care plan. The DON stated the interventions were reused on the care plan. The DON stated resident 62 refused the brace to her left knee. The DON stated the therapy evaluation was reused because there were different types of therapy that were done. The DON stated the intervention for 5/8/25 with devices to use, was referring to her knee brace because she refused it. The Administrator stated having structured activities, getting her hair done, and going to the dining room were helpful for her. The Administrator stated resident 62 was frustrated and annoyed when she was admitted and was now engaging more. A QAPI (Quality Assurance and Performance Improvement) Plan for Cedar health and Rehab Skilled Nursing Facility 3/18/25 document indicated a Performance Improvement Project (PIP) was started for an increased number of falls. It further indicated a Problem Statement, “Increased numbers of falls, not implementing interventions.” It further indicated root causes identified were, “opened unit-higher census.” It indicated Steps to include, “Develop and Implement Interventions: -interventions added to Kardex-increased rounding-Angel rounds;” and “Monitor and Measure: -bring to QA [Quality Assurance] -review falls at weekly fall meeting (root Cause) -reduce clutter.” A Quality Improvement Activity Sheet dated 3/18/25 indicated, “Facility seeing an increase in number of falls Increase in number of falls with injury.” It further indicated Year 2025 Incident Rates of: a. Falls with Injuries had a percentage of 0% in March, April, and May; b. Resident with Falls March 19.12%, April 15.58%, and May 19.23%; c. Total Number of Documented Falls March 42.0, April 45.0, and May 56.0; d. Total Number of Falls with Injuries 0.0 for March, April, and May; and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	e. Total Number of Resident with Falls March 13.0, April 12.0, and May 15.0. It should be noted resident 62 and resident 63 experienced falls with injuries after 3/18/25 when the QAPI was initiated. 3. Resident 1 was admitted to the facility on [DATE] with diagnoses which consisted of malignant neoplasm, dementia, alcohol abuse, epilepsy, nondisplaced fracture of right tibial tuberosity, history of falls, altered mental status, and major depressive disorder. On 6/23/25 at 9:10 AM, an interview was conducted with resident 1. Resident 1 stated that he broke his leg from a fall he had while in the facility. Resident 1 stated that he slipped and that was what caused the fall. Resident 1 stated that he was independent with transferring and mobility and did not need any help from the facility staff. Resident 1 was observed seated in his wheelchair and a reacher bar and call light were within reach. Resident 1's medical record was reviewed. On 12/5/23, the Quarterly Minimum Data Set (MDS) assessment documented a BIMS score of 15/15, which would indicate that the resident was cognitively intact. The assessment documented no impairment to the functional Range of Motion (ROM) of both upper and lower extremities and no mobility devices were utilized. On 3/4/24, the Annual MDS assessment documented a BIMS of 15/15. The assessment documented a functional impairment to the ROM of one side of the lower extremity and a w/c was utilized as a mobility device. Resident 1's progress notes, incident reports, and care plan revealed the following: a. On 2/24/24 at 6:18 PM, the Incident Note documented, CNA [name omitted] reported that pt [patient] had a fall in the dining room. CNA [name omitted] witnessed the fall and pt bonked his head to the fridge. Assisted the pt to the WC [wheelchair]. Advised to use WC when ambulating until seen by the ear doctor. Pt denies pain. No injuries noted. Neuro and VS [vital signs] initiated. VSS [vital signs stable] and WNL [within normal limits]. PERRLA [pupils equal, round, reactive to light and accommodation]. NO changes in LOC [level of consciousness]. Incident reported to [name omitted] RN [registered nurse], [name omitted] (DON), MD [Medical Doctor] and [name omitted]. Will continue to monitor. b. On 2/24/24 at 11:53 PM, the nursing note documented, Resident had a fall earlier on day shift and hit his head on the fridge in the cafeteria. He said he lost his balance and fell. No other observed injuries d/t [due to] fall. He asked for APAP [Tylenol] before bed and rested comfortably throughtout [sic] the night. (continued on next page)

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	465143	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Health and Rehabilitation	411 West 1325 North Cedar City, UT 84721

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F 0689 Level of Harm - Actual harm Residents Affected - Few	c. On 2/26/24 at 12:00 AM, the provider note documented, [AGE] year-old male who has a history of vascular dementia as well as alcohol abuse in the past was seen after ground-level fall. The patient was in the dining room when he tripped and fell down. Afterwards he has not been putting any weight on his right hip or right knee. He states that they are very tender to the touch and when he tries to weight-bear it hurts him so he is not using them. He has had to use a wheelchair to get around which is different for him Patient has right knee pain after fall he also has some right hip pain I have ordered plain films of both of these to see if there is any bony abnormalities. d. On 2/26/24 at 12:00 PM, the nursing note documented, Resident is doing well post fall. He is hesitant to ambulate and is using a w/c at this time. Resident has weakness and is unsteady. Gait is off-balance at this time. Resident is encouraged to use the w/c and verbalized understanding. He is cautious. Neuros have been completed and WNL. VSS. New order for a R [right] hip and R knee x-ray from [provider name omitted] today. Requisition given to med records and he will get this done tomorrow. No other concerns. e. On 