| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465158 | A. Building<br>B. Wing | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Meadow Brook Rehabilitation and Nursing | 433 East 2700 South<br>Salt Lake City, UT 84115 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the dishmachine washing temperature was not reaching the required temperature, uncooked meat was stored with cooked foods, and the shelf above the steam table was soiled. Findings included: 1. On 9/22/25 at 9:13 AM, an initial tour was conducted of the facility kitchen. The following was observed with the dishmachine. (Note: All temperatures were in degrees Farenheit.)a. The wash temperature was 115 and the rinse 120. Dietary Aide (DA) 2 was observed to remove the bowls from the dishwasher and place them in the clean dish area. b. The wash temperature was 115 and rinse was over 120. DA 2 was observed to remove the dishes from the dishwasher and place them with the clean dishes. c. The wash temperature was 118 and the rinse temperature was 120. The Dietary Manager (DM) was observed to check the sanitizer which was 50-100 parts per million of chlorine. DA 2 was observed to remove the dishes from the dishwasher and place them with the clean dishes. d. At 9:45 AM, the wash temperature was 118 and rinse was 120. The dishes were removed from the dishwasher and placed with clean dishes. The September 2025 dishwasher temperature log was reviewed and the rinses were documented at 120 and the sanitizer was 100 parts per million. There was no column to record the wash temperature. The steam table had a shelf above the food and under the shelf was soiled. An interview was conducted with DA 2 who stated it was his first day and he did not check the dishmachine temperatures. An interview was conducted with the DM. The DM stated he checked the dishmachine temperatures before the meals.The DM stated he was not sure if both wash and rinse both needed to reach 120. The DM stated the shelf under the trayline was cleaned after each meal service. The freezer was observed to have two boxes of beef sirloins stored on the same shelf as pizza crust and buttermilk biscuits. The DM was observed to remove the boxes and place them in another freezer. The DM stated the uncooked meats should not be stored on the same shelf as pizza crust and buttermilk biscuits. 2. On 9/29/25 at 2:37 PM, a follow up observation was made of the kitchen. The trayline shelf was observed to be soiled. |

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 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observation and interview, the facility was not clean, comfortable and homelike. Specifically, there was no process for cleaning dirty wheelchairs and mechanical lifts. In addition, there was a medication cart in the dining room that was soiled with dead bugs in it. Resident identifiers: 1 and 11.Findings included:1. On 9/22/25 at 11:32 AM, an observation was made of resident 11's wheelchair. The wheelchair was soiled with a white substance. On 9/29/25 at 2:58 PM, an observation was made of resident 1 and resident 11's wheelchair. Resident 1 and resident 11's wheelchair was soiled. Resident 11's wheelchair was soiled with a white substance on the side and on the cushion. 2. On 9/22/25 at 1:15 PM, an observation was made of a medication cart and emergency cart in the dining room. There were dead bugs, crumbs, and debris in the side of the medication cart. The emergency cart was observed to have dust and debris in a drawer with the suction machine. On 9/22/25 at 1:30 PM, an observation was made of the mechanical lifts in the dining room. The foot plates of the mechanical lifts were soiled with a black substance and debris. On 9/25/25 at 1:28 PM, an observation was made of the mechanical lifts in the dining room. One of the sit to stand lifts was soiled on the foot plates. Another sit to stand lift was observed to be dirty at the bottom of the lift. There were dead bugs, crumbs, and debris in the medication cart in the dining room. An emergency cart had dust in the bottom drawer where there was a suction machine. On 9/29/25 at 2:52 PM, an interview was conducted with the Administrator. The Administrator stated the lifts and wheel chairs were cleaned regularly. The Administrator stated they were planning to come up with a cleaning plan. On 9/29/25 at 2:56 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was not sure when the lifts were cleaned but after each use she wiped down the handrails. CNA 1 stated she did not know of a cleaning schedule for the wheelchairs or mechanical lifts. |

