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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility did not have menus that were prepared in advance and were followed. Specifically, the menu had 4 ounces of Asian noodles and two small egg rolls for lunch and residents were served unmeasured Asian noodles and one small egg roll. Findings included:Review of the facility lunch menu for a regular diet on 5/27/26 documented the meal options and serving size of each food item were Egg Drop Soup (6 ounces), General Tso's Chicken (3 ounces), Asian Noodles (4 ounces), Oriental Blend Vegetables (4 ounces), and Mini Egg Rolls (2 each).On 5/27/26 at 11:53 AM, an observation was made of the lunch meal service. An observation was made of the Chef during plating of the lunch meal. The Chef was observed to serve the Asian Noodles with tongs and the amount was not measured and varied from plate to plate. The Chef was observed to place one egg roll onto each regular diet plate. On 5/27/26 at 11:55 AM, an interview was conducted with Chef 1. Chef 1 stated that she was serving 3 ounces of fries and noodles with the serving tongs. Chef 1 stated that she had been doing this for a long time and could guess the serving size without measuring it. Chef 1 stated that the ladle used to serve the chicken was 4 ounces. On 5/27/26 at 1:27 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that staff should be measuring the food servings with scoops and not using tongs. The DM stated that the menus should be followed exactly as they are written.On 5/27/26 at 1:57 PM, an interview was conducted with the Registered Dietitian (RD). The RD stated that she would expect the kitchen staff to follow the menu's serving size. The RD stated that any changes to the menu would have to be approved by the dietitian.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, food items in the refrigerator and freezer were undated, and sanitation buckets did not meet the required sanitation testing levels.Findings included:1. On 5/26/26 at 8:12 AM, an initial tour of the kitchen was conducted. The following observations were made:a. A male kitchen staff member was observed to be serving food onthe tray line and was not wearing a hair net.b. Celery chunks were not dated in the refrigerator.c. A bag of mozzarella cheese was opened and undated in the refrigerator.d. A bag of cheese slices was opened and undated in the refrigerator.e. Sliced roast beef in a metal container was undated in the refrigerator.f. A bag of garlic bread was opened and undated in the freezer.g. A bag of frozen carrots was opened and undated in the freezer.h. A bag of frozen meat patties was open to air and undated in the freezeri. A bag of meatballs was opened and undated in the freezer.j. A box of tiramisu was open to air and undated in the freezer.2. On 5/27/26 at 7:42 AM an observation of the servery sanitation bucket was made. Chef 2 was observed to be wiping down the counter tops with a rag that was in the sani bucket. Chef 2 was observed to place a sanitation strip into the solution. The strip was observed to not change color. Chef 2 stated that the strip should turn green to be at 400 PPM (parts per million). Chef 2 was observed to continue using the sanitizer bucket. 3. On 5/27/26 at 11:30 AM, lunch tray line service was observed. The following observations were made:a. Chef 1 was observed to fill her sanitation bucket and not check the sanitation levels. Chef 1 was observed to clean the shelves with the sani bucket water.b. Chef 1 was observed to not remove gloves that she had used to clean shelves with and began plating cake onto small Styrofoam plates.c. Chef 1 was observed to change gloves without performing hand hygiene or washing her hands. d. Chef 1 was observed to touch multiple surfaces with gloved hands and to touch food that was being served to residents. 4. On 5/27/26 at 1:19 PM, a follow-up tour was conducted of the kitchen. The following observations were made:a. Multiple chicken breasts were in a bin full of liquid and was undated in the refrigerator.b. Carrots were in a bowl full of water and were undated in the refrigerator.c. Sliced pepperoni was open and undated in the freezer.d. A bag of beef patties was open to air and undated in the freezer.On 5/26/26 at 8:25 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that all kitchen staff should be wearing a hairnet. The DM stated that any foods that have been opened should have an opened date on them.On 5/27/26 at 11:35 AM, an interview was conducted with Chef 1. Chef 1 stated that she had forgotten to test the sanitizer solution before she used it. On 5/27/26 at 1:27 PM, a follow-up interview was conducted with the DM. The DM stated that sanitizer buckets were changed at least every 4 hours. The DM stated that he was informed that he did not need to record the sanitation levels. The DM stated that he expected staff to check the sanitation levels before they were used to sanitize surfaces. The DM stated that hands should be washed any time it is needed. The DM stated that he expected staff to wash their hands any time they took their gloves off and staff should not be touching food that was served to residents.On 5/27/26 at 1:57 PM, an interview was conducted with the Registered Dietitian (RD). The RD stated that freezer and refrigerator items should be labeled with opened dates and use by dates. The RD stated that all kitchen staff should be wearing hairnets and beard covers. The RD stated that sanitation buckets should be changed at least twice a day and testing should be done prior to using it to ensure that it is at the appropriate sanitation level.

