STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465146	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare South Salt Lake	2472 South 300 East Salt Lake City, UT 84115

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and observation, the facility did not treat residents with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, residents dining in the dining room were served beverages in Styrofoam cups and prepackaged juice cups. Findings included: On 6/9/25 at 11:55 AM, an observation was made of residents in the dining room for the lunch meal. Staff members were passing out beverages as residents entered the dining room and took their seats. Juices were being served in 4 ounce (oz), foil-covered cups and 4 oz. cartons, chocolate milk was served in a carton, white milk and water was being served in a Styrofoam cup. Coffee and tea were being served in a coffee cup. On 6/9/25 at 12:00 PM, an observation was made of resident 2 sitting at the dining table with 2 cartons of chocolate milk, 2 cartons of orange juice, 2 containers of red juice, a Styrofoam cup with a brown liquid in it and a coffee cup with a brown liquid in it. On 6/10/25 at 8:18 AM, an observation was made of the dining room during the breakfast meal. Staff members were passing beverages as residents entered the dining room and took their seats. Milk and water were being served in Styrofoam cups. Juices were being served in 4 oz. cartons and foil covered cups, coffee and tea was being served in coffee cups, chocolate milk was served in cartons. On 6/12/25 at 8:32 AM, an observation was made of the 200 hallway lunch service. There were strawberries served in a disposable container on the trays. On 6/18/25 at 11:55 AM, an interview was conducted with the Dietary Manager (DM) who stated the mugs in the dining room were used for hot drinks. The DM stated the Styrofoam cups were being used in the dining room because several cups had gone missing and it took several weeks for those to arrive once they are ordered. The DM stated they had some cups, but not enough for everyone.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 2 of 61 sampled residents, that the facility failed to ensure each resident had the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Specifically, one resident representative was not informed in advance of starting an antidepressant medication and another resident representative was not informed in advance of a wanderguard being placed. Resident identifiers: 82 and 103.Findings included:1. Resident 82 was admitted to the facility on [DATE] with diagnoses which included severe vascular dementia, hypertension, attention and concentration deficit following cerebral infarction, depression, and cognitive communication deficit. Resident 82's medical record was reviewed 6/9/25 through 6/19/25.A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident 82's Cognitive Skills for Daily Decision Making was, Severely impaired-never/rarely made decisions.A nurse's note dated 10/12/24 at 1:13 PM indicated, New orders received from [behavioral health services] to start Lexapro [antidepressant medication] 5 mg [milligrams] QD [every day]. [Physician name redacted] agreed with recommendation.A physician order dated 1/8/25 at 3:54 PM indicated, Escitalopram Oxalate Oral Tablet 10 MG .Give 1 tablet by mouth one time a day for Depression.An interview was conducted on 6/18/25 at 3:15 PM with the Administrator. The Administrator stated resident 82's representative was her sister.An interview was conducted on 6/19/25 at 9:44 AM with the Regional Nurse Consultant (RNC). The RNC stated they were unable to find a consent notifying the resident representative before starting the Escitalopram. 2. Resident 103 was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease, essential hypertension, type 2 diabetes, bipolar disorder, muscle weakness, and difficulty in walking. Resident 103's medical record was reviewed on 6/9/25 through 6/19/25. According to a facility investigation, resident 103 eloped from the facility on 4/22/25 and was returned to the facility on 4/23/25.On 4/23/25 at 3:38 PM, an order was started to Check skin integrity around wanderguard on R [right] ankle every shift for Skin integrity. Beginning on the 4/23/25, nursing staff began to document in the Treatment Administration Record that this order was being completed every shift. On 4/23/2025, the intervention Wander guard to R ankle was initiated in Resident 103's care plan.No progress note was located in resident 103's medical record regarding when the wanderguard was placed. On 4/25/25, an informed consent for a wanderguard restraint was dated 4/25/25 and contained resident 103's signature, a facility representative's signature, and a note that stated verbal consent from her guardian [name redacted] obtained.On 4/25/25 at 8:05 PM, a progress note stated Resident signed her consent for the wanderguard today. UM [Unit Manager] manager called her State Guardian to inform her the need of it and to get a verbal. She is in agreement. Wander guard is on her right ankle.On 6/19/25 at 11:10 AM, an interview was conducted with the Administrator and the RNC. The Administrator stated that the wanderguard was placed on resident 103 on the day she returned to the facility after the elopement. The Administrator further stated that he was present when the wanderguard was placed on resident 103. The RNC stated that consent for the wanderguard should be given before the wanderguard was placed.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, it was determined, 1 of 61 sampled residents, the facility failed to keep residents free from abuse. Specifically, a Registered Nurse (RN) employee had a sexual relationship with a resident who resided in the facility. Resident identifier: 118Based on interview and record review, it was determined, 1 of 61 sampled residents, the facility failed to keep residents free from abuse. Specifically, a Registered Nurse (RN) employee had a sexual relationship with a resident who resided in the facility. Resident identifier: 118Findings included:On 3/28/25 at 12:22 PM, the facility reported that on 3/28/25 at 10:00 AM an investigator from the Division of Professional Licensing (DOPL) came into the facility on a complaint from resident 118. It was reported to DOPL that RN 3 had been sexually inappropriate with resident 118. On 3/28/25 at 11:00 AM, RN 3 was placed on leave from the facility while an investigation was conducted. The form titled 359, the final investigation, was submitted to the State Survey Agency (SSA) on 4/2/25. The form revealed the Administrator (Admin) interviewed RN 3. RN 3 stated that he had been having a consensual sexual relationship with resident 118. RN 3 stated that inappropriate messages and images were sent by both parties. RN 3 stated that there had been physical contact between him and resident 118. On 6/18/25 at 8:32 AM, an interview was conducted with the Admin. The Admin stated that he was notified about the abuse about one month after resident 118 discharged from the facility. The Admin stated that the DOPL investigator would not disclose a lot of information regarding the complaint or investigation. The Admin stated that RN 3 was suspended and then later terminated from the facility. The Admin stated that he interviewed RN 3 via telephone and RN 3 confirmed that he had been having a sexual relationship with resident 118 and that he should have let the facility know. On 6/18/25 at 9:21 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that staff should not have any type of relationship with residents. The RNC stated that even if a resident agreed to have a consensual relationship, it should not occur.On 6/18/25 at 9:28 AM, a follow-up interview was conducted with the Admin. The Admin stated he did not know about the relationship so he was unable to prevent the abuse. The Admin stated resident 118 consented to the relationship so it was not abuse. A review of the facility Resident Rights/Dignity Policy documented:Policy StatementResidents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.Policy Interpretation and ImplementationThe resident abuse, neglect and exploitation prevention program consists of a facility-widecommitment and resource allocation to support the following objectives:1. Protect residents from abuse, neglect, exploitation or misappropriation of property byanyone including, but not necessarily limited to:a. facility staff;b. other residents;c. consultants;d. volunteers;e. staff from other agencies;f. family members;g. legal representatives;h. friends;i. visitors; and/orj. any other individual.2. Develop and implement policies and protocols to prevent and identify:a. abuse or mistreatment of residents;b. neglect of residents; and/orc. theft, exploitation or misappropriation of resident property.3. Ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and high turnover rates.4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has:a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;b. had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; orc. a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems.6. Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.7. Implement measures to address factors that may lead to abusive situations, for example:a. adequately prepare staff for caregiving responsibilities;b. provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation;c. instruct staff regarding appropriate ways to address interpersonal conflicts; andd. help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts.8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.9. Investigate and report any allegations within

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 3 out of 61 sampled residents, the facility did not ensure that all alleged violations involving abuse and neglect were reported immediately, but no later than two hours after the allegation was made, to the State Survey Agency (SSA) and Adult Protective Services (APS). Specifically, notification to the SSA and APS was not done when a resident eloped from the facility and another resident alleged that a Certified Nursing Assistant (CNA) put their fingers into her private parts. Additionally, a resident eloped from the facility and APS was not notified. Resident identifiers: 64, 113, and 115.Findings included:1. Resident 115 was admitted to the facility on [DATE] with diagnoses which included, unspecified focal traumatic brain injury, cognitive communication deficit, and vascular dementia.Resident 115's medical record was reviewed 6/9/25-6/19/25.On 3/31/24 at 8:53 PM, an alert note documented, At 1715 [5:15 PM], Medicare CNA answered a phone call from a person living in the area stating he saw a resident leave the facility. CNA looked outside for the resident and got in her vehicle and went down two blocks and the resident was walking on the sidewalk at 1718 [5:18 PM]. CNA safely helped the resident into her vehicle and brought the resident back to the facility. CNA notified DON [Director of Nursing] of Elopement . On 6/19/25 at 11:02 AM, an interview was conducted with the Administrator (Admin). The Admin stated that resident 115 had been in the facility for a while and was a wander risk. The Admin stated that resident 115 was spotted walking down the street by a member of the community and was brought back into the facility and placed on a 1:1 (one to one). The Admin stated that he was unsure if he contacted APS about the elopement and would look to see if he had.It should be noted that no further documentation was submitted regarding APS notification. 2. Resident 113 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia, major depressive disorder, generalized anxiety disorder, cutaneous abscess of left lower limb, muscle weakness, and difficulty in walking. Resident 113's medical record was reviewed 6/9/25 through 6/19/25. A Medication Administrative Note dated 3/21/25 at 9:04 PM indicated, Pt [patient] checked out at 1300 [1:00 PM] today, and has not yet returned. A Medication Administrative Note dated 3/22/25 at 1:01 AM indicated, As of 3/22/25 @0101 [at 1:01 AM], patient has not yet returned to the facility. A Medication Administrative Note dated 3/22/25 at 6:23 AM indicated, resident is LOA [leave of absence]. A Progress Note dated 3/22/25 at 6:04 PM indicated, Resident continues to be LOA throughout shift. Residents phone called with no answer. Management aware. A Medication Administrative Note dated 3/25/25 at 7:45 PM indicated, resident has not returned to the facility. A Medication Administrative Note dated 3/26/25 at 8:29 AM indicated, pt is away. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Progress Note dated 3/27/25 at 2:39 PM indicated, [Resident 113] left the facility with a friend on 3/21 and has not returned. Attempts to contact him has been unsuccessful. A Social Services Quarterly & Annual Note dated 1/15/25 at 10:26 AM indicated, [Resident 113] has appeared to become more confused. He is pleasant and enjoys socializing. [Resident 113] has outside support. He has been approved for long term care and participates well in his care plan. A provider Progress Note dated 1/23/25 indicated, .he would like to think about discharging the facility he states. will have the discharge planner and others help w [with]/ this. will need to recheck BIMS [Brief Interview for Mental Status] to ensure able to make this decision for himself . On 6/19/25 at 9:47 AM, an interview was conducted with the Admin. The Admin stated a relative came and signed resident 113 out and he did not return the next day. The Admin stated he was not sure if resident 113 needed someone to sign him out. The Admin stated they called him on his phone, but they were unable to get a hold of him. The Admin stated that after a couple of days, resident 113 came back to the facility to get some of his items and told them that he would not be returning and then left again. The Admin stated he did not provide resident 113 with an AMA (leaving against medical advice) form or discharge instructions because resident 113 was in a rush. The Admin stated resident 113 had a BIMS of 10 (a BIMS of 10 indicated a moderate cognitive impairment) and was alert and oriented x3 (times 3). The Admin stated resident 113 had been unhappy about his share of cost and kept talking about discharging. The Admin stated it had not crossed his mind to call law enforcement. The Admin stated if a resident had a BIMS that was a 12 or higher, they could sign themselves out, but other circumstances were taken into consideration and the Director of Nursing would be consulted to make that decision. On 6/19/25 at 10:01 AM, an interview was conducted with the Admissions Marketing Director (AMD). The AMD stated resident 113's friend came to sign him out LOA and he decided not to come back. The AMD stated he would consider that leaving AMA because they expected him to come back. The AMD stated when he asked resident 113 about a discharge plan during his stay, resident 113 told him multiple times that he was fine and did not have anywhere else to go. On 6/19/25 at 10:43 AM, a concurrent interview was conducted with the Admin and the RNC. The Admin stated if a resident eloped they would notify the doctor, family, and the police. The RNC stated if a resident signed themselves out on an LOA they should try to call and contact them if they did not return when they were expected and that if they could not get a hold of them they would call in a wellness check with law enforcement. The Admin stated if the resident stated they were coming back the day they signed out that they would start to get concerned if they were not back by that same evening and start calling. On 6/19/25 at 11:38 AM, an interview was conducted with DON 2. DON 2 stated if a resident was approved for LOA the resident would indicate how long they intended to be gone and if it went over that time, she would start to call the resident or family. DON 2 stated she would notify the police if the resident or family did not answer those calls. On 6/19/25 at 1:12 PM a follow-up interview was conducted with the Admin. The Admin stated the reason police were not called was because he signed out with someone and it was their responsibility to keep an eye on him. The Admin stated he did not think he contacted the Ombudsman about resident 113 leaving and not returning to the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that no further documentation was provided regarding resident 113's elopement. 