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| F 0775<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Keep complete, dated laboratory records in the resident's record.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not file in the resident's clinical record laboratory (lab) reports that were dated and contained the name and address of the testing laboratory. Specifically, for 3 out of 29 sampled residents, residents that had labs completed did not have those lab reports in their medical record. Resident identifiers: 3, 15, and 17. Findings included:<br><br>1. Resident 17 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, diabetic chronic kidney disease, iron deficiency anemia, hypomagnesemia, acidosis, hyperkalemia, and diabetic polyneuropathy.<br><br>Resident 17's medical record was reviewed.<br><br>On 8/26/25, a physician's order documented obtain Microalbumin Creatinine Ratio (MAC) in 4 weeks for proteinuria one time only for to rule out proteinuria until 08/26/2025 23:59 [11:59 PM] -Start Date 08/26/2025 0430 [4:30 AM].<br><br>On 9/10/25, a physician's order documented UA [urinalysis] with culture and sensitivity by PCR [polymerase chain reaction] for ongoing UTI [urinary tract infection] one time only until 09/10/2025 23:59 -Start Date 09/10/2025 1130 [11:30 AM].<br><br>On 9/12/25, a physician's order documented obtain BMP [basic metabolic panel] one time only until 09/12/2025 23:59 -Start Date 09/12/2025 0645 [6:45 AM].<br><br>The lab results were unable to be located in resident 17's medical record.<br><br>2. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, stage 4 pressure ulcer of sacral region, cellulitis of buttock and right upper limb, and dehydration.<br><br>Resident 3's medical record was reviewed.<br><br>On 8/12/25, a physician's order documented obtain wound culture on coccyx wound. one time only until 08/12/2025 23:59 -Start Date 08/12/2025 1230 [12:30 PM].<br><br>On 8/22/25, a physician's order documented obtain cbc [complete blood count], crp [c reactive protein], ESR [erythrocyte sedimentation rate] weekly while one [sic] abx [antibiotics]. every day shift every Fri [Friday] until 09/04/2025 23:59 -Start Date 08/22/2025 0600 [6:00 AM].<br><br>On 9/1/25, a physician's order documented Draw CMP [comprehensive metabolic panel] monthly for at risk of hyponatremia one time a day every 1 month(s) starting on the 1st for 3 day(s) Draw labs monthly -Start Date 09/01/2025 0600.<br><br>On 9/10/25, a physician's order documented obtain cbc, cmp, crp, ESR in 1 week due to coccyx wound infection one time only until 09/10/2025 23:59 -Start Date 09/10/2025 0645.<br><br>On 9/16/25, a physician's order documented obtain wound culture to coccyx wound one time only until 09/16/2025 23:59 -Start Date 09/16/2025 1300 [1:00 PM].<br>(continued on next page) |

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| F 0775<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 9/18/25, a physician's order documented repeat cbc, ESR, CRP in 1 week one time only until 09/18/2025 23:59 -Start Date 09/18/2025 0600.<br><br>The lab results were unable to be located in resident 3's medical record.<br><br>3. Resident 15 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included schizoaffective disorder, extrapyramidal and movement disorder, diabetes mellitus, pseudobulbar, generalized anxiety disorder, and dementia.<br><br>Resident 15's medical record was reviewed on 9/22/25 through 9/59/25.<br><br>Physician's orders revealed the following laboratory orders:<br><br>a. On 7/17/25, Magnesium level<br><br>b. On 7/23/25, Urine analysis<br><br>c. On 7/28/25, CBC<br><br>d. On 8/28/25, Ammonia level<br><br>e. On 9/11/25, BMP, Valproic acid, CMP<br><br>There were no laboratory results in resident 15's medical record.<br><br>On 9/24/25 at 12:09 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility had a lab portal where they could get the lab results. The DON stated she would print the lab orders out and match them with the lab to make sure they were drawn. The DON stated that she would print the individual lab orders to draw for the next lab day. The DON stated when the lab came to the facility they would look in the lab book for the orders for that day. The DON stated once the labs were in the portal she would print them and put them in the lab book. The DON stated once the Nurse Practitioner signed off on the labs she would put them in the basket to be uploaded to the resident medical record.<br><br>On 9/29/25 at 12:05 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that the labs she provided were on a website that she and the nurses have access to. The ADON stated staff printed the lab results from the website and then downloaded them to the residents medical record.<br><br>On 9/29/25 at 1:30 PM, an interview was conducted with the DON. The DON stated the laboratory results should be in the residents medical record. The DON stated she was unable to locate resident 15's laboratory results in the medical record. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation and interview, the facility did not serve food that was palatable. Specifically, for 4 out of 29 sampled residents, residents complained of the palatability of the food and a test tray was not palatable. Resident identifiers: 2, 5, 13, and 25.Findings included: On 9/22/25 at 11:36 AM, an interview was conducted with resident 25. Resident 25 stated that the food was bad. Resident 25 stated the quality of food was important. On 9/22/25 at 12:09 PM, an interview was conducted with resident 2. Resident 2 stated the kitchen staff needed to check temperatures of the food because the food was served cold.On 9/22/25 at 12:47 PM, an interview was conducted with resident 13. Resident 13 stated the food tasted good that day but she usually ate cereal because the food did not look or taste good. On 9/22/25 at 1:32 PM, an interview was conducted with resident 5. Resident 5 stated his food was usually blended and he did not know what he was served. On 9/24/25 at 12:37 PM, a test tray was obtained. (Note: All temperatures were in degrees Farenheit.)a. Meatloaf was 148.2, bland to the taste with a slimy texture and not palatable. b. Au gratin potatoes were 128.3, bland to the taste with a mushy texture. c. Mixed vegetables were 125.0, dull in color with a mushy texture. d. Corn bread was 103.2, and had an extra grainy texture. e. Dessert was 75.7, and was bland to the taste. On 9/29/25 at 11:21 AM, a phone interview was conducted with the Registered Dietitian (RD). The RD stated she did a test tray on 9/18/25, when she was at the facility. The RD stated she did not have concerns regarding the food quality. The RD stated that she had not asked residents about food quality. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were offered the Coronavirus disease 2019 (COVID-19) vaccines. Specifically, for 3 out of 5 sampled residents, no documentation was located to demonstrate how the residents accepted or refused the COVID-19 vaccination. Resident identifiers: 2, 6, and 31. Findings included:1. Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included quadriplegia, protein-calorie malnutrition, and anxiety disorder. Resident 6's medical record was reviewed on 9/29/25.There was no information that the COVID-19 vaccine was offered or refused for 2024.2. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus, protein-calorie malnutrition, morbid obesity due to excess calories, and schizoaffective disorder.Resident 2's medical record was reviewed on 9/29/25. There was no information that the COVID-19 vaccine was offered or refused for 2024.3. Resident 31 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder, dementia, and adult failure to thrive. Resident 31's medical record was reviewed on 9/29/25. There was no information that the COVID-19 vaccine was offered or refused for 2024.On 9/29/25 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was no documentation that the residents were offered or refused the COVID-19 vaccine. The DON stated if a resident refused a vaccine there should be a form completed regarding refusal. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident was free from abuse and neglect. Specifically, for 1 out of 29 sampled residents, a resident was left in a sling unattended by staff and the same resident experienced staff yelling at them. Resident identifiers: 15 and 18.Findings included: Resident 15 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, extrapyramidal and movement disorder, and dementia. 1. The facility reported to the State Survey Agency (SSA) on 8/7/25 at 8:00 PM, resident 15 was left in a Hoyer lift for approximately one hour after the Certified Nursing Assistant (CNA) became frustrated with resident 15. Resident 15's medical record was reviewed on 9/22/25 through 9/29/25. Resident 15's progress notes were reviewed and there were no progress notes regarding resident 15 being left in the lift. A care plan dated 11/8/23 and revised on 10/12/24, revealed resident 15 had an activity of daily living performance deficit related to cognitive impairment, impaired mobility, arthritis, schizophrenia, dementia, and anemia. One of the interventions included Transfers: Provide dependent assistance with two staff for Sit To Stand with transfers. According to the facility reported incident investigation, the incident was an improper transfer procedure. The description of the How Injury/Critical Incident Occurred revealed a CNA was preparing resident 15 for bed. The CNA got resident 15 in the hoyer lift and left her there for approximately an hour after getting frustrated with resident 15. The standard suspension process was started until the schedule was reviewed and the CNA had already put in her resignation and no additional shifts were completed. The five day investigation report provided to the SSA revealed resident 15 was in the sit-to-stand lift and a CNA heard resident 15 calling out for help. The CNA that left resident 15 in the lift unattended refused to talk to management about the incident and resigned immediately. The incident was not verified as abuse or neglect. The rationale was cut off on the final investigation.On 9/25/25 at 1:12 PM, an interview was conducted with CNA 4. CNA 4 stated when using a mechanical lift there needed to be two CNA's. CNA 4 stated a staff member should never leave a resident unattended in the mechanical lift but heard a CNA left a resident in a sit-to-stand lift. On 9/29/25 at 9:58 AM, an interview was conducted with resident 18. Resident 18 was resident 15's roommate at the time of the incident. Resident 18 stated the CNA left resident 15 alone in a lift because she got frustrated with resident 15. Resident 18 stated she noticed resident 15 was getting frustrated because the CNA was not using the lift correctly and it was hurting her. Resident 18 stated she noticed