3/1/24 at 3:50 AM, the incident report documented, CNA reports entering room and discovering resident sitting on floor. Resident reported to CNA he had slipped out of bed after transferring from wheelchair to bed. Nurse and CNA assisted resident back in to bed. Resident denies any injury or pain at this time. Resident denies having hit his head at time of incident. Resident 1's care plan did not have any new interventions identified status post fall. f. On 3/1/24 at 12:00 AM, the provider note documented, Today is being seen and evaluated for x-ray results following a fall that occurred just over a week ago. He was able to obtain an x-ray of his leg which she has had difficulty walking on since the time of the fall. The x-ray was obtained in [name omitted] while also getting an MRI [magnetic resonance imaging] that had been scheduled of his head related to some dizziness and an ear infection. X-ray results have returned after several days and after the patient has seen the pain specialist. Indicating that he has a positive tibial plateau fracture of the right leg. The patient states his pain is been fairly tolerable there have been days that he does not report any pain at all that although he did report pain to the pain specialist. There have been some mild inconsistencies in his case and how he does report his discomfort. Which has led to some inconsistencies in his treatment plan. He has establish safety by using a wheelchair over the past week. He will receive a referral to orthopedics at this time. g. On 3/5/24 at 7:26 AM, the nursing note documented, The fall committee met on 3/5/24 to discuss the incident that occurred on 3/1/24, the resident was found on the floor in his room, the resident stated that he slid off of his bed onto the floor, the resident did not have complaints of pain, the resident was then educated to use the call light to ask for assistance to transfer, the resident's MD and the DON were made aware of the incident, the resident's care plan has been updated. It should be noted that resident 1's care plan had an intervention of Be sure the call light is within reach and encourage to use it to call for assistance as needed that was initiated on 1/16/19. Resident 1's care plan did not have any new interventions identified status post fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	h. On 3/6/24 at 3:49 PM, the nursing note documented, Resident received an x-ray order on Monday, [DATE]th from [name omitted]. Resident had an appt [appointment] for a procedure that coming Thursday in [name omitted], and gave the okay for resident to have his x-ray done when he goes to [name omitted] for his MRI so he can complete at the same time while there, as resident had no c/o pain or discomfort to MD at this time. Resident went to [name omitted] on Thursday, [DATE]th and had an MRI of the spine and brain, and a R knee x-ray completed. Resident returned from appt that same day, we

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined, for 1 out of 41 sampled residents, that the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, a resident did not receive her morning dose of Metoprolol due to the medication being out of stock. Resident identifier 37.Findings included:Resident 37 was admitted to the facility on [DATE] with diagnoses which consisted of essential hypertension and chronic kidney disease stage 3.On 6/24/25 at approximately 8:00 AM, an observation was made of Licensed Practical Nurse (LPN) 1 during morning medication administration for resident 37. LPN 1 did not administer resident 37's scheduled Metoprolol due to the medication not being available.Resident 37's medical records were reviewed.On 11/26/24, resident 37 had an order initiated for Metoprolol Tartrate Oral Tablet 50 milligram (mg), give 1 tablet by mouth two times a day for hypertension. The order documented that the medication was scheduled to be administered during 7:00 AM to 9:00 AM and again at 8:00 PM to 10:00 PM.On 6/24/25 at 9:26 AM, an interview was conducted with LPN 1. LPN 1 confirmed that the Metoprolol was out of stock. LPN 1 stated that she called the pharmacy and they said that the medication would be filled today. LPN 1 stated that the pharmacy would deliver the medication around 3:00 PM today. On 6/24/25 at 1:09 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that to order medications they went into the electronic medical records for that resident and under the medication clicked reorder. RN 1 stated that they could also call the pharmacy to request a refill. RN 1 stated that when she observed a medication blister pack that had only the marked blue section of pills remaining that was time to place an order. RN 1 stated that the blue section of a medication blister pack was usually 8 days from when the medication would be out of stock. RN 1 stated that the purpose of blue section on the blister pack was to trigger the nurse to reorder so they did not run out of medication. RN 1 stated that they did not want residents missing medication doses. RN 1 reviewed a list of medications that were available in the Cubix and stated that they did not have an emergency supply of Metoprolol. RN 1 stated that resident 37's Metoprolol was last ordered on 6/7/25. RN 1 stated that the medication was to manage resident 37's blood pressure. RN 1 stated that if resident 37 missed a dose she would monitor her blood pressure or any complaints of a headache or restlessness. RN 1 stated that she would put resident 37 on 30 minute checks until the medication was available and administered. RN 1 stated that she would inform the Director of Nursing (DON) and Medical Doctor (MD) of any missed doses of medications and would also document the missed dose and notifications in a progress note. RN 1 reviewed resident 37's progress notes and stated that the nurse had not made a progress note today. RN 1 stated that the Metoprolol was scheduled