3. Resident 64 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, schizoaffective disorder, chronic respiratory disease, dementia, and morbid obesity. On 6/9/25 at 10:40 AM, an interview was conducted with resident 64 who stated that while receiving cares approximately one month ago, a CNA had inserted her fingers into her private parts and then bragged about it. Resident 64 stated she told the director of the CNA's about the incident. Resident 64 stated she did not know the name of the CNA, but that the CNA was still providing cares for her. Resident 64 stated the incident made her feel awful and that nobody aided her when the incident happened. On 6/18/25 at 9:38 AM, an interview was conducted with the CNA Coordinator who stated resident 64 briefly mentioned the incident to her. The CNA Coordinator stated if the DON and the Admin were busy they asked her to talk to the resident. The CNA Coordinator stated she did not remember who the CNA involved was, but that she ended up changing resident 64's brief and bed and wanted to talk with the DON and administrator about it. Later in the interview, the CNA Coordinator stated she believed the CNA involved was CNA 3. The CNA Coordinator stated CNA 3 no longer worked with resident 64. The CNA Coordinator stated resident 64 told her that CNA 3 was wiping her too aggressively and put her finger in her anus. The CNA Coordinator stated resident 64 no longer wanted CNA 3 to work with her and that CNA 3 hurt her. The CNA Coordinator stated the way that scheduling worked was that if CNA 3 was scheduled on that hallway, she would just switch residents with another CNA that was working on the same hallway so she was not working with resident 64. The CNA Coordinator stated the schedulers try not to schedule CNAs on hallways where there are residents that prefer not to work with them but sometimes they forget. The CNA Coordinator stated that she spoke with the DON specifically about the particular situation but she did not know if the DON spoke with resident 64 or told the administrator about the situation. The CNA Coordinator stated she did not know if the incident was investigated. The CNA Coordinator stated she did not talk to CNA 3 about the incident or ask her what happened. The CNA Coordinator stated she felt that those conversations should come from the DON or administrator. On 6/18/25 at 9:19 AM, an interview was conducted with CNA 4 who stated some categories of resident abuse were psychological, physical, and sexual. CNA 4 stated some symptoms of abuse to watch for could be a change in resident behavior, the resident being withdrawn, bruises, a resident refusing cares or not wanting cares from a certain person. CNA 4 stated his role in preventing resident abuse included answering resident call lights quickly, being aware of changes in resident's behavior, reporting immediately to a nurse if he became aware of something, or reporting to the administrator who is the abuse coordinator immediately. On 6/18/25 at 10:06 AM, an interview was conducted with Registered Nurse (RN) 4 who stated resident 64 did not like to have male aides in her room. RN 4 also stated she was not aware of resident 64 not wanting to work with any specific CNAs or making any allegations of abuse. On 6/18/25 at 10:08 AM, an interview was conducted with RN 1 who stated resident 64 had not made any allegations of inappropriate touching by CNAs. An attempt was made to contact DON 1, but the call was not returned. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/18/25 at 2:30 PM, an interview was conducted with the Admin who stated he was not made aware of resident 64's allegations until earlier in the day. The Admin stated he was aware of a prior complaint about a month ago by resident 64 that a CNA was not cleaning her well enough. The Admin stated he self-reported to the state agency the allegations that resident 64 made about the incident a month ago, and had begun an investigation. The Admin stated the CNA involved had been suspended until the investigation had been completed. The Admin stated he had spoken with the DON 1 who told him she did not remember resident 64's allegations. The Admin stated his process as the abuse coordinator was to educate all staff to report any abuse immediately. The Admin stated if the allegation was about staff, the staff member would be suspended immediately pending the investigation. The Admin stated he would interview the resident, interview other residents for other claims or complaints, and interview other staff members to collect more information. If there were additional complaints, the Admin stated the employee would be terminated. The Admin stated if there were no other concerns, the employee would be re-educated. The Admin stated when there was an allegation of abuse, the physician would be notified, the responsible party or family member, and based on the allegation, the police, adult protective services, and the ombudsman. The Admin stated there was a 2 hour time frame for initial reporting of abuse, and 5 days to submit the investigation report. The Admin stated that it was not reported to the state and that he was not aware that it was an abuse allegation until earlier in the day.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 2 out of 61 sampled residents, that the facility did not notify the resident of the discharge and the reasons for the move in writing and in a language and manner they understand; or send a copy of the notice of transfer or discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman as soon as practicable or when a resident had not resided in the facility for 30 days. Specifically, the Ombudsman was not notified when one resident was discharged to the hospital and the ombudsman was not notified of a resident's discharge and the reasons why the resident left the facility. Resident identifiers: 54 and 113.Findings included:1. Resident 54 was admitted to the facility on [DATE] with diagnoses which included type 1 diabetes mellitus and end-stage renal disease. Resident 54's medical record was reviewed 6/9/25-6/19/25.On 3/15/24 at 2:45 AM, a nursing progress note documented, .Patient was handed off with report to EMS [emergency medical services] and resident left the facility at approx. [approximately] 0245 [2:45 AM] with no new complaints.On 4/1/24 at 10:22 AM, a nursing progress note documented, .[resident 54] was admitted to [local hospital] on Saturday .On 10/16/24 at 7:33 AM, a nursing progress note documented, Resident was found unresponsive at 0650 [6:50 AM] when aide went to take vitals, aide called for assistance, on assessment residents BG [blood glucose] was 29, skin was cold and clammy, presented w/ [with] labored breathing and thready pulse. EMS called immediately after injection was given resident remained unresponsive, at time of EMS arrival BG was at 41,Resident Transferred to [local hospital] .On 12/6/24 at 12:51 AM, a nursing progress note documented, Resident is still c/o [complaining of] SOB [shortness of breath] and difficulty breathing feels that breathing treatment did not help, and wants to be sent out for further evaluation, called the on call and they said to have her be sent out resident presents as non emergent, she is having her mom come and get her to take her to[local hospital] . On 6/17/25 at 11:05 AM, an interview was conducted with the Admissions Marketing Director (AMD). The AMD stated that he kept a log of all the residents that were discharged from the facility. The AMD stated that he notified the Ombudsman monthly regarding the residents that left the facility AMA (against medical advice) or discharged to the community. The AMD stated that he did not notify the Ombudsman when a resident was discharged to a hospital. On 6/18/25 at 9:11 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that the Ombudsman should be notified monthly of all residents that were discharged home, AMA, and hospital transfers. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 113 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia, major depressive disorder, generalized anxiety disorder, cutaneous abscess of left lower limb, muscle weakness, and difficulty in walking.Resident 113's medical record was reviewed 6/9/25 through 6/19/25.A Medication Administrative Note dated 3/21/25 at 9:04 PM indicated, Pt [patient] checked out at 1300 [1:00 PM] today, and has not yet returned.A Progress Note dated 3/27/25 at 2:39 PM indicated, [Resident 113] left the facility with a friend on 3/21 and has not returned. Attempts to contact him has been unsuccessful.On 6/19/25 at 9:47 AM, an interview was conducted with the Administrator (Admin). The Admin stated a relative came and signed resident 113 out and he did not return the next day. The Admin stated they called him on his phone, but they were unable to get a hold of him. The Admin stated that after a couple of days, resident 113 came back to the facility to get some of his items and told them that he would not be returning and then left again. The Admin stated he did not provide resident 113 with an AMA form or discharge instructions because resident 113 was in a rush. The Admin stated resident 113 had been unhappy about his share of cost and kept talking about discharging.On 6/19/25 at 10:01 AM, an interview was conducted with the AMD. The AMD stated resident 113's friend came to sign him out LOA (leave of absence) and he decided not to come back. The AMD stated he would consider that leaving AMA because they expected him to come back. The AMD stated when he asked resident 113 about a discharge plan during his stay, resident 113 told him multiple times that he was fine and did not have anywhere else to go. On 6/19/25 at 10:43 AM, a concurrent interview was conducted with the Admin and the RNC. The Admin stated if a resident eloped they would notify the doctor, family, and the police. The RNC stated if a resident signed themselves out on an LOA they should try to call and contact them if they did not return when they were expected and that if they could not get a hold of them they would call in a wellness check with law enforcement. The Admin stated if the resident stated they were coming back the day they signed out that they would start to get concerned if they were not back by that same evening and start calling.On 6/19/25 at 11:38 AM, an interview was conducted with the Director of Nursing (DON) DON 2. DON 2 stated if a resident was approved for LOA the resident would indicate how long they intended to be gone and if it went over that time, she would start to call the resident or family. DON 2 stated she would notify the police if the resident or family did not answer those calls.On 6/19/25 at 1:12 PM a follow-up interview was conducted with the Admin. The Admin stated the reason police were not called was because he signed out with someone and it was their responsibility to keep an eye on him. The Admin stated he did not think he contacted the Ombudsman about resident 113 leaving and not returning to the facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 of 61 sampled residents, that the facility failed to ensure the assessment accurately reflected the resident's status. Specifically, a diagnosis of depression was not included on the assessment. Resident identifier: 82.Findings included:Resident 82 was admitted to the facility on [DATE] with diagnoses which included severe vascular dementia, hypertension, attention and concentration deficit following cerebral infarction, depression, and cognitive communication deficit.Resident 82's medical record was reviewed 6/9/25 through 6/19/25.A Psych (psychiatric) Follow Up note dated 10/4/24 at 6:00 AM indicated, .suggest Lexapro 5mg [milligrams] daily for depression and anxiety A Nursing note dated 10/12/24 at 1:13 PM indicated, New orders received from [mental health services] to start Lexapro [antidepressant medication] 5 mg QD [every day]. [Physician name redacted] agreed with recommendation.A Psych Follow Up note dated 10/18/24 at 6:30 AM indicated, .Endorses depression, poor appetite, no interest in ADL's [activities of daily living]. She is tolerating the lexapro 5mg well.A Psych GDR (Gradual Dose Reduction) note dated 11/15/24 at 8:15 AM indicated, .Escitalopram Oxalate [antidepressant medication] Tablet 5 MG Give 1 tablet by mouth one time a day for Depression .A physician order dated 1/8/25 at 3:54 PM indicated, Escitalopram Oxalate Oral Tablet 10 MG .Give 1 tablet by mouth one time a day for Depression.A review of resident 82's medical diagnoses list did not include depression.A Quarterly Minimum Data Set (MDS) dated [DATE] did not include a diagnosis of depression.On 6/18/25 at 9:42 AM, an interview was conducted with Registered Nurse (RN) 6. RN 6 stated they were not sure if resident 82 had depression. RN 6 reviewed resident 82's physician orders and stated she had escitalopram ordered for depression.On 6/18/25 at 12:55 PM, an interview was conducted with RN 7. RN 7 stated resident 82 did not have depression.On 6/18/25 at 1:19 PM, an interview was conducted with the Social Service Worker (SSW). The SSW stated resident 82's face sheet did not indicate she had depression.On 6/18/25 at 3:10 PM, an interview was conducted with the Director of Nursing (DON) 2. The DON 2 stated resident 82 was diagnosed with depression in February of 2025 but it did not get updated in the medical chart. The DON 2 stated the MDS should have been updated with the diagnosis of depression.