resident 15 was alone in the lift and she alerted other CNA's who came and attended to resident 15. On 9/29/25 at 10:03 AM, an interview was conducted with the CNA coordinator. The CNA coordinator stated there needed to be two staff when conducting a mechanical lift transfer. The CNA coordinator stated one CNA needed to be a spotter and the other to operate the lift. The CNA coordinator stated there was an incident with a CNA leaving a resident in a lift. The CNA coordinator stated resident 15 was placed in a hoyer lift above the bed. The CNA coordinator stated immediate education was provided to all staff since the incident. On 9/29/25 at 10:25 AM, a phone interview was conducted with Nursing Assistant (NA) 1. NA 1 stated she was in the dining room and another CNA stated the resident was upset with her. NA 1 stated resident 15 was left in the sit-to-stand lift. NA 1 stated there always needed to have two CNA's to transfer. NA 1 stated education was not provided after the incident. NA 1 stated resident 15 seemed stressed afterwards. The CNA coordinator provided education to the CNA's dated 5/21/24, which revealed Hoyer lifts must be operated by two or more trained staff members to minimize the risk of injury to both residents/patients and medical personnel. Additionally, if a Hoyer lift or sit to stand device were not being used immediately after a transfer, it should be returned to the designated storage area to ensure safety and accessibility for future use. On 9/29/25 at 1:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated all residents should have two<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | staff members during transfers with mechanical lifts. The DON stated there was an incident reported to the SSA. The DON stated the CNA was educated on using the sit-to-stand with two staff members but failed to comply. The DON stated resident 15 was left alone in a lift for about an hour. The DON stated she was not part of the investigation so she did not know where the resident was left. The DON stated she would have substantiated the allegation as neglect. On 9/29/25 at 2:05 PM, an interview was conducted with the Administrator. The Administrator stated he was not sure why the allegation of resident 15 being left in the lift alone was not substantiated. The Administrator stated the previous Administrator did the investigation and he guessed it was because there were no signs and symptoms of psychological stress.2. The facility reported to the SSA on 9/2/25 at 11:22 AM, that on 8/30/25 at 6:50 PM, resident 15 requested toileting assistance and a CNA raised her voice at the resident, stated she was only required to provide toileting assistance every two hours and told resident 15 she was not a child. Another CNA witnessed the event. There was no documentation in resident 15's medical record. The facility investigation was reported to the SSA and concluded it was not verified. The previous Administrator completed the investigation. The reasoning why the allegation was not verified was cut off in the documentation provided.On 9/25/25 at 1:12 PM, an interview was conducted with CNA 4. CNA 4 stated she heard there was a verbal altercation between a staff member and resident but did not know any details because she was not working that day. On 9/29/25 at 1:49 PM, an interview was conducted with the DON. The DON stated she was not sure she was there for the abuse investigation into the verbal altercations. The DON stated the previous Administrator asked her to remove the CNA from the schedule and did not know the details. On 9/29/25 at 2:05 PM, an interview was conducted with the Administrator. The Administrator stated he was not sure why the allegation of verbal abuse to resident 15 was not substantiated. The Administrator stated the previous Administrator did the investigation and he guessed it was because there were no signs and symptoms of psychological stress.The facility Identifying Types of Abuse policy and procedure revised September 2025 was reviewed and revealed the following:Abuse of any kind against residents was strictly prohibited. Abuse prevention included recognizing and understanding the definitions and types of abuse. Abuse was defined as punishment with resulting physical harm, pain or mental anguish. Abuse also included the deprivation by an individual, including caretaker, of goods or services that were necessary to attain or maintain physical, mental, and psychosocial well-being. c. Abuse includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.5. Abuse toward a resident can occur from staff-to resident.Neglect/Deprivation of Goods and Services by staffNeglect was the failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress.Mental and Verbal AbuseVerbal abuse may be considered to be a type of mental abuse. Verbal abuse included the use of verbal or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Examples of mental and verbal abuse included harassing a resident; mocking, insulting, ridiculing and; yelling or hovering over a resident with the intent to intimidate. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure all alleged violations involving abuse or neglect were reported immediately, but not later than 24 hours if the events that caused the allegations did not involve abuse. Specifically, for 1 out of 29 sampled residents, the facility did not report within the timeframe when a resident was left in a sling unattended by staff and experienced staff yelling at them. Resident identifier: 15. Findings included:Resident 15 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, extrapyramidal and movement disorder, and dementia. 1. The facility reported to the State Survey Agency (SSA) on 9/22/25 at 12:07 PM, that on 8/7/25 at 8:00 PM, resident 15 was left in a Hoyer lift for approximately one hour after the Certified Nursing Assistant (CNA) became frustrated with resident 15. 2. The facility reported to the SSA on 9/2/25 at 11:22 AM, that on 8/30/25 at 6:50 PM, resident 15 requested toileting assistance and a CNA raised her voice at the resident, stated she was only required to provide toileting assistance every two hours and told resident 15 she was not a child. Another CNA witnessed the event. On 9/29/25 at 1:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was an incident reported to the SSA regarding a CNA leaving resident 15 in a sit-to-stand lift unattended. The DON stated she was notified of the incident on 8/8/25, the morning after the incident. The DON stated she reported to the Administrator who was the abuse coordinator. The DON stated she did not know why it was not reported until 8/9/25. The DON stated she was not aware of why the allegation of verbal abuse was not reported to the SSA within 24 hours. On 9/29/25 at 2:05 PM, an interview was conducted with the Administrator. The Administrator stated there was documentation that the previous Administrator reported the incident with resident 15 being left in the sit-to-stand lift on 8/9/25 at 1:48 AM. The Administrator stated he reported the incident to the State again on 9/22/25, because the SSA did not have record of it being reported prior to 9/22/25. The Administrator stated the incident should have been reported within 24 hours. The Administrator stated the verbal altercation should have been reported within 24 hours. |

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|---|---|---|---|
| | 465158 | A. Building<br>B. Wing | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Meadow Brook Rehabilitation and Nursing | 433 East 2700 South<br>Salt Lake City, UT 84115 |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide the State Long-Term-Care Ombudsman notification when a resident was discharged from the facility. Specifically, for 1 out of 29 sampled residents, a resident left Against Medical Advice (AMA) and the ombudsman was not notified. Resident identifier: 35. Findings included:Resident 35 was admitted to the facility on [DATE] and discharged on 8/2/25 with diagnoses which included poly neuropathy, systolic heart failure, atrial fibrillation, and chronic kidney disease. Resident 35's medical record was reviewed on 9/22/25 through 9/29/25. A nursing progress note dated 8/1/25 at 2:22 PM, revealed, Resident stated that she is leaving AMA today. She stated that she is going to be going to the women's homeless shelter for a week or so in order to have their SSW [Social Service Worker] assist her in getting into low income housing. Resident was educated that [name of facility] could also help her with this, however she was determined to have the women's shelter help her. MD [Medical Doctor] was notified regarding residentv [sic] decision. She will be send [sic] with her scheduled medications and 14 day supply of her PRN [as needed] medications. Resident was also educated on the need to have another primary care provider in order to ensure that she can continue to receive her medications. Resident verbalized understanding. She stated she ?really needs to do this to get into an apartment'. DON [Director of Nursing] advised against it.A nursing progress note dated 8/2/25 at 8:30 PM, revealed Resident's family here with former resident to pick up resident belongings.The resident signed an AMA form on 8/1/25. On 9/24/25 at 1:17 PM, an interview was conducted with the Resident Advocate (RA). The RA stated she emailed the ombudsman when residents were discharged from the facility. The RA stated she was unable to find the email that the ombudsman was notified of the AMA discharge. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents maintained acceptable parameters of nutritional status unless the resident's clinical condition demonstrated that this was not possible. Specifically, for 1 out of 29 sampled residents, a resident who had experienced a significant weight loss did not have recommendations from the Registered Dietitian (RD) implemented and the recommendations were not implemented in a timely manner. Resident identifier: 1.Findings included:Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, unspecified calorie protein malnutrition, adult failure to thrive, dysphagia, and anemia.On 9/22/25 at 12:22 PM, an observation was conducted. Resident 1 was observed in the dining room for lunch. Resident 1 was observed dropping his drinks on