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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 it was determined that the facility did not ensure that all alleged violations involving abuse, neglect, and misappropriation of resident property were reported immediately, but no later than 2 hours after the allegation was made, if the events involved abuse or resulted in serious bodily injury, to the State Survey Agency (SSA) and Adult Protective Services (APS); and the results of the investigation were reported to the SSA within 5 working days of the incident. Specifically, for 3 of 42 sampled residents, the facility did not report to the SSA alleged violations involving abuse or neglect no later than 2 hours after the allegation was made or submit the results of the investigation to the SSA within 5 working days; and the facility did not report alleged violations to APS. Resident identifiers: 48, 66, and 67. Findings included:1. Resident 48 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy, sepsis, adult failure to thrive, cataracts, vertigo, hypertension, and supraventricular tachycardia.The facility reported on 3/25/26 at 7:20 PM that on 3/25/26 at approximately 7:20 AM the resident was found on the floor in her bathroom.On 3/25/26 at 12:53 PM, resident 48's nursing progress note documented, At approximately 0720 [7:20 AM], patient was heard yelling out by nurse. Nurse went into room and patient was found laying faceup with her back making contact with the floor. Patient head was in the shower area and her lower body was just outside of shower. Patient right leg was positioned different with her right foot laying rightward out. Patient was not able to bed her right leg and had pain when nurse tried to bend her leg. The facility abuse investigation was reviewed. No documentation could be found that APS was notified of the incident and the SSA was not notified of the results of the investigation. 2. Resident 67 was admitted to the facility on [DATE] with diagnoses which included syncope, congestive heart failure, atrial fibrillation, metabolic encephalopathy, sepsis, and ventricular tachycardia. On 5/5/26 at 4:33 PM the facility reported that on 5/5/26 at 2:30 AM the resident was found on the floor in the bathroom. The resident reported hitting their back and a bruise was observed. The resident was transferred to the hospital for evaluation on 5/5/26 at 6:30 AM. It should be noted that 14 hours lapsed between the time the incident occurred and the time that the SSA was notified of the incident. The facility abuse investigation was reviewed. No documentation could be found that APS was notified of the incident and the SSA was not notified of the results of the investigation. On 5/27/26 at 11:40 AM, an interview was conducted with Administrator (ADM) 1. ADM 1 stated that she did not have verification that APS was notified or the SSA was notified of the investigation results within 5 days of the incident. ADM 1 stated that when investigating allegations she would attempt to determine the precipitating events that may have caused the accident/injury and what the outcome from the fall was. ADM 1 stated she would look to see if she could find any other investigation documentation. ADM 1 stated that she was aware of the regulatory timeframes for initial reporting of the incident to the SSA and the 5 day reporting of results to the SSA. 3. Resident 66 was admitted to the facility on [DATE] with diagnoses which included periprosthetic fracture of left hip joint, difficulty in walking, and muscle wasting and atrophy.On 7/23/25 at 3:12 PM, the facility reported that on 7/22/25 at 10:30 AM, resident 66 was found on the floor after sustaining a fall. Resident 66's spouse had just left the room when a crash was heard by her and the staff. Resident 66 was transferred to the emergency room for sutures to a bleeding laceration. Resident 66's medical records were reviewed.On 7/22/25 at 7:29 PM, resident 66's Nurses Note documented, At approximately 1630 [4:30 PM], nurse was getting meds ready for patient. Nurse and two CNA's [Certified Nurse Assistants] heard loud crash from nurse station. Wife was walking down the hall and said That's [name omitted]. Nurse and CNA's went running into room. Pt [patient] was found in room laying on floor on his left side. Patient was bleeding from his head. Patient had large laceration above left eye and on nose. Patient also had skin tear to back of head. Wife was in room and was assissting [sic] (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with holding back of head with a washcloth to help stop bleeding. VS 132/88, pulst [sic] 130 and oxygen sats 97% room air. 911 was called to send pt to [name of hospital omitted] ER for eval [evaluation] and tx [treatment]. MD [Medical Doctor], family, and nurse management notified.On 7/23/25 at 4:59 AM, resident 66's Nurses Note documented, Patient Returned 1945 [7:45 PM]. Management Notified. Wound Care Orders: Keep Wounds Moistened with ABX [antibiotic] Ointment. Remove Staples 10 Days, Sutures 5 Days. Neuro [Neurological] Checks Continued. No Problems.On 05/27/26 at 1:51 PM, the Administrator located one document for resident 66 regarding his fall. There was no name to identify that this document was the investigation for resident 66's fall. On 5/27/26 at 3:11 PM, an interview was conducted with ADM 1. ADM 1 stated that she was unable to locate an investigation into resident 66's incident/fall on 7/22/25. No documentation could be found that APS was notified of the incident and the SSA was not notified of the results of the investigation. Additionally, it should be noted that the facility's initial reporting of the incident to the SSA was approximately 28.5 hrs after the incident occurred.On 5/28/26 at 10:11 AM, a follow-up interview was conducted with ADM 1. ADM 1 stated that incidents were reported to her and she determined whether or not there was immediate harm. ADM 1 stated that initial reporting to the SSA was within 2 hours or 24 hours if there was no immediate harm to the resident and was completed on the SSA online portal. ADM 1 stated that APS was notified through their website where she filled out a report. ADM 1 stated that the investigation included interviewing whomever reported the incident to her, staff, residents, and anyone with information or a witness statement. ADM 1 stated that she would type a statement or have the staff write a statement. ADM 1 stated that after her investigation was completed she would type a summary of the investigation and submit it to the SSA within 5 days of the initial incident.