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 1 of 61 sampled residents, the facility did not provide care and services to maintain or improve a resident's ability to carry out the activities of daily living. Specifically, a resident's bed was positioned against a wall so that his inoperable hand was facing his environment, diminishing his abilities in activities of daily living. Resident identifier: 67.Findings included:Resident 67 was admitted on [DATE] with diagnoses which included hemiplegia, cerebral infarction, contracture left elbow, memory deficit, major depressive disorder, contracture left knee, and mood disorder.On 6/9/25 at 1:08 PM, an observation was made of resident 67 lying slumped down in bed with his head of bed elevated to 90 degrees, shirt pulled up and blankets partially covering his lower extremities. Resident 67's legs were bare, knees were bent and lying sideways in the bed with feet against the footboard and resident 67's upper body positioned approximately at midpoint in his bed so that he was not sitting upright in bed. Resident 67 was lying with the right side of his body against the wall and hemiplegic left side of his body facing his environment. Resident 67's water mug was placed on the bedside table out of reach and an over the bed table with a water cup was placed on the left side of the bed out of reach. Resident 67's food was delivered and resident was observed immediately before and after the lunch tray was delivered. Resident 67 was found to be in the same slumped down position after his tray was delivered as he was before his tray was delivered. Resident 67 was not repositioned in bed when his meal was delivered but the bedside table was placed half over resident 67's bed on his left side. Resident 67 was able to reach his water cup and tray with his right hand, reaching cross body.On 6/9/25 at 1:53 PM, an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated that resident 67 was able to feed himself if he was sitting up in bed. CNA 5 stated that resident 67 refused to go to the dining room for meals and sometimes received help from a CNA to eat because he was able to feed himself.On 6/9/25 at 2:11 PM, an additional observation was made of resident 67. Resident 67 was observed to have his head of bed upright at 90 degrees and was slid down in bed in the same position as during lunch. Resident 67 stated he could not straighten his left leg but did prefer to sit up in bed.On 6/11/25 at 01:19 PM, an observation and interview were conducted with resident 67. Resident 67 was observed with lunch and was able to eat ice cream with his right hand with a spoon, reaching cross body to his tray placed on his left side halfway over the bed. Resident 67 was upright at an approximately 60 degree angle and was sitting in the middle of the bed and not against the wall. Resident 67 stated he would like to have his bed position changed so his active arm was not against the wall and he was able to access his environment. Resident 67 stated the staff put his head of bed up when he ate and sometimes repositioned him in bed to sit up.On 6/12/25 at 8:45 AM, an observation was made of resident 67 lying in the center of the bed, at a 60 degree angle during breakfast and was able to reach his food and water to eat with his right hand. Resident 67 was able to demonstrate he was able to pull his body and roll to the left side somewhat but was not able to reposition himself in bed. Resident 67's medical record was reviewed 6/9/25 though 6/19/25.On 06/17/25 at 11:15 AM, resident 67's minimum data set (MDS) for 4/30/25 was reviewed and stated that Resident 67 was able to roll left and right with substantial or maximal assist. Resident 67 was dependent with moving from sitting to lying and lying to sitting in bed. Resident 67's care plan dated 7/15/21, revealed resident 67 required up to extensive assistance by staff for turning and repositioning.On 6/18/25 at 9:15 AM, an interview and observation was made of resident 67. Resident 67 was observed to be positioned at the lower portion of his bed with the head of bed at approximately a 75 degree angle. Resident 67 stated he was not uncomfortable and did not mind the position he was in. Resident 67 was not positioned against the wall and he had eaten all of his breakfast but stated he had to reach across his bed to eat or drink and felt it would be easier if his good arm was not positioned next to the wall.On 6/18/25 at 9:23 AM, an interview was conducted with Unit Manager (UM) 1 and Certified Medication Aide (CMA) 1. UM 1 stated resident 67 was previously on the 300 hall with the right side of his body positioned against the wall. UM 1 stated he believed resident 67 preferred his current positioning. CMA 1 stated the protocol for tray delivery was to reposition resident 67 for meals, sitting him up in bed with the head of bed elevated and the over bed table placed in front of resident 67 on his left side. CMA 1 stated resident 67 moved around in bed and slid down on his own.On 6/18/25 at 9:28 AM, an interview was conducted with the Certified Occupational Therapy Assistant (COTA) who stated she treated resident 67 in April 2025 but had not considered the positioning of resident 67's dominant side against the wall and whether

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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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 1 out of 61 sampled residents, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice and resident's choices. Specifically, a resident's diabetes was not managed with required documentation, timely referral to outside services or diet management according to physician's orders and resident's choice. Resident identifier: 36.Findings included: Resident 36 was re-admitted on [DATE] with diagnoses of hemiplegia/hemiparesis, chronic respiratory failure, morbid obesity, major depressive disorder, type 1 diabetes, epilepsy and generalized anxiety disorder.On 6/12/25 at 8:07 AM, an interview was conducted with resident 36. Resident 36 stated he was not doing so great. Resident 36 stated he had a reminder on his amazon echo in the evening on 6/11/25, to take his blood glucose level which was reading Hi (high) on his continuous monitor, indicating his blood glucose level was over 400 milligrams per deciliter (mg/dL). Resident 36 stated he called for the graveyard nurse, Licensed Practical Nurse (LPN) 1, to check his blood glucose level using the facility's glucometer. Resident 36 stated LPN 1 tested his glucose level at about 10:30 PM and his blood glucose level was over 400 mg/dL. Resident 36 stated he did not recall the specific results. Resident 36 stated he asked LPN 1 to contact the Physician's Assistant (PA) to get an order for insulin to reduce his glucose level. Resident 36 stated LPN 1 said it was too late to call and refused to contact the PA. Resident 36 stated LPN 1 suggested resident 36 was eating snacks after dinner which accounted for the high blood glucose results. Resident 36 stated he did not eat snacks after dinner and reported that the meals he received from the facility were very high in carbohydrates. Resident 36 stated he wanted lower carbohydrate food as he had type 1 diabetes and that it was hard for him to keep his blood glucose level low like they should be especially considering he was bed bound and didn't get much exercise. Resident 36 stated he did not have an as needed (PRN) order for insulin so he did not receive an insulin shot through the night and stated he was still high in the morning. Resident 36 stated he asked LPN 2 to check his blood sugar this morning 6/12/25 at about 7:30 AM due to his continuous monitor still reading Hi. At 8:10 AM, resident 36's Freestyle Libre 3 monitor was observed to read Hi.On 6/12/25 at 1:30 PM, an observation was made of resident 36's lunch meal which consisted of ham, corn, scalloped potatoes, a roll and bread pudding with caramel. Resident 36 did not have fruit instead of dessert as the meal ticket stated and he stated he would prefer lower carbohydrate food options.On 6/12/25 at 8:27 AM, an interview was conducted with resident 36's family member. The family member asked resident 36 if he was still alive. Resident 36 told the family member about the Hi blood glucose reading on the continuous monitor and that the facility's monitor read 389 mg/dL. The family member stated resident 36's high glucose had been going on for a long time. Resident 36's family member stated resident 36 was a type 1 diabetic and the facility did not allow insulin pumps. Resident 36's family member stated resident 36's glycated hemoglobin (A1C) was 6.2 prior to admission to the facility but had been 8.1 or higher and was routinely above 9 since admission. Resident 36's family member complained that resident 36 was given a flat amount of insulin before meals, regardless of the carbohydrates in the meal. Resident 36's family member stated his glucose level was 393 initially then 400 when tested later in the night on 6/11/25. The family member stated that resident 36 should have an insulin shot if blood glucose levels were higher than 250.On 6/12/25 at 10:08 AM, a phone interview was conducted with LPN 1. LPN 1 stated that he did not contact the PA as resident 36 requested since there was no order to notify the PA of a high blood glucose level. LPN 1 stated he would generally notify the PA for guidance if the glucose level was unusually high for a resident or there was an order to do so. LPN 1 stated the facility had two after hours providers to contact in an emergency. LPN 1 stated he took blood glucose levels if asked by a resident and usually documented it in the electronic medical record and a progress note if the levels were high, above 400. LPN 1 stated resident 36's continuous monitor read Hi but the facility's glucose monitor read resident 36's glucose level in the 200's. LPN 1 stated he did not recall what the specific number was on the glucometer and stated he did not document the results. LPN 1 stated he did not know how resident 36's continual glucose monitoring system worked or if there were sometimes different readings than the facility glucometer. LPN 1 stated the night shift calibrated the facility glucometers weekly and documented the results in the narcotics binder. LPN 1 stated that, to his knowledge, the facility glucometer was working and accurate. LPN 1 stated he checked Resident 36's glucose level around midnight and again about 2:30 AM. LPN 1 stated he did not know why he checked it again at 2:30 AM when the glucose was

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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, 20 of 61 sampled resident, that the facility failed to ensure residents were providing supervision to prevent accidents. Specifically, hot water temperatures in resident rooms throughout the facility were observed to range in temperatures from 121.7-145.5 degrees Fahrenheit. This deficient practice occurred at an Immediate Jeopardy level. In addition, residents who were assessed as requiring supervision while smoking were observed smoking unsupervised, a resident was not evaluated for smoking and was observed smoking, residents with a history of wandering eloped from the facility without staff knowing, the front doorbell was not working and residents were locked outside unable to alert staff, and metal bed frames and boxes were stored in a dayroom that residents were observed to be in. Resident Identifiers: 3, 21, 24, 25, 32, 42, 48, 66, 71, 72, 73, 87, 100, 103, 110, 115, 119, 418, 421, and 424. NOTICE: Notice of Immediate Jeopardy (IJ) was given verbally to the Administrator on 6/10/25 at 2:30 PM. The Administrator was asked to develop an immediate plan to ensure resident safety related to hot water temperatures. PLAN: On 6/10/25 at 9:17 PM, the facility Administrator provided the following abatement plan for the removal of the IJ effective 6/10/25 at 8:30 PM. [Facility name] is providing the following information to demonstrate that the immediacy of the cited deficiency F689 has been removed. Summary of Actions Taken: Resident #3: Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #24 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #25 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #66 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #71 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #72 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #73 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #87 Water temperature in the resident's room was measured by the Administrator/Maintenance (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #100 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #103 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Resident #110 Water temperature in the resident's room was measured by the Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Skin check was completed on Resident by a licensed nurse and documented in medical record and no identified burns were present. Residents at Potential Risk: A plumber was dispatched to the facility on 6/10/25 to evaluate the water heater, mixing valve and holding tanks. The Plumber was able to make repairs that will maintain water temperature compliance. Full facility Skin check audit conducted on all other residents and a progress note was entered into the residents' medical record. No additional burns were identified. Full facility water temperature audit was conducted by Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Audits were conducted on the evening of 6/10/25. A new thermometer was purchased that is compliant with testing water temperatures. Systemic Changes and Education (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administrator and Maintenance Director were educated by Chief Operations Officer regarding safe water temperatures and proper temperature measurement, monitoring, and management. This education occurred on 6/10/25 at 16:15 [4:15 PM] hrs. [hours] Administrator and Maintenance Director were educated by Chief Operations Officer that regular water temperature checks must be performed, logged, and monitored to ensure resident