the floor and on his lap. There were no covers on the drinks. Resident 1 was also left with his feet up in his Geri chair for five minutes, before the Resident Advocate came to set resident 1 up for lunch.Resident 1's medical record was reviewed.On 7/10/25, resident 1 weighed 137.6 pounds (lbs). On 8/13/25, resident 1 weighed 128.2 lbs. Resident 1 had a 6.83% weight loss in approximately one month.On 9/22/25 at 11:24 AM, a Nutrition/Dietary Note documented Weight indicates significant weight loss. Loss is not clinically desired considering BMI [Body Mass Index] of 22.7. Loss is RT [related to] decreased PO [by mouth] intake. Diet texture was recently downgraded to puree. Hx [history] fortified diet. Medpass 60 ml [milliliters] BID [two times daily] is in place. He often accepts 240 ml BID. Magic Cup BID is also in place and he accepts this supplement. REC [recommendations]:1. document weight now 2. Change Medpass order to 180 ml QID [four times daily] 3. Evaluate efficacy of adding PO stimulant.It should be noted that the recommendation was added approximately a month after resident 1's significant weight loss.On 9/29/25 at 11:14 AM, an interview was conducted with the RD. The RD stated that she was in the facility once or twice a month. The RD stated the last weight on resident 1 was 8/13/25, because resident 1 refused weights. The RD stated if she made a recommendation to get a mid arm circumference (MAC) on a resident she would hope to see it if the resident agreed. The RD stated if a weight was obtained on 8/13/25, but entered later by staff, when the weight report was run she would not see that the resident had weight loss. The RD stated that either the weight for resident 1 was entered after she ran the report or she missed it.On 9/29/25 at 12:03 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the RD did not come to the facility often and when the RD did put in dietary recommendations she did not usually agree with the recommendations and had to discuss them with the Medical Director. The DON stated that resident 1 did not have an interest in eating. The DON stated the skin and weight meetings were held weekly and the Interdisciplinary Team attended those meetings. The DON stated that the RD did not attend the skin and weight meetings. The DON stated that resident 1 had been declining and was not doing well. The DON stated the staff had tried increasing resident 1's snacks and added a fortified diet. The DON stated that resident 1 refused to let the staff get a MAC.On 9/29/25 at 12:16 PM, a follow up interview was conducted with the RD. The RD stated resident 1's significant weight loss on 8/13/25, was missed.The facility policy Weight Assessment and Intervention was reviewed. Policy StatementResident weights are monitored for undesirable or unintended weight loss or gain.Policy Interpretation and ImplementationWeight Assessment1. Residents are weighed upon admission and at intervals established by the interdisciplinary team.2. Weights are recorded in each unit's weight record chart and in the individual's medical record.3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation.a. If the weight is verified, nursing will notify the dietitian.4. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time.5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | weight - actual weight)/(usual weight) x 100]:a. 1 month - 5% weight loss is significant; greater than 5% is severe.b. 3 months -7.5% weight loss is significant; greater than 7.5% is severe.c. 6 months - 10% weight loss is significant; greater than 10% is severe.6. If the weight change is desirable, this is documented.Evaluation1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for ?significant' weight change has been met. The evaluation includes:a. the resident's target weight range (including rationale if different from ideal body weight);b. the resident's calorie, protein, and other nutrient needs compared with the resident's current intake;c. the relationship between current medical condition or clinical situation and recent fluctuations in weight; andd. whether and to what extent weight stabilization or improvement can be anticipated. |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not obtain laboratory (lab) services to meet the needs of the residents. Specifically, for 1 out of 29 sampled residents, a resident that had a physician's order to collect a glycated hemoglobin (A1c) did not have the A1c completed. Resident identifier: 17.Findings included:Resident 17 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus with hyperglycemia, diabetic chronic kidney disease, and diabetic polyneuropathy.Resident 17's medical record was reviewed.On 8/13/25, a physician's order documented obtain A1c. one time only until 08/13/2025.The A1c lab was unable to be located.On 9/24/25 at 12:09 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility had a lab portal where they could get the lab results. The DON stated she would print the lab orders out and match them with the lab to make sure they were drawn. The DON stated that she had called the lab and they stated to her that they drew the A1c for resident 17 but they did not run the lab. The DON stated that she would print the individual lab orders to draw for the next lab day. The DON stated when the lab came to the facility they would look in the lab book for the orders for that day. The DON stated once the labs were in the portal she would print them and put them in the lab book. The DON stated once the Nurse Practitioner signed off on the labs she would put them in the basket to be uploaded to the resident medical record. |