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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. Based on observation, interview, and record review it was determined that the facility did not store all drugs and biologicals in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys. Specifically, for 11 of 42 sampled residents, medications were stored at temperatures below the manufacturer's instructions. Furthermore, the facility's Purified Protein Derivative (PPD), the testing solution used in the Tuberculosis (TB) screening process for new admits, was stored at temperatures below the manufacturer's instructions. Resident identifiers: 9, 10, 19, 30, 37, 59, 76, 77, 78, 79, and 80.Findings Included: On 5/27/26 at 10:10 AM, an observation was made of the facility's medication storage refrigerator with Registered Nurse (RN) 3, who confirmed the thermometer in the refrigerator read 32.5 degrees Fahrenheit. RN 3 confirmed that the facility's TB testing solution and residents' overstocked medications were stored in the refrigeratorOn 5/27/26 at 10:18 AM, an interview was conducted with the Director of Nursing (DON), who stated that night shift nurses would document the refrigerator temperature in the Nurses Daily Checklist. The DON provided the Nurses Daily Checklist, which provided the following parameters of Fridge Temp less than 41 Degrees. It should be noted that there was not a greater than parameter provided for a refrigerator temperature. The DON stated that if a refrigerator temperature was 32.5 degrees Fahrenheit she would expect nurses to adjust the refrigerator settings to increase the temperature. On 5/27/26 at 10:53 AM, an observation was made of the facility's medication storage refrigerator with RN 4, who confirmed that the thermometer in the refrigerator read 32.5 degrees Fahrenheit. RN 4 stated that she was not sure what the temperature range was for safely storing medication, because night shift was responsible for checking fridge temperature, but she could find out. RN 4 stated that if medications were stored outside of the manufacturer's recommended temperature range they would become less effective. Inventory of the refrigerator was completed with RN 4, and the following medications were observed: a. Two vials of Aplisol (tuberculin PPD, diluted). RN 4 stated that they were used for TB skin testing. b. Two sealed bottles of Latanoprost Ophthalmic Solution 0.005%, one labeled for resident 37 and one labeled for resident 59. c. Two sealed pens of Ozempic Subcutaneous Solution Peninjector 4 MG/3ML [milligram/milliliter] both labeled for resident 9. d. One sealed pen of Tresiba FlexTouch Subcutaneous Solution Peninjector 200 UNIT/ML, labeled for resident 19. e. Two sealed vials of Admelog Injection Solution 100 UNIT/ML, one labeled for resident 10 and one labeled for resident 30.f. One sealed pen of Admelog Injection Solution 100 UNIT/ML, labeled for resident 76.g. Two sealed pens of Humalog Injection Solution 100 UNIT/ML, labeled for resident 80.h. One sealed pen of Toujeo Max SoloStar Subcutaneous Solution Peninjector 300 UNIT/ML, labeled for resident 77.i. One sealed pen of Lantus Subcutaneous Solution 100 UNIT/ML, labeled for resident 79. j. Two sealed pens of Tresiba Subcutaneous Solution 100 UNIT/ML, both labeled for resident 78.It should be noted that the manufacturer instructions for these medications stated that the medications should be stored refrigerated at temperatures between 36 and 46 degrees Fahrenheit.On 5/27/26 at 2:22 PM, an interview was conducted with RN 3, who stated that the facility would call the pharmacist if a medication froze and follow the pharmacist's advice.The medication room's medication refrigerator temperature logs for the month of May 2026 were reviewed, revealing that for 25 of 25 days the temperature was documented between 32 and 35.5 degrees Fahrenheit. It should be noted that all of the temperatures documented were below the manufacturer guidelines to store the medications above 36 degrees Fahrenheit.On 5/27/26 at 4:03 PM, an additional interview was conducted with the DON, who stated that when a medication was stored outside of the manufacturer's guidelines it could decrease the efficacy or action of the medication. The DON stated that when the night shift nurses were checking the refrigerator temperatures she expected them to adjust the temperature so it remained within the appropriate (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	parameters. The DON stated that she thought that if the medication was frozen or too hot they would need to notify the pharmacy to get a refill of the medication. The medication room's medication refrigerator temperature logs for the month of May 2026 were reviewed with the DON, who stated that the documented temperatures were too low. The DON stated that the temperatures had not been communicated to her. The facility's Medication Storage policy dated 4/12/21, stated the facility stores all drugs and biologicals in a safe, secure, and orderly manner, and stated the procedures as: 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. 2. Drugs and biologicals are stored in packaging, containers or other dispensing systems in which they are received. Only issuing pharmacies were authorized to transfer medications between containers. 3. Nursing staff were responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Drug containers with missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 5. Hazardous drugs are clearly marked and stored separately from other medications. 6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. 7. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. 8. Schedule 11-V controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medications separate from access to non-controlled medications. a) Controlled medications that are part of a single unit dose distribution system may be stored with non-controlled medications when the supply is minimal and shortages are readily detectable.(Cross refer to F880)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility did not provide at least three meals daily with no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack was served at bedtime, up to 16 hours may lapse between a substantial evening meal and breakfast the following day if a resident group agreed to this meal span. Specifically, the dinner and breakfast were served 15 hours apart and there was no substantial evening snack being offered. Findings included:Scheduled meal times for the facility were posted. Breakfast was served at 7:30 AM-8:30 AM, lunch was served at 12:00 PM-1:00 PM, and dinner was served at 5:15 PM-6:30 PM. On 5/27/26 an observation was made of the breakfast service. The following was observed:a. The first breakfast meal was served at 7:47 AM.b. At 8:51 AM, a resident in the dining room asked if she was going to be served breakfast sometime this morning.c. At 9:08 AM, the last breakfast meal was served to a resident in the 100 hallway. The resident stated it was about time. On 5/27/26 at 2:20 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that she worked the day shift and sometimes the residents asked for snacks to eat. RN 5 stated that they had biscuits and crackers to offer as a snack. RN 5 stated that there was not a dedicated snack