safety. This education occurred on 6/10/25 at 16:15 hrs. Facility water temperature management logs are set up in the TELS [The Equipment Lifecycle System] system to be performed regularly by the Maintenance Director; Administrator will ensure this is completed appropriately and timely. Monitoring and Quality Improvement Measure: The Administrator/Maintenance Director/Designee will conduct full audits of facility water temperatures weekly x 4 weeks, followed by audits of 5 random resident rooms on each hallway monthly x 3 months to ensure water temperatures are within appropriate range for resident safety. Medical Director was informed of the incident an QAA [Quality Assessment and Assurance] Review & [and] Recommendations Results will be reported to the QAA committee for monitoring and follow-up The Administrator is responsible for substantial compliance of this Plan of Action The facility alleges the immediacy with the deficient practice has been removed on June 10, 2025 by 8:30 PM. The abatement was verified by the survey team on 6/11/25 at 10:30 AM. Findings included: WATER TEMPERATURES [Note: All temperatures were in degrees Fahrenheit and were obtained using a digital probe thermometer.] The surveyors' thermometers were calibrated in ice water on 6/9/25 at 1:00 PM. On 6/9/25 at 1:05 PM, room [ROOM NUMBER], occupied by 2 residents, had a sink in the room with a water temperature of 131.0 in 30 seconds. Residents in room [ROOM NUMBER] were ambulatory. One required a walker and had a diagnosis of Parkinson's disease. On 6/9/25 at 1:09 PM, room [ROOM NUMBER]'s bathroom sink had a water temperature of 142.7. Resident 72 resided in 315-A and used a walker to ambulate. Resident 24 resided in 315-B and stated he was able to ambulate to the bathroom on his own. Resident 24 had moderate cognitive impairment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/9/25 at 1:13 PM, room [ROOM NUMBER]'s bathroom sink water was 145.5. Resident 25 resided in 320-A and used a wheelchair. Resident 66 resided in 320-B and used a manual wheelchair. Resident 66 had a moderate cognitive impairment. On 6/9/25 at 1:29 PM, room [ROOM NUMBER]'s bathroom sink water was 141.7. Resident 73 and resident 3 were ambulatory. Resident 3 had moderate cognitive impairment. On 6/9/25 at 2:23 PM, room [ROOM NUMBER] occupied by one resident who had a bathroom sink water temperature of 124.1. On 6/9/25 at 2:25 PM, room [ROOM NUMBER] occupied by two residents, had a bathroom sink water temperature of 123.5. An interview was conducted with resident 71. Resident 71 stated that the water got very hot in the bathroom sink. Resident 71 stated that she used the sink water to make noodles in a cup because of how hot the water was. On 6/9/25 at 2:32 PM, room [ROOM NUMBER], which had 2 residents who occupied the room, had a water temperature of sink water temperature was 121.7. Resident 87 had moderate cognitive impairment. On 6/9/25 at 2:47 PM, room [ROOM NUMBER], which had 2 residents who occupied the room, had a water temperature of sink water temperature was 126.0. Resident 100 and resident 103 resided in room [ROOM NUMBER]. Both residents had moderately impaired cognition. On 6/9/25 at 3:50 PM, room [ROOM NUMBER]'s bathroom sink was 130.1 and room [ROOM NUMBER]'s bathroom sink was 130.0. Resident in 313 B had paranoid schizophrenia. Resident in 313 and used an electric wheelchair for mobility. On 6/9/25 at 2:58 PM, a tour of the facility's water boiler room with the Maintenance Director was conducted. The Maintenance Director stated the facility received hot water from the boiler and the kitchen received hot water from a water heater. The Maintenance Director stated that the water temperatures for the facility should be between 105-115. On 6/9/25 at 3:02 PM, an observation was made of the boiler, The boiler showed a temperature of 188. The Maintenance Director stated the water went from the boiler to the mixing valve. There was no temperature gauge observed on the mixing valve. The Maintenance Director stated that there were two holding tanks for water and that there were no thermometer gauges on the tanks. On 6/9/25 at 3:09 PM, room [ROOM NUMBER]'s bathroom sink, the Maintenance Director tested the water temperature with an infrared thermometer. The Maintenance Director's thermometer read at 102. The surveyors thermometer read 122.2. On 6/9/25 at 3:13 PM, room [ROOM NUMBER]'s bathroom sink water was tested by the Maintenance Director. The Maintenance Director's infrared thermometer read 115. The surveyors thermometer read 128.9. On 6/9/25 at 3:16 PM, room [ROOM NUMBER]'s bathroom sink water was tested by the Maintenance Director. The Maintenance Director's infrared thermometer read 114.4. The surveyors thermometer read 121. 7. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/9/25 at 3:19 PM, room [ROOM NUMBER]'s bathroom sink water was tested by the Maintenance Director. The Maintenance Director's infrared thermometer read 98.2. The surveyors thermometer read 123. 1. On 6/9/25 at 3:50 PM, room [ROOM NUMBER]'s bathroom sink was 130.1 and room [ROOM NUMBER]'s bathroom sink was 130.0. On 6/10/25 at 9:17 AM, an interview was conducted with the Administrator (Admin). The Admin stated that last night and this morning the facility had tested the water with different probe thermometers and the infrared thermometer and the temperatures all varied. The Admin stated that the low temperatures from the monthly maintenance log should have been a red-flag with the water temperature. A review of the facility water temperature log over the past six months revealed the highest water temperature was 108 in room [ROOM NUMBER] on 4/28/25 and the lowest temperature was 81 in room [ROOM NUMBER] on 5/23/25. The weekly water temperatures for 6/2/25 in room [ROOM NUMBER] was 98, in room [ROOM NUMBER] was 96, in room [ROOM NUMBER] was 97, in room [ROOM NUMBER] was 98, and in room [ROOM NUMBER] was 87. SMOKING: 1. Resident 48 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, and nicotine dependence. On 6/11/25 at 12:56 PM, an observation was made of resident 48 smoking in the supervised area of the facility. On 6/11/25 at 1:38 PM, an observation was made of resident 48 smoking outside unsupervised on the facility lawn near the sidewalk. Resident 48's medical record was reviewed 6/9/25-6/19/25. A review of resident 48's smoking evaluation dated 4/15/25 revealed that resident 48 may smoke supervised by facility staff in the designated area and at supervised smoking times. The facility would store resident 48's smoking materials between designated smoking times. A care plan dated 4/16/25 revealed that resident 48 wished to smoke while remaining at the facility. The goal was that resident 48 would smoke safely through the review date. Interventions included Facility staff will supervise me while smoking at designated times and will store my smoking materials between designated times; I have been educated that smoking materials are for use only in designated smoking areas and; I will continually demonstrate safe smoking techniques including safe lighting materials, holding smoking materials safely, disposal of ashes, response to fallen ashes, secure storage of materials etc. 2. Resident 418 was admitted to the facility 6/2/25 and readmitted [DATE] with diagnoses which included aphasia following cerebral infarction, epilepsy, spastic hemiplegia, and difficulty walking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/11/25 at 12:56 PM, an observation was made of resident 418 smoking in the supervised area of the facility. A review of resident 418's smoking evaluation dated 6/12/25 revealed that resident 418 required supervision while smoking. There was no care plan that addressed smoking located in resident 418's medical record. It should be noted that resident 418 received a smoking evaluation 10 days after he was admitted . 3. Resident 421 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, muscle weakness, and asthma. On 6/9/25 at 12:04 PM, an observation was made of resident 421 remove a pack of cigarettes from his pocket and give resident 42 cigarettes in the dining room during lunch. On 6/12/25 at 6:31 AM, an observation was made of resident 421 outside the facility smoking by a dumpster in the parking lot. On 6/18/25 at 8:30 AM, an observation and concurrent interview was conducted with resident 421. Resident 421 was observed to have a pack of cigarettes in his shirt pocket and a lighter was on the floor next to his bed. Resident 421 stated that the facility let him smoke unsupervised but that he had to be outside the facility property. Resident 421 stated that he had his smoking supplies on him even though he knew that he was not supposed to. Resident 421's medical record was reviewed 6/9/25-6/19/25. A review of resident 421's smoking evaluation date 4/15/25 revealed that resident 421 required supervision while smoking. A care plan dated 4/16/25 revealed that resident 421 wished to smoke while remaining at the facility. The goal was that resident 421 would smoke safely through the review date. Interventions included Facility staff will supervise me while smoking at designated times and will store my smoking materials between designated times; I have been educated that smoking materials are for use only in designated smoking areas and; I will continually demonstrate safe smoking techniques including safe lighting materials, holding smoking materials safely, disposal of ashes, response to fallen ashes, secure storage of materials etc. 4. Resident 424 was admitted to the facility on [DATE] with diagnoses which included paraplegia, muscle spasms, and muscle weakness. On 6/11/25 at 7:35 AM, an observation was made of resident 424 outside the facility near the sidewalk smoking. On 6/12/25 at 7:57 AM, an observation was made of resident 424 outside of the facility near the sidewalk smoking. Resident 424's medical record was reviewed 6/9/25-6/19/25. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of resident 424's smoking evaluation dated 5/21/25 revealed that resident 424 required supervision while smoking. A care plan dated 5/21/25 revealed that resident 424 wished to smoke while remaining at the facility. The goal was that resident 424 would smoke safely through the review date. Interventions included Facility staff will supervise me while smoking at designated times and will store my smoking materials between designated times; I have been educated that smoking materials are for use only in designated smoking areas and; I will continually demonstrate safe smoking techniques including safe lighting materials, holding smoking materials safely, disposal of ashes, response to fallen ashes, secure storage of materials etc. 5. Resident 21 was admitted to the facility on [DATE] with diagnoses which included paranoid schizophrenia, tobacco use, adult failure to thrive, and epilepsy. On 6/12/25 at 7:15 AM, an observation was made of resident 21 wheeling in front of the facility in their wheelchairs. Resident 21 was observed to stop on the side walk east of the facility. Resident 21 was observed to use resident 89's lighter to light his cigarette. Resident 21 was not supervised by staff when smoking. Resident 21's medical record was reviewed 6/9/25 through 6/19/25. A quarterly smoking evaluation dated 4/15/25 revealed Resident may smoke SUPERVISED. A care plan dated 4/16/25 revealed resident 21 wished to smoke while residing at this facility. The goal was resident 21 would smoke safely through the review date. Interventions included Facility staff will supervise me while smoking at designated times and will store my smoking materials between designated times; I have been educated that smoking materials are for use only in designated smoking areas and; I will continually demonstrate safe smoking techniques including safe lighting materials, holding smoking materials safely, disposal of ashes, response to fallen ashes, secure storage of materials etc. On 6/19/25 at 9:36 AM, an interview was conducted with resident 21. Resident 21 stated he was able to smoke unsupervised any time. Resident 21 stated he was able to keep his smoking materials. Resident 21 stated if there were specific times that he had to smoke, he would not like that. On 6/19/25 at 9:46 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated there were set times for supervised smokers to smoke. LPN 2 stated there was a list of residents who smoked at each nurses station. LPN 2 stated resident who were evaluated to smoke independently could go outside into the community, off of facility grounds and smoke anytime. LPN 2 stated independent smokers needed to sign out at the front desk before leaving. LPN 2 stated resident 21 was on the list as requiring supervision while smoking. LPN 2 stated all residents had a smoking evaluation conducted upon admission and when there was a change in condition. LPN 2 stated residents who were not deemed as safe were not allowed to keep their smoking materials. LPN 2 stated residents who required supervision were not allowed to sign out and go off property to smoke. LPN 2 stated resident 21 kept his smoking materials and smoked independently when signed out because when a resident signed out they were responsible for themselves. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/12/25 at 9:03 AM, an interview was conducted with RN 2. RN 2 stated if a resident was capable of lighting their own cigarettes, then they can go smoke off property to smoke. RN 2 stated the resident needed to be able to sign themselves out and push themselves out the door to go off property. 