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| F 0773<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide or obtain laboratory (lab) services only when ordered by a physician. Specifically, for 1 out of 29 sampled residents, a resident did not have a physician's order for an ammonia level, Complete Blood Count (CBC), and magnesium. Resident identifier: 15. Findings included: Resident 15 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included schizoaffective disorder, extrapyramidal and movement disorder, diabetes mellitus, pseudobulbar, generalized anxiety disorder, and dementia. Resident 15's medical record was reviewed on 9/22/25 through 9/59/25. An ammonia level was drawn on 7/7/25, a CBC was drawn on 7/9/25, and a Magnesium and CBC were drawn on 9/15/25. There were no physician's orders for the labs drawn. On 9/29/25 at 1:00 PM, an interview was conducted with the Director or Nursing (DON). The DON stated that all laboratory draws need to be ordered by the physician. The DON stated she did not know why there were no physician's orders for resident 15's laboratory values. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure each resident received food prepared in a form designed to meet individual needs. Specifically, for 1 out of 29 sampled residents, a resident with a physician order for thickened liquids was not provided the appropriate thickened liquids. Resident identifier: 15. Findings included: Resident 15 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included schizoaffective disorder, extrapyramidal and movement disorder, pneumonia, dementia, and moderate oropharyngeal dysphagia. On 9/22/25 at 12:35 PM, an observation was made of resident 15 during the lunch meal. Resident 15 was observed to be fed by Certified Nursing Assistant (CNA) 2. CNA 2 was feeding resident 15 a pink frozen substance and resident 15 was coughing after each bite. Resident 15 was observed to have thickened milk and juice which were observed to have a nectar consistency and resident 15 was coughing after drinking the liquids. CNA 2 was interviewed and stated the pink frozen substance was a magic cup and was a thickened nutritional ice cream. CNA 2 stated resident 15's magic cup was thicker than her drinks. At 12:39 PM, resident 15 was coughing after a bite of the magic cup. CNA 2 stated it sounded bad girl and do your lungs hurt. Resident 15 stated yes. On 9/24/25 at 12:32 PM, an observation was made of resident 15 during the lunch meal. Resident 15 was observed coughing while she was drinking and eating. Resident 15 was observed to have a white thickened beverage and a red thin beverage. CNA 2 stated resident 15 had thickened milk and cranberry juice. CNA 2 stated the nurses, CNA's, and dietary staff were able to thicken beverages. CNA 2 stated they followed a chart on the back of the thickener to thicken beverages. CNA 2 stated resident 15 needed her liquids mildly thickened. CNA 2 picked up the cranberry juice which was in a mug and swirled it around. CNA 2 stated the cranberry juice was not thickened. On 9/24/25 at 12:35 PM, an interview was conducted with Dietary Aide (DA) 1. DA 1 stated he thickened beverages for residents who required thickened liquids. DA 1 stated he put three scoops of thickening powder into resident 15's cranberry juice. DA 1 stated it was full which was 550 milliliters or 18 ounces (oz) of cranberry juice. Resident 15's medical record was reviewed on 9/22/25 through 9/29/25. A diet order dated 7/22/25, revealed Fortified diet, Mechanical Soft texture, Honey consistency.An annual Minimum Data Set assessment dated [DATE], revealed that resident 15 did not have a swallow disorder. Resident 15 had a mechanically altered diet which included mechanically altered liquids. A care plan dated 11/16/23 and revised on 9/15/25, revealed resident 15 was at risk for malnutrition related to diabetes, dysphagia, poor cognition, impaired communication, psychotropic medications, diuretic use. Resident 15 was on a therapeutic diet with altered consistency and thickened liquids. Resident 15 was often adamant about refusing her diet. The goal was resident 15 would maintain adequate nutritional and hydrational status through the review date. Interventions included to Monitor/document/report as needed any signs and symptoms of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Other interventions included to provide and serve diet as ordered, supplements per order, diet texture per order, and encourage her to follow her diet/fluid orders, and educate her on the importance of following her orders. A Dysphagia Evaluation was conducted on 5/28/25, which revealed oral diet orders for pureed and