STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465155	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine View Transitional Rehab	1497 East Skyline Drive Ogden, UT 84405

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on observation, interview and record review the facility failed to provide reasonable accommodations of needs and preferences except when to do so would endanger the health or safety of resident or other residents for 1 of 15 sampled residents. Specifically, a resident was not provided assistive devices for bed mobility. Resident identifier: 13. Findings include: Resident 13 was admitted to the facility on ,d+[DATE]//25 with diagnoses which included type 2 diabetes mellitus, chronic wounds and wedge compression fracture of second lumbar vertebra. On 4/14/25 at 9:32 AM, an interview was conducted with resident 13. Resident 13 stated he used a rail at another facility that helped him with repositioning in bed. Resident 13 stated he had asked CNAs, nurses, and therapy staff about a rail but was told the state did not allow them. Resident 13 stated it would be helpful with repositioning in bed and sitting on the side of the bed. Resident 13 stated there were not always 2 staff member when changing his brief and he felt nervous without a positioning bar. An admission Minimum Data Set, dated dated dated [DATE] revealed resident 13 had limited range of motion to to both sides of his upper extremity. Resident 13 required partial/moderate assistance with the helper providing less than half the effort for roll left to right, sit to lying position, lying to sitting on the side of the bed and sit to stand. Resident 13 had Brief Interview for Mental Status score of 14 out of 15 indicating cognition was intact. A care plan dated 12/20/24 during the prior admission revealed resident 13 required and received staff assistance with activities of daily living (ADL) related to limited mobility, generalized weakness wounds and neuropathy. The goal was resident 13 would increase strength and endurance. Approaches included functional mobility would improve throughout the patient's stay, Staff to allow for and encourage patient choices and preferences and Staff to encourage independence / participation with ADLs as able. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 2:18 PM, a follow up interview was conducted with resident 13. Resident 13 stated when he turned onto his side, it would help for him to have a positioning bar. Resident 13 stated he had asked Certified Nursing Assistants (CNA), nurses and therapy for something to help him with bed mobility but was told side rails and bed canes were illegal. Resident 13 stated when he was rolled to his side he was afraid he would fall off of the bed. Resident 13 stated he felt it was harder for staff when he was unable to help with an assistive device. Resident 13 stated CNAs opened the top drawer to the night stand next to his bed and he held onto that when he was on his side. Resident 13 stated he tried to use the overbed table but it rolled away and was dangerous. Resident 13 stated when he rolled to his other side he used his walker against the bed to hold onto to reposition. Resident 13 stated the walked moved so it was not stable. An observation was made of resident 13 positioning the walker while lying in bed against the bed to hold the handle to reposition. The walker was observed to move. Resident 13 stated CNAs tried their best to help me feel secure but it would be nice if he could reposition himself with an assistive devices while in bed. On 4/15/25 at 2:39 PM, an interview was conducted with the Director of Rehab (DOR). The DOR stated resident 13 had some bed mobility with minimal assistance. The DOR stated resident 13 did not get out of bed very often for therapy and refused therapy 2-3 times per week. The DOR stated resident 13 had not asked for anything to help him reposition in bed. The DOR stated he did not think of a bed cane because the facility did not allow them. The DOR stated as we were talking the facility had trapeze's that could be used for bed mobility and that might help him with lift up in bed but not side to side. On 4/16/25 at 1:44 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated the admitting nurse reviewed discharge instructions to determine how much assistance residents needed with ADL's. RN 1 stated therapy completed an evaluation the next day and provided staff with information on what ADL assistance a resident needed. RN 1 stated there had not been any reports of resident 13 requesting an assistive device for bed mobility. RN 1 stated resident 13 was unable to readjust himself while in bed. RN 1 stated resident 13 was alert and oriented and able to use his call light for staff assistance. RN 1 stated a bed cane or repositioning bar would be considered a restraint, so they were not allowed in the building. On 4/16/25 at 1:52 PM, an interview was conducted with CNA 1. CNA 1 stated resident 13 required 1 to 2 