6. Resident 32 was admitted to the facility on [DATE] with diagnoses which included polyneuropathy, need assistance with personal care, cognitive communication deficit and muscle weakness. Resident 32's medical record was reviewed 6/9/25 through 6/19/25. A smoking evaluation dated 4/15/25 revealed resident 32 scored a 0. There was no information if resident 32 was able to smoke independently or supervised. A care plan dated 6/30/23 revealed resident 32 was a smoker or used electronic cigarette/vape device. The goal was resident 32 would follow all smoking rules through review date. Intervention created on 6/12/25 revealed I have been educated that smoking materials are for use only in designated smoking areas and I have been oriented to smoking procedures and areas including designated supervised smoking times, if applicable. An intervention dated 10/19/24 revealed Resident was deemed an independent smoker. On 6/18/25 at 1:53 PM, an interview was conducted with DON (Director of Nursing) 2 and Regional Nurse Consultant (RNC). The RNC stated resident 32 was an independent smoker but the second question of the smoking assessment was not answered so the assessment was not completed on 4/15/25. The RNC stated the assessment was not completed so there was no information on the assessment if resident 32 required supervision or not. The RNC stated resident 21 was a supervised smoker according to the smoking evaluation. The RNC stated there resident 21 had leave of absence privileges, so he could sign out and smoke off property. The RNC stated the parking lot by the dumpster and the sidewalk on the east side of the facility were off the property. The RNC stated based on resident 21's smoking assessment and because he was trying to smoke outside on property so he was changed to a supervised smoker. The RNC stated that was based on the smoking policy. On 6/11/25 at 12:59 PM, an interview was conducted with Human Resources (HR). HR stated that every resident in the facility was a supervised smoker and that the facility kept the residents' smoking supplies in a locked box. HR stated that if residents refused to have their smoking supplies locked up then it was care planned that the resident kept their smoking materials. HR stated that there was not a written list of residents that required assistive devices while smoking and that it was more of a verbal list between staff. HR stated that nursing staff determined if residents required assistive devices. On 6/17/25 at 10:15 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that it the resident's Brief Interview of Mental Status (BIMS) score determined if the resident required supervision while smoking. RN 1 stated that resident's smoking materials were stored in a toolbox that was locked. RN 1 stated that any resident could sign themselves out of the facility and could smoke off property unsupervised. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/17/25 at 10:55 AM, an interview was conducted with the Certified Nursing Assistant (CNA) Coordinator. The CNA Coordinator stated that there were 5 scheduled times that residents could smoke at. The CNA Coordinator stated that there was a locked black box that was outside that smoking materials were kept in. The CNA Coordinator stated that lighters, cigarettes, and vapes were kept in the locked box. The CNA Coordinator stated that all residents in the facility should go outside to the designated smoking area at the scheduled times, but there were residents that signed themselves out of the facility and smoked off property. The CNA Coordinator stated that residents were not able to keep their smoking supplies with them. The CNA Coordinator stated that there was a list of supervised smokers that was observed to be dated 2/2/25 located at the 300 hallway nurse's station. The CNA Coordinator stated that the list was not current and needed to be updated. On 6/18/25 at 1:53 PM, an interview was conducted with the RNC and DON. The RNC stated when a resident admitted to the facility and they were a smoker, an evaluation was performed. The RNC stated there were both supervised and independent smokers currently in the facility. The RNC stated that if residents were supervised smokers, the facility kept their smoking supplies to ensure they were secured. The RNC stated that resident's signed a smoking contract upon admission which instructed residents to not share smoking materials. The RNC stated that residents could sign themselves out on a leave of absence (LOA) and smoke independently even if they were deemed to be supervised smokers by the facility. The RNC stated that a resident is able to leave on LOA based on their cognition. ELOPEMENT:1. Resident 115 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included traumatic brain injury, cognitive communication deficit, and vascular dementia. Resident 115's medical record was reviewed 6/9/25-6/19/25. On 2/14/24 a Minimum Data Set (MDS) Assessment for BIMS was conducted on resident 115. Resident 115 score was 6. A score of 0-7 would indicate severe cognitive impairment. Resident 115 had a care plan dated 6/22/21 and revised on 4/18/23, which had a care plan focus of, Resident is an elopement risk without exit seeking behaviors. [resident 115] is very impressionable and would leave with a friend or family member. Interventions included, Document wandering behavior and attempted diversional interventions in [electronic medical record] PRN [as needed] if resident is exhibiting exit seeking behaviors and Wander Guard in place to alert staff of exit seeking. On 10/8/23 a wander risk assessment revealed a score of 14 which indicated that resident 115 was at risk for wandering/elopements. On 3/31/24 at 8:53 PM, an alert note documented, At 1715 [5:15 PM], Medicare CNA answered a phone call from a person living in the area stating he saw a resident leave the facility. CNA looked outside for the resident and got in her vehicle and went down two blocks and the resident was walking on the sidewalk at 1718 [5:18 PM]. CNA safely helped the resident into her vehicle and brought the resident back to the facility. CNA notified DON of Elopement . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 6/19/25 at 8:18 AM, an interview was conducted with Unit Manager (UM) 2. UM 2 stated that resident 115 had dementia and was very sneaky about things and had had a few elopements while a resident. UM 2 stated that resident 115 would hide around corners and sneak out of the facility whenever she could. UM 2 stated that resident 115 had a wanderguard on and staff were educated that when they left the building to make sure resident 115 did not follow. UM 2 stated that resident 115 was not safe outside of the facility and would be unable to find her way back. UM 2 stated that the facility determined it was not secure enough for resident 115 and she was transferred to a facility with a locked unit. On 6/19/25 at 10:41 AM, an interview was conducted with the RNC. The RNC stated there was an elopement evaluation that nursing staff filled out and depending on the score interventions will be put in place to prevent elopement. The RNC stated once someone had eloped, staff should do an internal search to see of they could locate the resident. The RNC stated that resident 115 was an elopement risk and would not be safe out in the community on her own. The RNC stated that resident 115 had a wanderguard on and it was checked by nursing staff every shift to ensure that it was in place on the resident. The RNC stated that the wanderguard was checked twice on 3/31/24. On 6/19/25 at 11:02 AM, an interview was conducted with the Admin. The Admin stated that resident 115 was a wander risk. The Admin stated that resident 115 was spotted outside and was brought back to the facility and placed on a one to one until she was transferred the next day. The Admin stated he was not sure how resident 115 got out of the building while wearing a wanderguard. 2. Resident 119 was admitted to the facility on [DATE] with diagnoses which included intercranial injury with loss of consciousness, dementia with behavioral disturbance, delirium, dysphagia, and repeated falls. The medical record of resident 119 was reviewed 6/9/25 through 6/19/25. On 6/17/25 at 9:05 am, a Facility Reported Incident (FRI) report was reviewed and documented, on 4/20/2025 at 12:13 PM, the facility reported that on 4/19/2025 at 10:30 PM, At 10:00 pm [staff nurse] went to give [resident 119] his meds [medications]. She was not able to find him she [sic] staff started looking for him. At 10:15 pm facility got a call that looking for him. At 10:15 pm facility got a call that [resident 119] was outside harassing people so the police were called. Once the police arrived [resident 119] became combative so the police took him to the hospital. The FRI report documented resident 119 as being independent. An investigation was completed by the facility and documented the following: On 4/20/25 at 9:00 pm the nurse was passing medications and could not find the resident. She asked the CNA who stated they had seen him before his break which was about 20 minutes earlier. They both started to look for the resident and could not find him. On 4/20/25 at 9:20 pm a [local hospital] called and said that the resident had been brought to the hospital by the police. They said that he was following people down the road so they called the police. He was not harmed or injured. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A progress note dated 4/19/25 at 11:03 PM documented, Patient was last seen walking around the facility at approximately 2100 [9:00 PM] At around 2130 [9:30 PM], patient was following a group of pedestrians in [local city], when they then called 911. Upon arrival, authorities encountered the patient, who then initiated an altercation with the responding police officers. The facility received a call from [local hospital] ED [emergency department] confirming that the patient had been brought in by law enforcement. No injuries were reported to the facility at the time of notification. Patients behavior was described as agitated and confrontational upon police contact. DON has been notified. [Local hospital]was going to get in contact with [hospice company] regarding the situation. Awaiting further updates from [hospital and hospice agency] staff regarding patients condition and potential return to facility. An admission MDS dated [DATE] indicated resident 119 had a

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 2 out of 61 sampled residents, the facility did not ensure that residents were offered a therapeutic diet when the therapeutic diet was ordered. Specifically, a resident on a diabetic diet was not provided a low carbohydrate option. In addition, a resident complained of not being provided a renal diet. Resident identifier: 36 and 79. Findings included: 1. On 6/12/25 at 8:07 AM, an interview was conducted with resident 36. Resident 36 stated he was not doing so great. Resident 36 stated he had a reminder on his amazon echo in the evening on 6/11/25, to take his blood glucose level which was reading Hi (high) on his continuous monitor, indicating his blood glucose level was over 400 milligrams per deciliter (mg/dL). On 6/12/25 at 8:27 AM, an interview was conducted with resident 36's family member. The family member asked resident 36 if he was still alive. Resident 36 told the family member about the Hi blood glucose reading on the continuous monitor and that the facility's monitor read 389 mg/dL. The family member stated resident 36's high glucose had been going on for a long time. Resident 36's family member stated resident 36 was a type 1 diabetic and complained that Resident 36 was given a flat amount of insulin before meals, regardless of the carbohydrates in the meal. The family member stated they had requested low carbohydrate food options but resident 36 was usually given a high carbohydrate meal. On 6/12/25 at 1:30 PM, an observation was made of resident 36's lunch meal. The meal was ham, corn, scalloped potatoes, a roll and bread pudding with caramel sauce on top. Resident 36 did not have fruit instead of dessert as the meal ticket stated. Resident 36 stated he would prefer lower carbohydrate food options. Resident 36's medical record was reviewed 6/9/25-6/19/25. Resident 36's diet order was carbohydrate controlled. On 3/19/2025 at 2:17 PM, the interdisciplinary team (IDT), met with resident 36 and a family member. The IDT note stated they discussed resident 36's diabetes and adjustments that were needed to his insulin and diet. On 6/19/25 at 12:01 PM, an interview was conducted with the Dietary Manager (DM). The DM stated all information about a resident's diet was at the bottom of the production sheet. The DM stated for Controlled Carbohydrate Diet (CCHO) diet, the dietary staff will send sugar free juice. The DM stated if the resident was on a renal diet, no tomato and other high potassium foods would be served. The DM stated residents were served foods listed on the menu. The DM stated the dining computer software automatically eliminated items that were not on the therapeutic diet. The DM stated he was not sure how many carbohydrates were served per meal for CCHO diets. The DM stated resident 36 was on a CCHO diet with no dessert but fruit was okay. The DM stated resident 36 had a blond brownie on the meal ticket for dinner at the time of the interview. The DM stated the planned dessert could not be removed from the production ticket so the dietary staff relied on the notes on the production ticket to adjust the foods delivered to the resident. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/19/25 at 12:20 PM, an interview was conducted with the Registered Dietitian (RD).The RD stated that a CCHO diet should be between 225 to 250 grams of carbohydrates per day, which was according to CCHO diet guidelines. The RD stated that residents who were not supposed to get a dessert should have it left off their tray and a substitute offered. The RD stated the management of the meals, meal computer system, meal cards, and meal prep was left up to the DM. The RD stated that she was not aware that resident 36 desired to have lower carbohydrate meals. The RD stated if a resident requested that, then she would evaluate the resident. 2. Resident 79 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included end stage renal disease with dialysis, gastroparesis, and type 2 diabetes mellitus. On 6/9/25 at 10:18 AM, an interview was conducted with resident 79. Resident 79 stated the facility did not provide a renal diet. Resident 79 stated the facility served him beans, high potassium foods, like lots of bananas. Resident 79 stated the food was not good, there was no seasoning and it was usually cold. Resident 79 stated he had talked to the head cook but nothing had changed. Resident 79's medical record was reviewed 6/9/25 through 6/19/25. A physician's order dated 4/20/25 revealed a renal/diabetic diet with regular texture, thin liquids, double protein portions and low potassium diet. A form titled Nutritional Data Collection and assessment dated [DATE] revealed a renal/diabetic diet. The facility provided a form titled Production Sheet for the meals. According to the form on Tuesday Day 10 for lunch residents with renal diets were served a #12 scoop of mashed potatoes. On 6/19/25 at 12:01 PM, an interview was conducted with the DM. The DM stated if a resident wanted a more strict diet, then the RD would evaluate them. On 6/19/25 at 12:24 PM, an interview was conducted with the RD. The RD stated if a resident was on a renal diet, then the computer system would take out the foods the resident should not be eating. The RD stated she was not aware of concerns with the renal diets. The RD stated she had not visited resident 79 and asked about dietary needs.