time and residents were always able to ask for a snack.On 5/27/26 at 2:24 PM, an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated that there was not a dedicated snack time and sometimes residents were snacky. CNA 3 stated they had yogurt, applesauce, jello, cookies, saltine crackers, and cream cheese available for snacks all the time. CNA 3 stated that snacks were not given out and residents had to request the snack. CNA 3 stated that they also had peanut butter, cereal, soup, and ice cream available. On 5/28/26 at 7:48 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that there was not a formal program for snacks at the facility. The DON stated that there were snacks available in the dining room for residents. The DON stated that the CNAs should be charting if they give a resident a snack. The DON stated that the CNAs could let residents know that the facility had snacks or the resident's family could bring snacks in for the resident.On 5/28/26 at 10:11 AM, an interview was conducted with Administrator (ADM) 1. ADM 1 stated that she was not sure who was responsible for providing residents snacks. ADM 1 stated that CNAs should be able to give resident snacks. ADM 1 stated that the facility offered fruit, cookies, crackers, sandwiches, yogurt, and applesauce for snacks. ADM 1 stated that snacks were available upon request. ADM 1 stated that she was not sure how dementia residents were made aware of the availability of snacks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 3 of 42 sampled residents, Enhanced Barrier Precautions [EBP] were not being implemented as ordered. Additionally, staff were not following hand hygiene procedures while serving meals. Furthermore, the facility's Tuberculosis (TB) screening process for new admits was inaccurate due to the testing solution (Purified Protein Derivative, or PPD) being compromised. Resident identifiers: 4, 38, and 28.Findings included:1. HAND HYGIENE On 5/27/26 at 11:45 AM, an observation of lunch service was conducted. The following was observed:a. Certified Nursing Assistant (CNA) 3 was assisting residents in the dining room while wearing gloves. CNA 3 was observed to touch multiple surfaces and residents without changing her gloves.b. CNA 2 was observed to deliver hallway lunch trays to residents. CNA 2 was observed to deliver a tray to a resident and to reposition the resident in their recliner. CNA 2 exited the resident's room and did not perform hand hygiene before picking up another lunch tray and entering a second resident's room to deliver the tray.c. CNA 2 was observed to deliver a lunch tray to a resident, open a package of crackers for the resident, and to move a resident in her wheelchair without performing hand hygiene.On 5/27/26 at 12:28 PM, an interview was conducted with CNA 3. CNA 3 stated that she was unsure how often she needed to change her gloves while assisting residents in the dining room. CNA 3 stated that she should probably change them more often.On 5/28/26 at 7:51 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff should be performing hand hygiene anytime they touch a patient or the patient's personal space. The DON stated that she preferred her staff to not wear gloves because then they become magic gloves and this can cause contamination. The DON stated that if staff assisted a patient they should change gloves. The DON stated that staff should perform hand hygiene upon exiting a resident room after delivering a meal tray. The DON stated that if staff touched a patient they should wash their hands. 2. ENHANCED BARRIER PRECATIONSa. Resident 28 was admitted to the facility on [DATE] with diagnoses which included, retention of urine and presence of urogenital implants.On 5/26/26 at 9:40 AM, an observation was made of resident 28. Resident 28 was observed to have a urinary catheter attached to the bottom of his bed frame. There was no EBP sign observed on resident 28's door and no Personal Protective Equipment (PPE) was observed to be seen inside or outside of resident 28's room.A physician's order was started on 5/11/26 to change the foley catheter every day shift every 29 day(s).A care plan intervention was initiated on 5/12/26 to follow enhanced barrier precautions due to resident 28 having a urinary catheter.On 5/27/26 at 2:56 PM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated that resident 28 was briefly on droplet precautions last night because he had a cough, but the precautions had been lifted. CNA 3 stated that resident 28 was not on any other precautions. On 5/28/26 at 7:42 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 28 was admitted with a urinary catheter on 5/10/26. The DON stated that an order for EBP was placed on 5/27/26 for resident 28 and there should be a sign that says EBP posted on his door. b. Resident 4 was admitted to the facility on [DATE] with diagnoses that included hydronephrosis with ureteral stricture, presence of urogenital implants, and urinary tract infection (UTI).A physician's order was started on 4/24/26 for EBP due to a wound or indwelling medical device. The order stated that gown and gloves to be worn during high contact resident care activities.A physicians order was started on 4/25/26 for a Foley catheter size __ french balloon inflate _____ as needed A care plan intervention was initiated on 4/24/26 to follow enhanced barrier precautions due to resident 4 having a urinary catheter due to bilateral hydronephrosis, AKI (Acute Kidney Injury), calcified bladder mass, and UTI.On 5/26/26 at 8:29 AM, an (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation was made of EBP signage posted to resident 4's door. No Personal Protective Equipment (PPE) was observed at that time.On 5/26/26 at 10:41 AM, an observation was made that no PPE was available in the hallway or resident 4's room and bathroom. Resident 4 stated that staff do not wear gowns when providing care. c. Resident 38 was admitted to the facility on [DATE] with diagnoses that included infection and inflammatory reaction due to indwelling urethral catheter, UTI, sepsis, and personal history of other infectious and parasitic diseases.A physicians order was started on 5/9/26 for EBP due to a wound or indwelling medical device. The order stated that gown and gloves to be worn during high contact resident care activities.A physicians order was started on 5/9/26 for a Foley catheter size 16 french balloon inflate 10 ml [milliliters] as needed. A care plan intervention was initiated on 5/9/26 to follow enhanced barrier precautions due to resident 38 having a urinary catheter.On 5/26/26 at 8:29 AM, an observation was made of EBP signage posted to resident 38's door. No PPE was observed at that time. On 5/27/26 at 7:38 AM, an observation was made that no PPE was available in the hallway or resident 38's room and bathroom. On 5/27/26 at 1:46 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2, who stated that she was aware of residents who had EBP orders due to a sign posted to their doors. CNA 2 stated that staff were required to wear only gloves if they needed to touch a resident on EBP. CNA 2 stated that there would be gowns stored in a cart in the hallway just outside the resident's room if staff needed to wear one. On 5/27/26 at 2:23 PM, an interview was conducted with Registered