person extensive assistance with bed mobility. CNA 1 stated he can shimmy himself up in bed a little bit and required assistance of a CNA to roll in bed. CNA 1 stated resident 13 having a positioning device maybe helpful because she had resident 13 hold onto an open drawer of the night stand to stabilize himself when he was rolled onto his side. CNA 1 stated a bed cane or positioning device might be helpful to pull himself upward in bed. CNA 1 stated during a previous admission resident 13 put his hands over his head and pulled himself up in bed by the head board. CNA 1 stated resident 13 did not have strength for that anymore. CNA 1 stated they had not notified therapy or nursing that they were having resident 13 use the night stand drawer. On 4/16/25 at 2:28 PM, an interview was conducted with CNA 2. CNA 2 stated when resident 13 was being rolled he held onto the towel around his neck to support his neck. CNA 2 stated resident 13 held onto the night stand drawer or the walker depending on the side. CNA 2 stated those supported and made him feel more comfortable. CNA 2 stated resident 13 liked to have another staff member on the side to hold onto. CNA 2 stated if resident 13 had an assistive device, they felt like it would help with with adjusting form side to side when in bed. CNA 2 stated they felt like it would be hard not have something to hold onto when repositioning in bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 1:59 PM, an interview was conducted with the Director of Nursing (DON). The DON stated repositioning devices for the facility included a trapeze, wedge pillows, a draw sheet to reposition and pillows. The DON stated they were a Restraint free facility because it was corporate policy. The DON stated therapy determined if a resident needed a trapeze. The DON stated resident 13 required 2 staff member to reposition him in bed. The DON stated resident 13 sometimes asked to hold onto the drawer to for comfort when he was on his side. On 4/16/25 at 2:05 PM, a follow up interview was conducted with the Director of Rehab (DOR). The DOR stated resident 13 had improved with bed mobility from moderate assistance to minimum assistance with bed mobility since admission. The DOR stated the trapeze might help scooting up in bed but not moving side to side. The DOR stated there should be a staff member for resident 13 to hold onto when he was rolled onto his side. The DOR stated resident 13 had not requested an assistive device. On 4/16/25 at 2:12 PM, an interview was conducted with the [NAME] President of Clinical Operations (VPCO). The VPCO stated a bed cane and side rails were a restraint according to corporate policy. The VPCO stated anything that had a risk for entrapment was not used because they were a restraint free company. The VPCO stated there was an assessment that could be done for the bed cane if a resident was insistent on that. The VPCO stated CNAs repositioned resident 13 using a draw sheet and he had declined a trapeze.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 30563 Based on interview and record review the facility failed to report an allegation abuse or neglect to the State Survey Agency immediately, for 1 of 15 sampled residents. Specifically, an allegation was not reported when a resident reported a nurse yelled at him. Resident identifier: 13. Findings include: Resident 13 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, chronic wounds, osteomyelitis, and wedge compression fracture of second lumbar vertebra. On 4/14/25 at 9:32 AM, an interview was conducted with resident 13. Resident 13 stated he had to wait for an hour for assistance one night and he was yelling out as loud as he could to get staff attention to assist him in changing his brief. Resident 13 stated a nurse came into his room and yelled Why are you yelling? Resident 13 stated he talked to management about the nurse yelling at him. Resident 13 stated he felt like they were non-caring and then he felt screw it all, I don't care. Resident 13 stated the manager sat with him and listened to his story. On 4/16/25 at 2:21 PM, a follow up interview was conducted with resident 13. Resident 13 stated he pushed his call light and it was going off for almost an hour and then he started yelling. Resident 13 stated a nurse finally came in and yelled What are you yelling for? in a gruff mean tone. Resident 13 stated the nurse told him there was an emergency but he did not know that. Resident 13 stated the nurse was really loud and she should not do that to him. Resident 13 stated he did not know what else to do. Resident 13 stated he talked to the person in charge of everything and he had not worked with that nurse since. Resident 14 stated sometimes he has trouble breathing so he was worried about the call light not being answered. Resident 13's medical record was reviewed 4/14/25 through 4/16/25. There was no information located in resident 13's medical record about the incident. On 4/15/25 at 7:30 AM, an interview was conducted with the Administrator in Training (AIT) and the Director of Nursing (DON) stated there were no abuse or neglect reports. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 1:39 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she was notified that resident 13 complained of a night shift nurse. The DON stated resident 13 stated the nurse yelled at him when she entered his room. The DON stated when she investigated what happened the night of 4/10/25 into the morning of 4/11/25, she found there were was an emergency that night so it took longer for resident 13's call light to be answered. The DON stated she talked to the nurse who stated resident 13 waited about 30 minutes for cares because of the emergency with another resident. The DON stated resident 13 was yelling because he was unable to find his call light and was anxious for waiting to long. The DON stated she called the nurse who stated they did not yell at resident 13 but resident 13 was yelling. The DON stated resident 13 originally stated the nurse yelled at him and there was a Certified Nursing Assistant (CNA) there also. The DON stated resident 13 reported he told the nurse thank you but he did not want to be treated that way because he was important. The DON stated with the original report she would have considered it possibly abuse but after talking to the nurse it was determined not to be. The DON stated she had not followed up with resident 13 since the initial interview. On 4/15/25 at 1:45 PM, an interview was conducted with the AIT. The AIT stated he talked to resident 13 on 4/11/25 and resident 13 was explaining that the call light was going a little to long. The AIT stated he provided education on not rushing through cares with residents to the CNA's. The AIT stated he was not aware resident 13 stated a nurse yelled at him. The AIT stated the incident was not reported to the State Survey Agency because he did not think to report it and write down an investigation. The AIT stated he was the staff member responsible for reporting allegations of abuse to the State Survey Agency. On 4/15/25 at 1:50 PM, an interview was conducted with the Regional Director of Operations (RDO). The RDO stated this event needed to be verified and it was maybe a misunderstanding and needed to be investigated. The RDO stated he would need to interview the resident and determine the allegations because yelling meant different things. The RDO stated if he felt there was verbal abuse then it would be reported to the State Survey Agency. The RDO stated there was a fine line of what verbal abuse was. The RDO stated verbal abuse needed to be derogatory to the resident and the nurse did not attack the patient about anything. The facility provided a grievance regarding resident 13 dated 4/15/25 which revealed the compliment/concern report to: Long call light time with complaint of raised voice by nurse. The concern using factual terms revealed Patient states that on the evening of 4/10-4/11 he waited an hour for the nurse to respond to his call light and started yelling, he states nurse came in with an aide and yelled 'What are you yelling about.' Patient expressed frustration with negative response by staff. The resolution of concern revealed patient was told of conversation with staff, he expressed gratitude and stated he 'just didn't want to be treated that way'. The form was signed. Additional information provided via email on 4/17/25 revealed the definitions of abuse with examples of abuse which included yelling or hovering over a resident, with the intent to intimidate. The facility policy revealed verbal abuse as oral, written, or gestured language that included disparaging and derogatory terms to patients and their families. The Administrator and DON completed an investigation of the incident including a written summary of the finding no later than five working day of the report. It should be noted the grievance was not started until after the Surveyor inquired about the incident.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review the facility failed to thoroughly investigate an allegation of abuse or neglect, for 1 of 15 sampled residents. Specifically, an allegation of a nurse yelling at a resident was not investigated. Resident identifier: 13. Findings include: Resident 13 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, chronic wounds, osteomyelitis, and wedge compression fracture of second lumbar vertebra. On 4/14/25 at 9:32 AM, an interview was conducted with resident 13. Resident 13 stated he had to wait for an hour for assistance one night and he was yelling out as loud as he could to get staff attention to assist him in changing his brief. Resident 13 stated a nurse came into his room and yelled Why are you yelling? Resident 13 stated he talked to management about the nurse yelling at him. Resident 13 stated he felt like they were non-caring and then he felt screw it all, I don't care. Resident 13 stated the manager sat with