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Monument Healthcare South Salt Lake	2472 South 300 East Salt Lake City, UT 84115

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that for 2 of 61 sampled residents, the facility did not ensure residents who displayed or were diagnosed with mental disorder or psychosocial adjustment difficulty, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Specifically, a resident who was diagnosed with mental disorders was observed to be at the end of a hallway for hours with a urine odor yelling at staff and residents, was not provided her psychotropic medication, and did not follow up on a Nurse Practitioner's recommendation of inpatient psychiatric admission. Resident identifiers: 48 and 59.Findings included:Resident 59 was admitted to the facility on [DATE] with diagnosis which included severe dementia with agitation, paranoid schizophrenia, type 2 diabetes, generalized anxiety disorder, delusional disorders, insomnia, schizoaffective disorder, and essential hypertension.Resident 59's medical record was reviewed on 6/9/25 through 6/19/25.On 6/9/25 at 10:14 AM, an observation was made of resident 59's room. The room did not contain any personal items.On 6/9/25 at 10:29 AM, an observation was made of resident 59 wandering up and down the hallways carrying 2 packages of briefs and a sack with toilet paper. Resident 59 was observed to be talking to herself which was not understandable.On 6/9/25 at 10:55 AM, an observation was made of resident 59 yelling out. During this time an interview was conducted with resident 48, who resided in the same hallway as resident 59. Resident 48 stated that this behavior was normal for resident 59 and resident 59's screaming often woke him up. Resident 48 stated that resident 59 could be verbally aggressive with other residents.On 6/10/25 at 8:45 AM, an observation was made of resident 59 in the west side 100 hallway near an exit. Resident 59 had plastic bags and blankets. Resident 59 had a strong urine odor. Resident 59 told surveyor to shut up when approached. Resident 59 appeared to be trying to exit the facility, however the door was locked. At 9:55 AM, resident 59 remained at the west side door intermittently screaming. At 11:03 AM, resident 59 remained at the west side door yelling out. [Note: Resident was observed for over 2 hours in the corner with a strong urine odor, yelling at staff and residents.]On 6/11/25 at 9:43 AM, an observation was made of resident 59 in her room yelling out and she could be heard from the hallway.On 6/11/25 at 10:09 AM, an observation was made of resident 59 in her room yelling out and she could be heard from the hallway.On 6/11/25 at 2:20 PM, an observation was made of resident 59 in her room yelling out and she could be heard from the hallway.A review of resident 59's progress notes revealed: a. On 4/10/25 at 4:21 PM, a medication administration note documented, Invega Sustenna Intramuscular Suspension Prefilled Syringe 117 MG [milligram]/0.75ML [milliliter] Inject 117 mg intramuscularly every day shift every 21 day(s) related to PARANOID SCHIZOPHRENIA (F20.0) Notify management if [resident 59] refuses Injection has not arrived, willadminister it when it does arrive within the facility. b. On 5/27/25 at 12:45 PM, a Psychiatric Follow Up note documented, .Continue with overall plan as stated. The patient does require continued monitoring due to their currentsituation [sic]/circumstance and potential forchange [sic] in presentation and need forpsychotropic [sic] options. Going forward willcontinue [sic] to round on patient, coordinate with staffand [sic] assessfor medication updates. Per today's visit:- Patient continues to yell/ screamoccasionally [sic] during the day andfrequently [sic]throughout the night, which is upsettingmultiple [sic] other residents. The pt [patient] could benefit from medication stabilization viainpatient [sic] care at a behavioral health facility where they can utilize specificmedications [sic] and psychiatric care which are not available at the current facility. c. On 6/9/25 at 3:35 PM, a progress note documented, Patient was due for her Invega injection today. Medication is currently unavailable. This nurse called the pharmacy to reorder the medication, and it is set to arrive by tomorrow per pharmacy.On 6/11/25 at 11:33 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that staff always tried to redirect resident 59 and find out what was bothering her when she screamed out. LPN 2 stated that resident 59 responded better to familiar staff.On 6/11/25 at 2:276 PM, an interview was conducted with Certified Nursing Assistant (CNA) 10. CNA 10 stated that staff did not try and stop resident 59 from carrying around items but did try to redirect her when she got upset.On 6/19/25 at 8:22 AM, a follow-up interview was conducted with LPN 2. LPN 2 stated that resident 59's medication was one of those injections that insurance would not cover repeat orders close together and staff were forgetting to contact the pharmacy. LPN 2 stated that she spoke with Unit Manager (UM) 1 about getting a reminder in the chart in May 2025, but the reminder had not been added to the chart. LPN 2 stated that resident 59 had been on the medication since she had worked at the facility and

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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 interview, and record review, it was determined that for 1 of 61 sampled residents, the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, a resident did not have an Invega injection available when it was scheduled to be administered. Resident identifiers: 59.Findings included:Resident 59 was admitted to the facility on [DATE] with diagnosis which included severe dementia with agitation, paranoid schizophrenia, type 2 diabetes, generalized anxiety disorder, delusional disorders, insomnia, schizoaffective disorder, and essential hypertension.Resident 59's medical record was reviewed on 6/9/25 through 6/19/25.On 4/10/25, a 117 milligram (mg) Invega intramuscular injection was scheduled for administration. This order, which was started on 2/6/25 and discontinued on 4/14/25, was scheduled to be administrated every 21 days. On 4/10/25 at 4:21 PM, a Medication Administration Note stated that the ordered Invega injection was not administered because Injection has not arrived, will administer it when it does arrive within the facility. According to the Medication Administration Record (MAR) a 117 mg Invega intramuscular injection was administered on 4/15/25. This order, which was started on 4/15/25 and discontinued on 5/7/25, was scheduled to be administered every 21 days. On 5/6/25, a 117 mg Invega intramuscular injection was scheduled for administration. On 5/6/25, it was documented in the MAR that the Invega injection was not administered, citing chart code 9, defined as Other/See Nurse Notes. No note could be found in resident 59's medical record providing a reason why the medication was not administered on 5/6/25. On 5/8/25, a 117 milligram (mg) Invega intramuscular injection was scheduled for administration. This order was started on 5/8/25 and ended on 5/9/25.On 5/8/25 at 1:52 PM, a Medication Administration Note stated that the ordered Invega injection was not administered because Patient refused multiple times today. On 5/9/25 an order was placed to administer a 234mg Invega intramuscular injection every 28 days starting 5/12/25. According to the MAR the medication was administered as scheduled. On 6/1/25, an order was started to call the pharmacy every 25 days and order the Invega medication. It was documented in the MAR that the Invega medication was ordered on 6/1/25. On 6/9/25, a 234mg Invega intramuscular injection was scheduled for administration. On 6/9/25 at 3:35 PM, a Progress Note stated that the Invega injection was currently unavailable and the pharmacy was called to reorder the medication. On 6/10/25, it was documented in the MAR that a 234mg Invega intramuscular injection was administered. On 06/19/25 at 10:08 AM, an interview was conducted with Unit Manager (UM) 1. UM 1 stated that the Invega injection was unavailable for administration due to issues with insurance coverage. UM 1 stated that the dosage and administration schedule for the Invega injection had been adjusted in an effort to accommodate insurance requirements.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined for 4 of 61 sampled residents, that the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable. Specifically, three resident's eye drops and one resident's insulin were expired. Resident identifiers: 31, 44, 106, and 107. Findings included: On [DATE] at 8:17 AM, an observation and interview were conducted with Registered Nurse (RN) 7. RN 7 was observed to pull Ketotifen Fumarate eye drops out of the Long Term [NAME] Medication Cart. The eye drops were labeled with an open date of 4/11. RN 7 stated eye drops were good for 28 days after they were opened and that the eye drops were expired. At 8:39 AM, RN 7 was observed to administer the Ketotifen Fumarate eye drops into resident 31's eyes. At 10:41 AM, RN 7 stated they talked with the nurse manager and the eye drops expired 30 days after they were opened. RN 7 stated they got rid of the eye drops and ordered more. On [DATE] at 1:18 PM, an observation and interview were conducted with Licensed Practical Nurse (LPN) 2. An opened bottle of Latanoprost Ophthalmic Solution 0.05% eye drops, labeled with resident 44's name, were located in the 400 Hall Medication Cart. There was no opened date labeled on the eye drops. LPN 2 stated there was supposed to be an open date written on the eye drops and that it should be discarded because it could be expired. Resident 44 had a physician order dated [DATE] at 1:13 PM which indicated, Latanoprost Ophthalmic Solution 0.005% (Latanoprost) Instill 1 drop in both eyes at bedtime for dry eye Instill 1 drop OU [both eyes] QHS [every night at bedtime]. A Medication Administration Record dated [DATE]-[DATE] indicated resident 44 was administered 1 drop of Latanoprost Ophthalmic Solution 0.005% (Latanoprost) in both eyes at bedtime from [DATE] through [DATE]. On [DATE] at 1:36 PM, an observation and interview were conducted with LPN 2. Located inside the 500 Hall Medication Cart was a used medication pen of Insulin Aspart for resident 107 with an open date labeled [DATE]. LPN 2 stated the Insulin Aspart pen expired on [DATE]. An open bottle of Olopatadine Hcl (hydrochloride) 0.2% eye drops for resident 106 with no open date was also located in this medication cart. LPN 2 stated all eye drops expire 28 days after opening. Resident 107 had a physician order dated [DATE] at 4:41 PM which indicated, Insulin Aspart Subcutaneous Solution Pen-injector 100 UNIT/ML [milliliters] (Insulin Aspart) Inject subcutaneously four times a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS. A Medication Administration Record dated [DATE]-[DATE] indicated resident 107 was administered Insulin Aspart Subcutaneous Solution Pen-injector six times prior to [DATE]. Resident 106 had a physician order dated [DATE] at 5:20 PM which indicated, Pataday Ophthalmic Solution 0.2% (Olopatadine Hcl) Instill 1 drop in right eye in the morning for itching and redness. On [DATE] at 1:50 PM, an observation and interview were conducted with RN 2. Three over the counter artificial tears and 1 bottle of Systane eye drops were located inside the Medicare Odd Medication Cart. All four eye drops were opened and they were not labeled with open dates. RN 2 stated they only go by the expiration date on the box, even if it was opened. RN 2 stated the opened Systane eye drops would expire on 2/27, which was observed to be the manufacturer's expiration date on the bottle. On [DATE] at 1:35 PM, an interview was conducted with the Director of Nursing (DON) 2. DON 2 stated all opened eye drops, including over the counter, were good for 28 days. DON 2 stated insulin expired 28 days after being opened and should have been discarded.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on observation, interview and record review it was determined the facility did not provide or obtain laboratory services to meet the needs of its residents. If the facility provided its own laboratory services, the services must meet the applicable requirement for laboratories. Specifically, facility glucometers were not being calibrated according to the manual. Findings included:1. The facility's 500 hall glucometer calibration and quality control tracking sheet was reviewed. The glucometer was calibrated on 4/24/25 at 6:30 AM, 5/4/25 at 9:45 AM, 5/17/25 at 4:40 PM, 6/1/25 at 1:00 AM, and 6/4/25 at 11:00 PM. On 6/12/25 at 10:08 AM, a phone interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that the night shift calibrated the facility glucometers weekly and documented the results in the narcotics binder. LPN 1 stated that, to his knowledge, the facility glucometer was working and accurate. On 6/12/25 at 10:40 AM, an interview was conducted with LPN 2. LPN 2 stated the glucometers were calibrated weekly by the graveyard shift nurse and the calibration log was kept in the narcotic binder. 