Nurse (RN) 3, who stated that EBP status was determined based off of doctors orders, but EBP orders were typically started for residents with indwelling catheters, Peripherally Inserted Central Catheter (PICC) lines, other invasive lines, wound vacs, or surgical wounds. RN 3 stated that EBP signs were put on resident doors and she would have to indicate in the Treatment Administration Record every shift that the residents were on EBP. RN 3 stated that staff were required to wear a gown, mask, and gloves any time they enter a room of a resident with EBP orders. RN 3 stated that the PPE for residents on EBP was stored either in the resident's room and in a cart in the hallway just outside the resident's door. RN 3 stated that PPE supplies were always available in the facility storeroom for staff to access. It should be noted that on 5/27/26 at 3:46 PM, an observation was made of RN 3 in resident 38's room without a gown or mask while she administered eye drops and changed the location that resident 38's catheter bag was hanging. On 5/27/26 at 2:00 PM, an interview was conducted with the Director of Nursing (DON), who stated that EBP were indicated for residents with an indwelling medical device or a significant wound. The DON stated that staff needed to wear a gown and gloves if they were providing direct resident care, to prevent cross contamination.3. INACCURATE TUBERCULOSIS [TB] SCREENING PROCESSOn 5/27/26 at 10:10 AM, an observation was made of the facility's medication storage refrigerator with Registered Nurse (RN) 3, who confirmed the thermometer in the refrigerator read 32.5 degrees Fahrenheit. RN 3 confirmed that the facility's TB testing solution was stored in the fridge. On 5/27/26 at 10:53 AM, an observation was made of the facility's medication storage refrigerator with RN 4, who confirmed that the thermometer in the refrigerator read 32.5 degrees Fahrenheit. RN 4 stated that she was not sure what the temperature range was for safely storing medication, because night shift was responsible for checking refrigerator temperature, but she could find out. RN 4 stated that if medications were stored outside of the manufacturer's recommended temperature range they would become less effective. Inventory of the refrigerator was completed with RN 4. Two vials of Aplisol (tuberculin PPD, diluted) were observed. RN 4 stated that they were used for TB skin testing. It should be noted that the manufacturer instructions for Aplisol stated DO NOT FREEZE This product should be stored at 2 -8 C (36 -46 F) and protected from light. Furthermore, manufacturer instructions stated Failure to store and handle Aplisol as recommended may result in a loss of potency and inaccurate test results. The medication room's medication refrigerator temperature logs for the month of May 2026 were reviewed, revealing that for 25 of 25 days the temperature was documented between 32 and 35.5 degrees Fahrenheit. It should be noted that all of the temperatures documented were below the manufacturer guidelines to store Aplisol (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	above 36-46 degrees Fahrenheit.On 5/27/26 at 4:03 PM, the medication room's medication refrigerator temperature logs for the month of May 2026 were reviewed with the DON, who stated that the documented temperatures were too low. The DON stated that the temperatures had not been communicated to her.On 5/28/26 at 10:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2, who stated that new admits received the first step of TB skin testing the day after admission and the results were checked two days later. LPN 2 stated that residents would then receive the second step of TP skin testing a week later, and those results were checked two days later. LPN 2 stated that both the initial placement of the PPD testing solution and the results were documented in the residents' Medical Administration Records. LPN 2 stated that the PPD solution was located in the medication refrigerator in the mediation storage room, and that she was not aware of any other PPD solution available in the facility. On 5/28/26 at 10:52 AM an interview was conducted with the DON, who stated that all new admits receive two step TB skin testing, with very rare exceptions. The DON stated that if the PPD testing solution was compromised the results of the TB skin test would be inaccurate. The DON stated that the facility PPD solution had been stored in the medication refrigerator, and that nursing staff would need to verify that the fridge temperature was in the appropriate range before reordering the PPD solution from the pharmacy. The DON stated that because previously tested residents received the compromised PPD solution, they would need to administer the TB skin tests.On 5/28/26 at 1:16 PM, an additional interview was conducted with the DON. The DON stated that she has spoken to the pharmacist and she was told that when there are additives placed in the PPD solution it can change the freezing range. The DON stated that the pharmacist would look into the effectiveness of the PPD solution if it had been frozen.(Cross refer to F761)

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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 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 (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, and two nurse managers and the DON subsequently witnessed when the medication was destroyed. The DON stated that there had not been any narcotic medications missing or miscounts since the narcotic count and storage procedures had been updated.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident who was given a psychotropic drug had adequate monitoring of that drug. Specifically, for 1 out of 42 sampled residents, a resident receiving an antidepressant for insomnia did not have hours of sleep monitored. Resident identifier: 60.Findings included:Resident 60 was admitted to the facility on [DATE] with diagnoses which included obstructive sleep apnea, anxiety disorder, and insomnia.A physician's order started on 5/21/26, documented, trazodone HCl [hydrochloride] Oral Tablet 50 MG [milligrams] (Trazodone HCl) Give 1 tablet by mouth at bedtime for sleep/anxiety. A physician's order started on 5/24/26, documented, Trazodone: Document # [number] of hours of sleep per shift two times a day.The May 2026 Treatment Administration Record (TAR) was reviewed. The number of hours of sleep were not documented on 5/24/26 and 5/25/26.On 5/28/26 at 7:59 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff nurses entered medication orders for new admissions and she performed a second check to ensure that orders were entered accurately. The DON stated that Trazodone required monitoring for adverse side effects and hours of sleep to ensure that there were no interruptions of sleep throughout the night. The DON stated that monitoring began when the resident was admitted to the facility. The DON stated that resident 60's adverse side effects and total number of hours sleeping was ordered on 5/24/26 and the hours of sleep were not charted until 5/26/26. The DON stated that she did not know why the hours of sleep were not documented. The DON stated that she performed double checks of resident's records for tracking and monitoring and somehow this was missed.