two times a day and was to be administered between 7:00 AM to 9:00 AM and again at 8:00 PM to 10:00 PM. RN 1 stated that resident 37 had missed the morning dose of the Metoprolol.On 6/24/25 at 2:50 PM, an interview was conducted with the DON. The DON stated that the medical records were integrated for medication reorders, and the order went straight to the pharmacy. The DON stated that the nurse should reorder the medication when the blister pack gets down to the last row in the card to ensure timely delivery of the medication. The DON stated that if a medication was not delivered the nurse should notify the MD and call the pharmacy. The DON stated that most of the time they would put a note in to document the MD notification. The DON stated that if the medication was going to be administered late they should have documentation that the MD was notified. The DON stated that he would have expected the nurse to notify the MD by 11:00 AM if the medication was still not available.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, for 5 of 41 residents, the facility did not provide food prepared by methods that conserve flavor and appearance or provide food and drink that was palatable, attractive, and at an appetizing temperature. Specifically, residents complained of cold food and too much processed food. Resident Identifiers: 6, 9, 15, 33, and 75.Findings Included:On 6/22/25 at 2:17 PM, an interview was conducted with resident 33 who stated he had received a cold hamburger with beef that tasted like fake meat. Resident 33 stated it tasted like it had been mixed with something. Resident 33 stated he had provided feedback to the kitchen staff, but it did not seem to help. Resident 33 stated he would eat lunch, but would not eat breakfast or dinner. Resident 33 stated if he wanted something to eat he could ask for a quesadilla. On 6/22/25 at 3:18 PM, an interview was conducted with resident 6. Resident 6 stated that the food was not that great. Resident 6 stated that the food was not always served warm when the food items should be warm. On 6/23/25 at 9:33 AM, an interview was conducted with resident 15. Resident 15 stated the food was horrible, bland, and came out cold. Resident 15 stated in the Resident Council meetings they had asked if Mrs. Dash or any other seasonings could be put on the food to give it flavor since too many resident’s had salt restrictions. On 6/23/25 at 11:38 AM, an interview was conducted with resident 9 who stated he only ate breakfast. Resident 9 stated the lunch and dinner meals included food that was too fabricated so he would just skip those meals. On 6/25/25 at 1:31 PM, an interview was conducted with resident 75. Resident 75 stated his biggest complaint was the food and shook his head back and forth. Resident 75 stated he did not want to talk about it any further. On 6/24/25 at 12:04, an observation was made of the lunch meal service. An interview was conducted with the cook who stated residents who dined in their rooms were served first and then the steam table was brought to the dining room where the remaining residents would be served. It was noted that the cook was using a plate warmer to heat the plates prior to plating the food. The hall carts were filled and left the kitchen as follows: a. At 12:15 PM, the 200 hall cart left the kitchen. b. At 12:27 PM, the 100 hall cart left the kitchen. c. At 12:44 PM, the 300 hall cart left the kitchen. d. At 12:52 PM, the 400 hall cart #1 left the kitchen. e. At 12:54 PM, a test tray was requested. f. At 12:57 PM, the 400 hall cart #2 left the kitchen. g. At 1:19 PM, the test tray was received. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The meal consisted of a grilled chicken sandwich (grilled chicken breast on a hamburger bun, leaf of lettuce, and tomato on the side), tater tots, green peas, apple pie dessert, resident drink of choice. Grilled chicken sandwich: 109.2 degrees Fahrenheit- lukewarm, bland to the taste, moist. Tater tots: 99.5 degrees Fahrenheit- lukewarm, lightly salted. Peas: 99.4 degrees Fahrenheit- lukewarm, no seasoning detected. Apple Pie dessert: 60.7 degrees Fahrenheit On 6/25/25 at 1:25 PM, an interview was conducted with the Cook. The cook stated he took the temperatures of the food before he put it on the steam table and plated the food. The cook stated he also took the temperatures of the food after he brought the steam table back from the dining room. The temperature book was reviewed with the cook and the temperatures for the hot foods were observed to be above 145 degrees Fahrenheit prior to meal service. The cook stated it was not a requirement to take the temperature of the food after meal service but that he was doing it to make sure the food was still within acceptable temperature ranges. The cook stated they had obtained a plate warmer to heat the plates for meal service in an effort to keep the food warm. On 6/25/25 at 2:06 PM, an interview was conducted with the Dietary Manager (DM) who stated she attended resident council every 4-6 months. The DM stated residents brought up food concerns during resident council, but that they would also approach her personally about concerns or preferences. The DM stated there were several ways in which she was notified of resident concerns about food, such as in the Interdisciplinary Team (IDT) meetings, residents would talk to the cook, or tell staff members who would then communicate concerns through a facility group text. The DM stated when she was made aware of a concern she would address it immediately. The DM stated she had received feedback about food items residents did not want on the menu, how residents wanted the grilled cheese sandwiches prepared, and that residents wanted the plates heated for hot meals. The DM stated the Quality and Performance Improvement (QAPI) Committee was digging into concerns about cold food and were currently fixing it.