him and listened to his story. On 4/16/25 at 2:21 PM, a follow up interview was conducted with resident 13. Resident 13 stated he pushed his call light and it was going off for almost an hour and then he started yelling. Resident 13 stated a nurse finally came in and yelled What are you yelling for? in a gruff mean tone. Resident 13 stated the nurse told him there was an emergency but he did not know that. Resident 13 stated the nurse was really loud and she should not do that to him. Resident 13 stated he did not know what else to do. Resident 13 stated he talked to the person in charge of everything and he had not worked with that nurse since. Resident 14 stated sometimes he has trouble breathing so he was worried about the call light not being answered. Resident 13's medical record was reviewed 4/14/25 through 4/16/25. There was no information located in resident 13's medical record about the incident. On 4/15/25 at 7:30 AM, an interview was conducted with the Administrator in Training (AIT) and the Director of Nursing (DON) stated there were no abuse or neglect reports and no investigations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 1:39 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she was notified that resident 13 complained of a night shift nurse. The DON stated resident 13 stated the nurse yelled at him when she entered his room. The DON stated when she investigated what happened the night of 4/10/25 into the morning of 4/11/25, she found there were was an emergency that night so it took longer for resident 13's call light to be answered. The DON stated she talked to the nurse who stated resident 13 waited about 30 minutes for cares because of the emergency with another resident. The DON stated resident 13 was yelling because he was unable to find his call light and was anxious for waiting too long. The DON stated the nurse stated they did not yell at resident 13 but resident 13 was yelling. The DON then stated that resident 13 originally stated the nurse yelled at him and there was a Certified Nursing Assistant (CNA) there also. The DON stated resident 13 reported he told the nurse thank you but he did not want to be treated that way because he was important. The DON stated with the original report she would have considered it possibly abuse but after talking to the nurse it was determined not to be. The DON stated she had not followed up with resident 13 since the initial interview. On 4/15/25 at 1:45 PM, an interview was conducted with the AIT. The AIT stated he talked to resident 13 on 4/11/25 and resident 13 was explaining that the call light was going a little to long. The AIT stated he provided education to CNA's about not rushing through cares with residents. The AIT stated he was not aware resident 13 stated a nurse yelled at him. The AIT stated the incident was not reported to the State Survey Agency because he did not think to report it and write down an investigation. The AIT stated he was the staff member responsible investigating allegations of abuse and he did not have an investigation. On 4/15/25 at 1:50 PM, an interview was conducted with the Regional Director of Operations (RDO). The RDO stated this event needed to be verified and it was maybe a misunderstanding and needed to be investigated. The RDO stated he would need to interview the resident and determine the allegations because yelling meant different things. The RDO stated if he felt there was verbal abuse then it would be investigated and reported to the State Survey Agency. The RDO stated there was a fine line of what verbal abuse was. The RDO stated verbal abuse needed to be derogatory to the resident and the nurse did not verbally attack the patient. The facility provided a grievance regarding resident 13 dated 4/15/25 which revealed the compliment/concern report to: Long call light time with complaint of raised voice by nurse. The concern using factual terms revealed Patient states that on the evening of 4/10-4/11 he waited an hour for the nurse to respond to his call light and started yelling, he states nurse came in with an aide and yelled 'What are you yelling about.' Patient expressed frustration with negative response by staff. The resolution of concern revealed patient was told of conversation with staff, he expressed gratitude and stated he 'just didn't want to be treated that way'. The form was signed. It should be noted the grievance was not started until after the Surveyor inquired about the incident. Additional information provided via email on 4/17/25 revealed the definitions of abuse with examples of abuse which included yelling or hovering over a resident, with the intent to intimidate. The facility policy revealed verbal abuse as oral, written, or gestured language that included disparaging and derogatory terms to patients and their families. The Administrator and DON completed an investigation of the incident including a written summary of the finding no later than five working day of the report.