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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** Based on interview and record review it was determined that the facility did not ensure that in response to allegations of abuse and neglect the facility must have evidence that all alleged violations were thoroughly investigated. Specifically, for 1 of 42 residents sampled, the facility did not have evidence that an alleged violation of neglect was investigated. Resident identifier: 66.Findings included:Resident 66 was admitted to the facility on [DATE] with diagnoses which included periprosthetic fracture of left hip joint, difficulty in walking, and muscle wasting and atrophy On 7/23/25 at 3:12 PM, the facility reported that on 7/22/25 at 10:30 AM, resident 66 was found on the floor after sustaining a fall. Resident 66's spouse had just left the room when a crash was heard by her and the staff. Resident 66 was transferred to the emergency room (ER) for sutures to a bleeding laceration. Resident 66's medical records were reviewed.On 7/22/25 at 7:29 PM, resident 66's Nurses Note documented, At approximately 1630 [4:30 PM], nurse was getting meds ready for patient. Nurse and two CNA's [Certified Nurse Assistants] heard loud crash from nurse station. Wife was walking down the hall and said That's [name omitted]. Nurse and CNA's went running into room. Pt [patient] was found in room laying on floor on his left side. Patient was bleeding from his head. Patient had large laceration above left eye and on nose. Patient also had skin tear to back of head. Wife was in room and was assissting [sic] with holding back of head with a washcloth to help stop bleeding. VS 132/88, pulst [sic] 130 and oxygen sats 97% room air. 911 was called to send pt to [name of hospital omitted] ER for eval [evaluation] and tx [treatment]. MD [Medical Doctor], family, and nurse management notified.On 7/23/25 at 4:59 AM, resident 66's Nurses Note documented, Patient Returned 1945 [7:45 PM]. Management Notified. Wound Care Orders: Keep Wounds Moistened with ABX [Antibiotic] Ointment. Remove Staples 10 Days, Sutures 5 Days. Neuro [Neurological] Checks Continued. No Problems.On 05/27/26 at 1:51 PM, Administrator (ADM) 1 located one document for resident 66 regarding his fall. There was no name to identify that this document was the investigation for resident 66's [NAME] 5/27/26 at 3:11 PM, an interview was conducted with ADM 1, who stated that she was unable to locate an investigation into resident 66's incident/fall on 7/22/25.On 5/28/26 at 10:11 AM, a follow-up interview was conducted with ADM 1. ADM 1 stated that incidents were reported to her and she determined whether or not there was immediate harm. ADM 1 stated that the investigation included interviewing whomever reported the incident to her, staff, residents, and anyone with information or a witness statement. ADM 1 stated that she would type a statement or have the staff write a statement. ADM 1 stated that she would type a statement or have the staff write a statement. ADM 1 stated that after her investigation was completed she would type a summary of the investigation and submit it to the SSA within 5 days of the initial incident.

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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 that the facility did not document in the resident's medical record the information that was provided to the receiving provider which must include a minimum of the practitioner responsible for the care of the resident; the resident representative contact information; advanced directive information; comprehensive care plan; a copy of the resident discharge summary; and all necessary information to ensure a safe and effective transition of care. Specifically, for 1 of 42 sampled residents, the facility did not document in the resident's medical record the information conveyed to the receiving provider when the resident was transferred to the Emergency Room. Resident identifier: 48.Findings included:Resident 48 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy, sepsis, adult failure to thrive, cataracts, vertigo, hypertension, and supraventricular tachycardia.Resident 48's medical records were reviewed.On 3/25/26 at 12:53 PM, resident 48's nursing progress note documented, At approximately 0720 [7:20 AM], patient was heard yelling out by nurse. Nurse went into room and patient was found laying faceup with her back making contact with the floor. Patient head was in the shower area and her lower body was just outside of shower. Patient right leg was positioned different with her right foot laying rightward out. Patient was not able to bed [sic] her right leg and had pain when nurse tried to bend her leg.Patient was notified that she needed to go to hospital for evaluation of right hip.Patient remained on floor in place found until EMS [emergency medical services] came to transport patient to ER [emergency room] .Patient was taken to [name omitted] hospital per husband choice of hospital at approximately 0740. [7:40 AM] It should be noted that the documentation did not include the information that was sent with EMS to the receiving provider. On 3/25/26, resident 48's Discharge/Transfer summary documented the resident was transferred to the hospital. The summary included resident 48's diet order, last bowel movement, Activities of Daily Living, bed hold policy, and a summary of the incident. The summary documented that the documents given upon discharge were Medication/Treatment flowsheets. It should be noted that this discharge summary was documented on 3/25/26 at 1:25 PM, which would have been almost 6 hours after the resident was transferred to the ER.On 5/27/26 at 1:54 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that a resident transfer should be charted in a progress note. The DON stated that the discharge transfer form and bed hold policy should be given upon transfer or discharge. The DON stated that staff should send the resident's facesheet, physician order for life sustaining treatment, current doctor's orders and a note of why they were sent out. The DON stated that the information that was sent to the receiving provider was not documented anywhere in resident 48's medical records.