moist, soft, easily formed bolus foods with honey thick liquids. On additional swallow following each/bite/sip for increased swallowing safety. Crush medications and place in yogurt/applesauce with no mixed consistencies. Ice chips or water per Speech Language Pathology (SLP). A physician's progress note dated 8/26/25, documented . Review of her recent course indicates that she previously demonstrated frustration and agitation regarding diet restrictions, specifically repeated requests for popcorn. These episodes were associated with yelling at staff when offered thickened liquids, and were documented earlier this month. Since that time, supportive redirection and substitution with<br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | safer snacks such as Pirate Booty have helped reduce fixation and agitation around food. Staff report that these behaviors have improved overall, and she has been more redirectable.On 9/25/25 at 8:08 AM, an observation and interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated resident 15 had aspiration pneumonia and was on antibiotics. LPN 1 stated resident 15 was ordered honey thickened liquids about one to two months ago. LPN 1 was observed to ask the CNA Coordinator to get her thickened juice from the kitchen for resident 15's medication administration. LPN 1 was observed to have whole pills for resident 15. It should be noted that the Dysphagia Evaluation on 5/28/25, recommended resident 15 have her medications crushed in yogurt or applesauce. An interview was immediately conducted with the CNA Coordinator who stated the kitchen staff thickened the liquids according to the resident care plan. The CNA Coordinator stated there was a label on the thickener that was a guide to thicken the liquids. Resident 15 was observed to tell LPN 1 that she did not like the thickened and that she did not want the thickened. Resident 15 was observed to throw the cup with thickened liquids. A follow up interview was immediately conducted with the CNA Coordinator who stated if a resident did not want thickened liquids then the resident was provided education on the risk and benefits and staff continued to provide the liquids as ordered. The CNA Coordinator stated resident 15 freaked out when she was served food and beverages she did not like. On 9/25/25 at 8:28 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 15 had cognitive impairment and mental illness with behaviors. The DON stated staff encouraged thickened liquids with resident 15 but she was non compliant at times. The DON stated the kitchen staff thickened the liquids. The DON stated resident 15 had a Barium Swallow Study completed and was provided SLP services. On 9/25/25 at 8:28 AM, an interview was conducted with the Dietary Manager (DM). The DM stated resident 15 was the only resident with thickened liquids. The DM stated resident 15 required honey thick liquids which were thickened by the kitchen staff. The DM stated if residents were not provided the correct thickened liquids, the liquids could go into their lungs and they could choke. On 9/25/25 at 8:30 AM, an interview was conducted with CNA 3. CNA 3 stated nurses and dietary staff thickened liquids. CNA 3 stated resident 15 required honey thickened liquids. CNA 3 stated if a resident was not served thickened liquids, then she would remove the liquids. CNA 3 stated resident 15 hated thickened liquids so she provided education to resident 15 about how it was safe for her and she understood the education. On 9/25/25 at 8:34 AM, an interview was conducted with the Assistant Dietary Manager. The Assistant Dietary Manager stated she was learning how to thicken and looked at the manufacturer instructions on the container. The Assistant Dietary Manager stated resident 15 required thickened liquids and she thickened to the moderate/mild thick. The Assistant Dietary Manager stated the CNAs asked the residents what drinks they want, then the kitchen staff thickened the beverage. The Assistant Dietary Manager stated sometimes juice did not thicken like it should and needed to be modified and she used her best judgement when thickening beverages. On 9/25/25 at 12:50 PM, an observation was made of the thickener and the scoop. For a International Dysphagia Diet Standard Initiative level 3 Moderately thick honey-like for 3 cups (24 oz) of water, coffee, and clear juices 2 1/2 cups should be used. The scoop had 1 tablespoon and the other side was 3/4 teaspoon.It should be noted resident 15's cranberry juice was 18 oz or 2 1/4 cup with 3 tablespoons of thickener.On 9/25/25 at 1:33 PM, a follow-up interview was conducted with the DON and the Regional Nurse Consultant (RNC). The DON stated resident 15 needed to have honey thick. The DON stated resident 15 was sent to the hospital and diagnosed with aspiration pneumonia. The DON stated staff tried to have resident 15 sit up when eating. The DON and RNC stated they did the training yesterday regarding thickening liquids. The RNC stated there was a standard order for residents to have their medications crushed if they needed it and there was not a specific order for resident 15 to have her medications crushed. |