2. On 6/12/25 at 10:38 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated Certified Nursing Assistants (CNA's) could be passed off to check glucose levels of residents, but he personally liked to do his own blood sugar checks. RN 2 stated that his medication cart had two glucometers to test resident's glucose levels. RN 2 stated that the glucometers in the facility were not required to be calibrated. RN 2 stated that the weekend manager was the one that signed the log when calibration was done.The medication cart for the 100/200 hall way odd side had a glucometer calibration log with the dates 4/24/25, 5/4/25, and 5/17/25. On 6/12/25 at 10:51 AM, an interview was conducted with RN 4. RN 4 stated that the nursing night shift performed calibration for the glucometers. RN 4 stated that she was unsure how often this was performed. RN 4 stated that she was unsure where the calibration log was kept and was unable to locate one on her medication cart for the 100/200 hallway even side. On 6/12/25 at 11:36 AM, an interview was conducted with the Director of Nursing (DON) 1. DON 1 stated that CNA's were not able to perform blood sugar checks because they had not been passed off. 3. On 6/12/25 at 10:30 AM, the 300 and 400 hallway glucometer calibration form was reviewed calibration was done 4/24/25, 5/4/25 at 10:30 AM, 5/9/25 at 4:45 PM, 5/17/25 at 4:45 PM, 5/30/25 at 11:30 PM, and 6/5/25 at 2:00 AM. On 6/12/25 at 10:40 AM, an interview was conducted with Certified Medication Aide (CMA) 1. CMA 1 stated medication aides were able to obtain blood glucose levels. CMA 1 stated that calibrations were done during the night shift weekly. On 6/12/25 at 10:45 AM, an interview was conducted with CMA 2. CMA 2 stated glucometers were calibrated weekly during the night shift. On 6/18/25 at 12:40 PM, an interview was conducted with the Regional Nurse Consultant (RNC) and DON 2. The RNC stated according to the manufacturer requirements glucometers needed to be calibrated weekly. The RNC stated they were not being calibrated according to the manufacturer instructions. The glucometer manual revealed controlled solution testing should be done when using the meter the first time, once per week to ensure the meter and test strips were working properly, using a new bottle of testing strips, or if it was suspected the testing strips and meter were not working properly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility did not ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Specifically, sanitizer solution was not measuring on the testing strips, there were soiled areas in the kitchen and spices were left open to air. Findings included:1. On 6/9/25 at 9:23 AM, an initial kitchen tour was conducted. The following was observed: a. The area behind the steamer had a white substance splattered on it, debris and grease splatter. The table it is sitting on is rusty, has a white splatter on the legs and the bottom shelf. b. The area under the storage shelves and under the storage carts in the dish room were soiled. The floor had a white substance on it. 2. On 6/18/25 at 11:54 AM, an observation was made of the Registered Dietitian (RD) in the kitchen without a hairnet, in the food preparation area. 3. On 6/19/25 at 11:19 AM, a follow-up tour of the kitchen was conducted. The following was observed: a. The sanitizer solution in the cooking area was tested. The test strip turned blue. Using the test strip comparing it to test strip container revealed there was no blue color to determine parts per million (PPM) of the quats sanitizer solution. The highest was 400 PPM of quats sanitizer solution which was the color was green. The preparation area sanitizer solution was tested and the strip turned blue. According to the label on the sanitizer it should be testing at 150 to 400 PPM. An observation was made of sanitizer solution container. The container revealed it was a quats sanitizer and needed to be 150-400 PPM for food surfaces. An interview was immediately conducted with the Dietary Manager (DM). The DM stated the sanitizers were just changed because the solution was warm. The DM stated the blue color meant it was 400 PPM. The DM confirmed there was no blue color on the sanitizer strips check. b. There were plastic drawers with serving utensils that was soiled. c. Behind the steamer there was debris and black substance. d. There was white substance on the floor under the preparation sinks. e. There was tape on the ceiling above the preparation sink. f. There were 4 large bins labeled powdered milk, sugar, flour and oatmeal. The bins were soiled around the tops that opened. g. Spices labeled cajun and thyme leaves were open to air. h. The steamer was broken and not available for use. On 6/29/25 at 12:01 PM, an interview was conducted with the DM. The DM stated the steamer had been broken for about a year. The DM stated the steamer was used for vegetables, pork ribs and mashed potatoes. The DM stated staff had to boil everything which took longer. The DM stated it was hard to get the same results with boiling foods over steaming. The DM stated every 2 weeks staff cleaned behind the steamer, stove and grill. The DM stated floors were cleaned daily. The DM stated the white containers were cleaned daily after the cook finished tray line and cleaning up. The DM stated the drawers with scoops should be cleaned weekly.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 2 of 61 sampled residents, the facility did not arrange services with an outside agency in a timely manner. Specifically, a resident that needed dental services did not have those services scheduled, and a resident did not have an endocrinology appointment scheduled after a referral from the physician. Resident identifiers: 36 and 64. Findings included: 1. Resident 64 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease, schizoaffective disorder, adult failure to thrive, dysphagia, dementia, and morbid obesity. On 6/9/25 at 11:00 AM, an interview was conducted with resident 64 who stated she had seen a dentist in 2024 and was told she needed to see an outside dentist for further treatment. Resident 64 stated she had not yet seen an outside dentist. Resident 64's medical records were reviewed between 6/9/25 and 6/19/25. A physician order dated 8/24/24 revealed, May have dental, vision & eye health, hearing, wound and podiatry consults as needed. A review of resident 64's documents revealed a dental visit note dated 9/25/24 with dental provider notes that stated the following, Facility visit in room for exam. Oral cancer screening complete IO/EO-WNL [Intraoral/Extraoral-Within Normal Limits]. Patient will need to be referred for fillings on teeth #4-6, 9-11. Decay is causing her to cut her lip.-[Dentist initials]. Resident 64's care plan dated 9/4/24 revealed a focus area, [resident 64] has oral/dental health r/t [related to] poor oral hygiene. The goal was, The resident will be free of infection, pain or bleeding in the oral cavity by review date. Interventions included, Coordinate arrangements for dental care, transportation as needed/as ordered. On 6/17/25 at 10:00 AM, an interview was conducted with Registered Nurse (RN) 1 who stated the Unit Manager (UM) or the Nurse were responsible to review the resident's notes after a provider visit. RN 1 stated if a follow-up was recommended, the nurse would submit a request transportation and enter an order for the scheduled appointment. RN 1 stated the entered order would alert nursing staff the day before the follow-up. RN 1 stated evening nurse reminded the resident the night before the appointment and put a reminder on the resident's door. RN 1 stated the process had recently changed and recommended the previous UM be interviewed. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 10:30 AM, an interview was conducted with the Respiratory Lead (RL) who stated she used to be the UM on the resident's hallway. The RL stated if a resident returned from an appointment with a follow-up appointment, she would put a physician's order for the appointment in the resident's orders, and would put in a request slip for transportation. The RL stated they would then coordinate with transportation and the schedule to ensure they did not have double rides on that day. The RL stated if a referral was needed, she would complete the referral and write down the information so the resident would know the referral had been completed and the appointment had been made. The RL stated if resident 64 did not want to go to an appointment she would call and cancel. The RL stated she did not remember what happened with resident 64 and her dental appointments. The RL stated another staff member was setting up resident 64's dental appointments. The RL stated she was unsure if resident 64's insurance covered visits with an outside dental provider. The RL stated that normally, a progress note was entered into the resident's medical record when an appointment was made or canceled. The RL stated she put notes in resident 64's progress notes for appointments she was responsible for scheduling. The RL stated she switched to a new position a few months ago. The RL stated she no longer knew what the process was for scheduling transportation or getting documents to medical records to be put into a resident's medical record. On 6/19/25 at 7:22 AM, an interview was conducted with the Regional Nurse Consultant (RNC) who stated she looked at resident 64's previous medical records and was unable to find any documentation stating that resident 64 had refused dental appointments or canceled them, and there was no information about scheduling or rescheduling the dental appointment. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 36 was re-admitted on [DATE] with diagnoses of hemiplegia/hemiparesis, chronic respiratory failure, morbid obesity, major depressive disorder, type 1 diabetes, epilepsy, generalized anxiety disorder. On 6/18/25 at 1:20 PM, an interview was conducted with resident 36's medical doctor (MD). The MD stated that he did not know if resident 36 had a PRN (as needed) insulin order for when glucose levels were high but stated a PRN order would help when resident 36's level was high. The MD stated that resident 36's family member requested a specific endocrinologist and a referral was made but there was some back and forth on scheduling with the endocrinologist. The MD stated resident 36's last A1C (glycated hemoglobin) was at 12. On 6/18/25 at 1:59 PM, an interview was conducted with UM 1. UM 1 stated the physician's assistant (PA) referred resident 36 to a preferred endocrinologist about 2 weeks ago. The referral was made on 5/27/25. UM 1 stated he was the unit manager for a couple months and was unaware of previous endocrinology referrals. UM 1 stated a nurse for the endocrinologist assessed resident 36 on 6/9/25 and resident 36 had an endocrinology appointment 7/1/25. Resident 36's medical record was reviewed 6/12/25 through 6/19/25. Resident 36's laboratory Hemoglobin A1c results were as follows: a. On 2/18/25 was 8.9, reference rate <5.7 b. On 5/23/25 was 9.8, reference rate <5.7Endocrinologist referrals a. On 12/26/24, a follow up PA report stated resident 36 may benefit from an outpatient endocrinology referral. b. On 2/12/25, a follow up MD report documented an endocrinology referral in resident 36's assessment and plan. This was signed by the MD on 2/21/25. c. On 3/17/25, a follow up PA report documented an endocrinology referral in resident 36's assessment and plan. d. On 3/19/2025 at 2:17 PM, the interdisciplinary team (IDT) care plan conference, attended by the social services worker (SSW), unit manager (UM 2) who was the 500 hall unit manager at this time, stated they discussed resident 36's diabetes and making adjustments to his insulin and diet and that the PA and the family member wanted him to see the endocrinologist. e. On 5/27/2025 at 14:56 PM, a progress note stated to notify the provider if low blood sugar occurs, and refer resident 36 to an endocrinologist for diabetes mellitus. f. On 6/11/2025 at 11:43 AM, a progress note stated that resident 36 was referred to an endocrinologist. On 6/9/25, resident 36 had his first assessment in the facility by a nurse for the endocrinologist. On 6/19/25, an interview with the SSW was conducted. The SSW was present at the IDT meeting on 3/19/25 and stated that resident 36's family member wanted him to see the endocrinologist. The SSW did not know if an endocrinology referral or attempt to set up an appointment was made after the IDT meeting. The SSW confirmed that UM 2 was present in the IDT meeting and was the person responsible to set up appointments with outside providers. UM 2 was not available for an interview during the survey.