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that the facility did not provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless the individual's clinical condition demonstrated that such diminution was unavoidable. Specifically, for 1 of 42 residents sampled, the facility did not provide dining assistance for a resident that required such assistance and other residents were observed feeding the resident. Resident identifiers: 8 and 11.Findings included:Resident 11 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included dementia, hallucinations, Parkinson's disease, and Alzheimer's disease.Review of resident 11's records was completed on 5/26/26 through 5/28/26.A Minimum Data Set (MDS) assessment dated [DATE] revealed that resident 11 had a Brief Interview of Mental Status (BIMS) score of 09 which indicated moderate cognitive impairment. The MDS also indicated that resident 11 required setup or clean up assistance with dining.Resident 11's diet orders were to have food cut up and offer finger foods when available. On 5/26/26 at 12:08 PM, an observation was made of resident 11 during the lunch meal service. Resident 11 was served turkey that was not diced or cut up. At 12:42 PM, resident 11 was observed to have difficulty eating his turkey. Resident 11's hands were shaking and he was unable to bring the fork to his mouth. Staff were observed to be present during the meal but did not offer dining assistance to resident 11. At 12:53 PM resident 11 continued to feed himself with difficulty, hand tremors were observed and resident 11 did not utilize any assistive eating devices such as built up utensils or a lipped plate. At 12:55 PM staff asked resident 11 if he was finished eating and he replied yes. Resident 11 consumed 50% of his lunch meal. On 5/27/26 at 8:27 AM, resident 11 was observed seated in the dining room for breakfast. Resident 11 was served pancakes, eggs and bacon and only the pancakes were cut up. Staff were observed to be present during the meal but did not offer dining assistance to resident 11.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice. Specifically, for 1 of 42 residents sampled, the resident developed skin breakdown at the facility and interventions were ordered but not implemented. Resident identifier: 54.Findings included:Resident 54 was admitted to the facility on [DATE] with diagnoses which included fracture of right lower leg, orthopedic aftercare, type 2 diabetes mellitus, and muscle wasting and atrophy. On 5/26/26 at 9:38 AM, an interview was conducted with resident 54. Resident 54 stated that he had a sore on his bottom and it developed after he was admitted to the facility. Resident 54 stated that he applied cream to the area and he believed it developed due to sitting on it too much. Resident 54 stated that now they had him wearing a brief, and it caused rashes. Resident 54 was observed seated in his recliner at the bedside. A tube of A & D ointment was observed at the bedside. Resident 54's medical records were reviewed. On 5/15/26, resident 54's Braden scale documented a score of 16 which indicated that the resident was at risk for pressure ulcers. Resident 54's orders revealed the following: SKIN: Zinc/Venelex Mixture to Bilateral Buttocks: Multiple Sites as needed for Skin Integrity. The order was initiated on 5/23/26. SKIN: Groin/In between Legs: Red, Soreness due to pullups cutting into him. Apply to clean, dry skin with peri/Cath cares as needed for Skin Integrity. The order was initiated on 5/23/26. Ensure Air Overlay to bed functioning properly every shift to alleviate pressure to bony prominences. The order was initiated on 5/24/26. Resident 54's May 2026 Treatment Administration Record (TAR) documented a check mark on 5/25/26 and 5/26/26 for the order to ensure that the air overlay was functioning properly. On 5/27/26 at 6:27 PM, the skin issues progress note documented, .Skin Issue: #002: New skin Issue. Location: Intergluteal cleft. Laterality / Orientation: Middle. Issuetype: Moisture associated skin damage (MASD). Progress: New: new wound. Wound acquired in-house. Exact date: 05/24/2026 Signs and symptoms of infection: None. Painful: Yes. Wound pain (Frequency): None. Pain description: Sharp. Wound pain interventions: Change in position. Relief from interventions: Yes. Staged by: In-house nursing. Length (cm) [centimenter]: 2.42 Width (cm): 1.38 Depth (cm): 0 Area (cm2): 2.56 Undermining: No. Tunneling: No. Exudate amount: None. Exudate type: None. Odor after cleansing: None. Surrounding tissue: Excoriated. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Skin Issues Note: Blancheable erythema with dry, peeling skin noted to bilateral buttocks. Discussed treatment options with resident; air overlay present on bed, Vitamin A&D ointment applied with peri cares, off-loading cushion to w/c [wheelchair]. Skin issue education: Care of skin issue(s). Additional skin issue education documentation: Educated resident to get assistance immediately with incontinent episodes. Resident 54's Care Plan for At risk for alteration in skin integrity as evidenced by Open Reduction and Internal Fixation of the right ankle, and urinary incontinence was initiated on 5/16/26. The goal was that the resident's skin would remain intact. No interventions were identified on the care plan for resident 54's Moisture Associated Skin Damage of the buttocks. On 5/27/26 at 7:38 AM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 54 used a urinal and straight catheterized himself. CNA 1 stated that resident 54 preferred to have his brief changed after he catheterized himself. CNA 1 stated that she was not aware of resident 54 having any skin breakdown and she had no reports of skin breakdown. On 5/27/26 at 8:10 AM, a follow-up interview with CNA 1 was conducted. CNA 1 stated that she had just provided incontinence care to resident 54 and had observed a scab on his sacrum and she applied A & D ointment to the area. CNA 1 stated that she would inform the nurse of the skin issue. On 5/27/26 at 8:26 AM, resident 54's room was observed. Resident 54's bed did not contain an air mattress overlay, the recliner did not have a cushion on it, and a pillow was observed in the seat of the recliner. On 5/27/26 at 8:28 AM, an interview was conducted with (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 54 had a dry scab on his buttocks and she would assess it when he returned from his appointment. LPN 1 stated that resident 54 had an order for zinc and velenelex cream for redness due to incontinence. LPN 1 stated that wound prevention was an air mattress, repositioning, and the registered dietitian would order a multi vitamin and vitamin C. LPN 1 stated that now that resident 54 had developed a skin issue they would implement an air mattress. LPN 1 stated that they typically did not initiate the air mattress until there was more than blanchable redness to the skin. LPN 1 stated that resident 54 did not currently have an air mattress overlay on his bed. On 5/27/26 at 8:40 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the air mattress should have been put on the bed on 5/24/26 when it was ordered. The DON stated that the staff on 5/25/26 that checked the TAR meant that the staff did not actually check that the air mattress was on and functioning properly.