STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465174	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfield Village Rehabilitation	1203 North Fairfield Road Layton, UT 84041

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure the residents were free from misappropriation of resident property. Specifically, for 2 of 42 sampled residents, a staff member diverted narcotic medications. Resident identifiers: 68 and 73.Findings included:1. Resident 68 was admitted to the facility on [DATE] with diagnosis that included fracture of upper end of right humerus, subsequent encounter for fracture with routine healing, pneumonia, and dementia. Resident 68 was discharged from the facility on 1/14/26. On 1/11/26, a physician order was started for Pregabalin Oral Capsule 100 milligram (MG) Give 1 capsule by mouth three times a day for nerve pain.On 1/11/26, a physician order was started for oxycODONE HCl (hydrochloride) Oral Tablet 15 MG (Oxycodone HCl) Give 1 mg by mouth every 4 hours as needed forpain 90mg Max [maximum] daily amount.On 1/13/26, a physician order was started for oxyCODONE HCl Oral Tablet 15 MG (Oxycodone HCl) Give 1 mg by mouth every 4 hours as needed for moderate to severe pain 90mg Max daily amount. 2. Resident 73 was admitted to the facility on [DATE] with diagnosis that included multiple fractures of ribs left side, fracture of unspecified part of left clavicle, subsequent encounter for fracture with routine healing, personal history of traumatic brain injury, and cognitive communication deficit. Resident 73 was discharged from the facility on 1/30/26. On 1/10/26, a physician order was started for oxyCODONE-Acetaminophen Oral Tablet 5-325 MG (Oxycodone w/ [with] Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. On 01/15/2026 at 4:12 pm, the State Survey Agency (SSA) received a Facility Reported Incident (FRI) from that facility stating that A RN [registered nurse] from our facility was pulled over on her way home from her night shift on 1/15/26 for erratic driving. During the traffic stop the officer found medications in her possession that were from our facility in the name of the resident named above. The officer called our facility at 8:00 am and we indicated that there was not a reason for her have [sic] the medications in her posession [sic]. The nurse was arrested and booked into the [redated] Jail. The medication were [sic] returned to our facility. Over the phone and in person our nurse and the officer verified the number of medications on the narcotic count sheet and what was in the bubble packs matched and there were no missing medications. The FRI went on to identify the residents whose medications were removed from the facility as resident 68, who had transferred to the emergency room (ER) earlier on 1/14/26, and resident 73, whose medications were discontinued on 1/14/26. The FRI documented that neither resident missed any doses of their medications. The FRI stated that A [sic] audit of all narcotics that should be present in the facility on the hall that this nurse worked was completed and all medications are accounted for. We will continue with audits to make sure that no other issues come to our attention. A statement dated 1/15/25 (sic) from the Director of Nursing (DON) documented that she had been notified that RN 1 had been taken into custody with medications from the facility. The medications included resident 68's Pregabalin and Oxycodone and resident 73's Oxycodone. The DON's statement revealed that Resident 68 had been transported to the ER on [DATE] due to a change of condition and was admitted to the hospital, while resident 73's Oxycodone had been discontinued on 1/14/26 by the physician per family request due to the sedative effects. The DON's statement documented that she drove to the Highway Patrol Office to receive the (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications at 10:00 AM. The DON stated that she verified the count sheets and medications were intact and untampered upon receipt. The DON's statement documented that she subsequently drove back to the facility to meet with Administrator [ADM] 1 and RN 2, where the DON and RN 2 again verified contents of the medication bubble packs and narcotic count sheet, confirming that no tampering had occurred. A statement dated 1/15/26 from ADM 2 documented that when the DON picked up the medications from the Highway Patrol Office she was provided with an Evidence Property Receipt Form, which indicated RN 1 was being cited for Driving Under the Influence (DUI). Additionally, the ADM 2 statement documented that We began the investigation to make sure that there were no other narcotics missing and verified no others were missing. No issues found. [RN 2] is now completing a full audit of all Narcs [narcotics] on current residents on Cedar. [RN 2] also confirmed that [RN 1] had not signed out any narcotics on the other two halls for our current residents. [RN 1] is now on administrative leave pending the results of the investigation.An audit completed by RN 2 and titled Process of Controlled Drug Audit completed 1/15/26 on [RN 1] was reviewed. The audit documented which Residents Narcotic Drug Count Sheets were reconciled against Residents Electronic Medication Administration Record (EMAR). The audit contained the statement from RN 2 The documentation does not appear to me that [RN 1] signed out, or administered Controlled Drugs in excess.On 1/16/26 at 3:19 PM, an email from RN 1 to the ADM 2 contained the following statement: On January 14th, I was working the night shift on cedar. When we have discontinued narcotics on that hall, I typically add them to the Birch narcotic drawer and notify management so they can all be collected. On this night, I put them with my belongings and drove home with them unintentionally. I was pulled over and the narcotics were found. I did not take any of the medication and all of the counts were accounted for. They were returned to the facility.On 1/16/26, the facility provided follow up information about the incident to the SSA, stating that they had put a new procedure for controlled substance logs and counts into place. Audits were completed that confirmed no other residents were affected and staff appropriately administered and documented all medications. Interviews were completed with all residents, who confirmed they received their medications as prescribed or when requested and experienced pain relief. On 5/28/26 at 12:59 PM, an interview was conducted with the DON, who stated that ADM 2 led the investigation and coordinated with staff. The DON stated that RN 2 compared the electronic medical records to the medication cart and found no other inaccuracies. The DON stated that they did not discover any concerns when all the residents were interviewed. The DON stated that RN 1 did not return to work at the facility after the incident. The DON stated that prior to the incident, two nurses reconciled the narcotic log sheet and manually counted individual narcotic contents (such as the number of tablets in a blister card or transdermal patches) during the narcotic count, but they did not manually count the total units of narcotics available in the cart. The DON stated that a missing narcotic medication could easily be overlooked if both the drug and its corresponding narcotic log sheet was removed from the medication cart. The DON stated that prior to the incident discontinued medications were kept in the medication cart until she conducted a narcotic count with a nurse and collected drugs to be destroyed. The DON stated that nurses failed to notice the missing narcotic medications for Residents 68 and 73 during the shift change narcotic count because the corresponding narcotic log sheets were absent as well. The DON stated that after the incident the narcotic count procedure was updated to include a total unit count of narcotic medications in the meditation cart (such as the total number of blister cards and boxes containing transdermal patches). The DON stated that following the incident when a resident was discharged from the facility with a narcotic medication with them, the nurse and the resident signed a form documenting a tablet count the resident received. The DON stated that the form was uploaded into the electronic medical record for reference and the unit count was updated in the narcotic log. Additionally, the DON stated that following the incident if staff removed a narcotic from the medication cart for destruction (for instance, a discontinued medication or one not taken by a discharging resident), two nurses counted the drug, locked it away in the medication storage room, (continued on next page)

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