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Monument Healthcare South Salt Lake	2472 South 300 East Salt Lake City, UT 84115

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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 2 of 61 sampled residents, that the facility failed to maintain medical records on each resident that was complete, accurately documented, readily accessible, and systematically organized; and failed to ensure the medical record contained the results of any preadmission screening and resident review evaluations and determinations conducted by the State; and physician, nurse, and other licensed professionals progress notes. Specifically, one resident had an updated Pre-admission Screening/Resident Review (PASRR) that was not located in the medical record and one resident had no documentation regarding an elopement. Resident identifiers: 82 and 103.Findings included:1. Resident 82 was admitted to the facility on [DATE] with diagnoses which included severe vascular dementia, hypertension, attention and concentration deficit following cerebral infarction, depression, and cognitive communication deficit.Resident 82's medical record was reviewed 6/9/25 through 6/19/25.A PASRR dated 1/3/24 did not indicate resident 82 had a diagnosis of depression.A Psych (Psychiatric) Follow Up note dated 10/4/24 at 6:00 AM indicated, .suggest Lexapro 5mg [milligrams] daily for depression and anxiety A Nursing note dated 10/12/24 at 1:13 PM indicated, New orders received from [mental health services] to start Lexapro [antidepressant medication] 5 mg QD [every day]. [Physician name redacted] agreed with recommendation.A Psych (psychiatric) Follow Up note dated 10/18/24 at 6:30 AM indicated, . Endorses depression, poor appetite, no interest in ADL's [activities of daily living]. She is tolerating the lexapro 5mg well.A Psych GDR (Gradual Dose Reduction) note dated 11/15/24 at 8:15 AM indicated, . Escitalopram Oxalate [antidepressant medication] Tablet 5 MG Give 1 tablet by mouth one time a day for Depression .On 6/18/25 at 1:19 PM, an interview was conducted with the Social Service Worker (SSW). The SSW stated a new PASRR would be completed if a resident had a new diagnoses added. The SSW stated that she probably had an old email that indicated she notified the PASRR evaluator when resident 82 was diagnosed with depression.On 6/18/25 at 3:10 PM, an interview was conducted with the Director of Nursing (DON) 2. DON 2 stated resident 82 was diagnosed with depression in February of 2025 but it did not get updated in the medical chart. DON 2 stated the PASRR should be updated with the new depression diagnosis.On 6/18/25 at 3:26 PM, an email was received from the SSW that indicated resident 82 was screened out on 1/9/25 for Depression due to Dementia.On 6/19/25 at 9:44 AM, a follow-up interview was conducted with the SSW. The SSW stated she updated resident 82's PASRR and uploaded the document to the medical record. 2. Resident 103 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, atherosclerotic heart disease, essential hypertension, type 2 diabetes, bipolar disorder, muscle weakness, and difficulty in walking.Resident 103's medical record was reviewed on 6/9/25 through 6/19/25. The facility reported that resident 103 eloped from the facility on 4/22/25. No documentation of this elopement was located in resident 103's medical record.On 6/19/25 at 11:10 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that any change of condition would require documentation in the progress notes.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, interview, and record review the facility did not ensure that policies were established and implemented to ensure that identified deficiencies were corrected. Specifically, areas of immediate jeopardy (IJ) were identified and not identified through the Quality Assurance and Performance (QAPI) process. In addition, multiple areas of non compliance were cited on the previous survey and again during the current recertification survey. Findings included:1. Based on observation, interview, and record review it was determined, for 12 out of 61 sampled residents, that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, hot water temperatures in resident rooms throughout the facility were observed to range in temperatures from 121.7-145.5 degrees Fahrenheit. The deficient practice identified, in regards to the hot water, was found to have occurred at an Immediate Jeopardy level. In addition, residents who were assessed as requiring supervision while smoking were observed smoking unsupervised, a resident was not evaluated for smoking and was observed smoking, and residents with a history of wandering eloped from the facility without staff knowing. Resident Identifiers: 3, 5, 21, 24, 25, 32, 48, 66, 71, 72, 73, 87, 100, 103, 110, 113, 115, 119, 418, 421, 424 A review of the facility's weekly water temperature logs from 5/9/25-6/2/25 revealed: a. On 5/9/25 the hottest water temperature recorded was 98 degrees Fahrenheit. b. On 5/15/25 the hottest water temperature recorded was 93 degrees Fahrenheit. c. On 5/23/25 the hottest water temperature recorded was 88 degrees Fahrenheit. d. On 5/27/25 the hottest water temperature recorded was 95 degrees Fahrenheit. e. On 6/2/25 the hottest water temperature recorded was 98 degrees Fahrenheit.A review of the facility QAPI plan dated 10/18/24 regarding supervised smoking revealed: a. The facility was not following its policy regarding supervised smoking b. Actions taken were to post signs specifically noting residents that were required to use assistive devices while smoking c. Audits were performed of the smoking area to ensure the smoking policy and procedures were being followed (staff supervising smoking, protective/safety equipment available and used appropriately)[Note: After the QAPI identified concerns with smoking, there were no updated lists of residents who required supervision, residents were not assessed for safety of smoking, residents who were assessed as requiring supervision while smoking were observed smoking independently during the survey.]A review of the facility QAPI plan dated 3/31/24 regarding resident elopements revealed: a. The Director of Nursing (DON) would review residents who were elopement risks to ensure appropriate interventions were in place b. Doors were checked to ensure that they were functioning properly c. Residents with adult electronic monitoring safety devices were checked daily to ensure the device was in place and functioning[Note: After the QAPI identified concerns with elopement, there was an elopement as recent as 4/22/25.][Cross refer to F689]2. There were repeat deficiencies from the survey on 1/25/24 that were recited on the current survey. Those regulations included F689, F609, F755, F761 and F880. On 6/19/25 at 1:12 PM, an interview was conducted with the Administrator (Admin). The Admin stated that QAPI was held monthly. The Admin stated that based off of concerns from residents, complaints, negative trends, or something that was consistently happening an action plan would be put in place. The Admin stated that the facility had done action plans for supervised smoking and elopements. The Admin stated that the facility had not identified hot water concerns. The Admin stated that any concerns for action plans were adjusted and then reviewed the following month.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a safe and sanitary environment to prevent the potential transmission of communicable diseases and infections for 1 out of 61 sampled residents. Specifically, staff were not wearing Enhanced Barrier Precautions (EBP) for a resident with chronic wounds and a tube feed when caring for the resident and the tube feed was not capped when not in use. Resident identifier: 90.Findings included:Resident 90 was admitted to the facility on [DATE] with diagnoses which included, pressure ulcer of sacral region stage 4, adult failure to thrive, and unspecified severe protein-calorie malnutrition.On 6/9/25 at 10:58 AM, an interview was conducted with resident 90. Resident 90 stated that his tube feed was continuous, but was stopped and disconnected when he went outside the facility to smoke. Resident 90 stated that staff wore gloves when changing him, but not gowns. On 6/9/25 at 1:03 PM, an observation was made of resident 90's tube feed. Resident 90 was disconnected from the tube feed and the end of the tube was not capped and was open to air. On 6/9/25 at 1:18 PM, an observation was made of Registered Nurse (RN) 1 reconnecting resident 90's tube feed. RN 1 was observed without wearing a gown.On 6/11/25 at 12:41 PM, an observation was made of resident 90 in the hoyer lift in his room. Certified Nursing Assistant (CNA) 1 was observed to change resident 90's bed linens without wearing a gown. On 6/17/25 at 8:02 AM, an observation was made of CNA 2. CNA 2 changed resident 90's brief without wearing a gown. On 6/17/25 at 6:31 AM, an interview was conducted with RN 2. RN 2 stated that resident 90 had a tube feed and wounds. RN 2 stated that resident 90 was on EBP which meant that gloves and gowns needed to be worn while providing care. RN 2 stated that when resident 90 was disconnected from his tube feed the end should be covered with a cap and not left open. On 6/17/25 at 6:47 AM, an interview was conducted with RN 1. RN 1 stated that resident 90 had contact precautions because of the feeding tube. RN 1 stated if resident 90 had to be disconnected from the feeding tube the nurse should put the cap on the end of the tube.On 6/17/25 at 8:02 AM, an interview was conducted with CNA 2. CNA 2 stated that she wore gloves when caring for resident 90 and did not know if she needed to wear a gown. On 6/18/25 at 9:15 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that when a resident needed their tube feed disconnected, staff flushed the tube and then capped it. The RNC stated that EBP should be used for all residents with tube feeds, chronic wounds, or catheters. The RNC stated that staff identified residents requiring EBP by a magnet with the number 6 hanging on the door frame and by reviewing the doctor's orders. The RNC stated bins outside the resident's door provided gowns and masks for staff, and gowns were required whenever staff had direct contact with the resident.

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (continued on next page)

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F 0921 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Specifically, a staff and public restroom had extremely hot water temperatures. These findings were found to have occurred at an Immediate Jeopardy (IJ) Level. NOTICE:Notice of Immediate Jeopardy (IJ) was given verbally to the Administrator on 6/10/25 at 2:30 PM. The Administrator was asked to develop an immediate plan to ensure resident safety related to hot water temperatures. PLAN:On 6/10/25 at 9:17 PM, the facility Administrator provided the following abatement plan for the removal of the IJ effective 6/10/25 at 8:30 PM.[Facility name] is providing the following information to demonstrate that the immediacy of the cited deficiency F689 has been removed. Summary of Actions Taken: Water temperatures were measured by Administrator/Maintenance Director to ensure it was at an appropriate temperature range.Residents at Potential Risk: A plumber was dispatched to the facility on 6/10/25 to evaluate the water heater, mixing valve and holding tanks. The Plumber was able to make repairs that will maintain water temperature compliance. Full facility water temperature audit was conducted by Administrator/Maintenance Director to ensure it was at an appropriate temperature range. Audits were conducted on the evening of 6/10/25. A new thermometer was purchased that is compliant with testing water temperatures.Systemic Changes and Education Administrator and Maintenance Director were educated by Chief Operations Officer regarding safe water temperatures and proper temperature measurement, monitoring, and management. This education occurred on 6/10/25 at 16:15 [4:15 PM] hrs. [hours] Administrator and Maintenance Director were educated by Chief Operations Officer that regular water temperature checks must be performed, logged, and monitored to ensure resident safety. This education occurred on 6/10/25 at 16:15 hrs. Facility water temperature management logs are set up in the TELS [The Equipment Lifecycle System] system to be performed regularly by the Maintenance Director; Administrator will ensure this is completed appropriately and timely.Monitoring and Quality Improvement Measure: The Administrator/Maintenance Director/Designee will conduct full audits of facility water temperatures weekly x 4 weeks, followed by audits of 5 random resident rooms on each hallway monthly x 3 months to ensure water temperatures are within appropriate range for resident safety. Medical Director was informed of the incident an QAA [Quality Assessment and Assurance] Review & [and] Recommendations. Results will be reported to the QAA committee for monitoring and follow-up The Administrator is responsible for substantial compliance of this Plan of Action.The facility alleges the immediacy with the deficient practice has been removed on June 10, 2025 by 8:30 PM.The abatement was verified by the survey team on 6/11/25 at 10:00 AM. Findings included:On 6/9/25 at 12:49 PM, an observation was made of the staff and public bathroom. The door was locked with a code. The water temperature was taken with a digital thermometer which read 142.0 degrees Fahrenheit after 30 seconds of running the hot water. On 6/9/25 at 2:58 PM, a tour of the facility's water boiler room with the Maintenance Director was conducted. The Maintenance Director stated the facility received hot water from the boiler and the kitchen received hot water from a water heater. The Maintenance Director stated that the water temperatures for the facility should be between 105-115. On 6/9/25 at 3:02 PM, an observation was made of the boiler, the boiler showed a temperature of 188. The Maintenance Director stated the water went from the boiler to the mixing valve. There was no temperature gauge observed on the mixing valve. The Maintenance Director stated that there were two holding tanks for water and that there were no thermometer gauges on the tanks. The Maintenance Director stated he used an infrared thermometer to test the water temperatures by having a steady stream of water and then pointing it toward the water. On 6/10/25 at 9:17 AM, an interview was conducted with the Administrator (Admin). The Admin stated that last night and this morning the facility had tested the water with different probe thermometers and the infrared thermometer and the temperatures all varied. The Admin stated that the low temperatures from the monthly maintenance log should have been a red-flag with the water temperature. A review of the facility water temperature log over the past six months revealed the highest water temperature was 108 in room [ROOM NUMBER] on 4/28/25 and the lowest temperature was 81 in room [ROOM NUMBER] on 5/23/25. The weekly water temperatures for 6/2/25 in room [ROOM NUMBER] was 98, in room [ROOM NUMBER] was 96, in room [ROOM NUMBER] was 97, in room [ROOM NUMBER] was 98, and in room [ROOM NUMBER] was 87.On 6/11/25 at 9:53 AM, a follow up interview was conducted with the Maintenance Director. The Maintenance Director stated he was instructed to use the infrared thermometer from the