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **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 that the resident's drug regimen was free from unnecessary drugs. An unnecessary drug was any drug when used in excessive dose; for excessive duration; without adequate monitoring; in the presence of adverse consequences; or any combination of the above. Specifically, for 1 out of 42 sampled residents, the facility did not monitor the resident's insulin administration through his insulin pump system. Resident identifier: 54.Findings included: Resident 54 was admitted to the facility on [DATE] with diagnoses which included fracture of right lower leg, orthopedic aftercare, type 2 diabetes mellitus, and muscle wasting and atrophy. On 5/26/26 at 9:47 AM, an interview was conducted with resident 54. Resident 54 stated that his blood sugars at the facility were terrible. Resident 54 stated that his insulin infused through the Omnipod insulin pump. Resident 54 stated that the insulin pump lasted 3 days before it needed to be replaced and he changed the unit himself. Resident 54 stated that he informed the staff of his blood sugar readings. On 5/27/26 at 10:45 AM, a follow-up interview was conducted with resident 54. Resident 54 stated that he monitored his blood sugars and adjusted his insulin accordingly. Resident 54 stated that he loaded the Omnipod with 50 milliliters of insulin and it lasted approximately 3 days. Resident 54 stated that he administered his own insulin and he did not tell the nurses how much insulin he had administered. Resident 54's medical records were reviewed.Resident 54's orders revealed the following:a. Patient managed own insulin pump. Change the omnipod every 3 days as needed. The order was initiated on 5/22/26. b. Print Blood Sugars for Medical Doctors to review every night shift every Sunday. The order was initiated on 5/17/26. c. Finger Stick Blood Sugar before meals and at bedtime for diabetes. The order was initiated on 5/15/26. Resident 54's May 2026 Medication Administration Record (MAR) documented blood sugar checks at 7:00 AM, 11:00 AM. 4:00 PM, and 9:00 PM. The MAR documented a check mark next to the order for the resident, managed his own insulin pump and changed it every 3 days. On 5/27/26 at 1:21 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she obtained resident 54's blood sugar readings throughout the day to ensure they were not dropping too low or going too high. LPN 1 stated that she documented this in the MAR. LPN 1 stated that the insulin was documented in the MAR as U-SA for self administered. LPN 1 stated that they could see that the resident was administering the dose of medication. LPN 1 stated that resident 54 set up his own insulin pump. LPN 1 stated that there was no way to determine how much insulin resident 54 was self administering. On 5/27/26 at 1:47 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 54 managed his insulin pump refill because they did not have the equipment at the facility. The DON stated that they monitored resident 54's blood sugars and notified the doctor of any irregularities. The DON stated that she did not know if they were tracking how much insulin resident 54 was getting from his pump. The DON stated if resident 54 had a complication they would not know how much insulin he had administered.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that the facility did not provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Specifically, for 1 out of 42 sampled residents, the resident was not provided the dietary preferences as requested to help manage his diabetes. Resident identifier: 54.Finding included: Resident 54 was admitted to the facility on [DATE] with diagnoses which included fracture of right lower leg, orthopedic aftercare, type 2 diabetes mellitus, and muscle wasting and atrophy.On 5/26/26 at 9:47 AM, an interview was conducted with resident 54. Resident 54 stated that the facility did not provide him with a diabetic diet. Resident 54 stated that for breakfast they gave him 2 packets of oatmeal and he could not eat it because it had too much sugar. Resident 54 stated that he had informed the staff of his concerns with his food but they did not do anything about it.Resident 54's medical records were reviewed. On 5/15/26, resident 54's physician ordered a regular diet, regular texture, thin consistency diet. The diet order had special instructions that stated prefers low sugar and low sodium foods and beverages. On 5/27/26 at 8:18 AM, resident 54's breakfast was observed. The breakfast meal contained a fruit bowl, bagel and cream cheese. On 5/27/26 at 9:37 AM, an interview was conducted with Certified Dietary Manager (CDM) 1. CDM 1 stated that she conducted the resident diet interviews. CDM 1 stated that the facility process was that the resident was self directed at meals and they did not fill out diet likes and dislikes. CDM 1 stated that she would put a low sugar preference in the diet order. CDM 1 stated that resident 54's meal ticket documented a fluid restriction, regular diet, and thin liquids. CDM 1 stated that resident 54's preferences of a low sugar and low sodium diet were not on the meal ticket. CDM 1 stated that because the resident was self directed at meals the kitchen was not aware of the low sugar or low sodium preference and he was served a regular diet. CDM 1 stated that the fruit salad served this morning for breakfast was a tropical fruit blend and was served in its own juices. CDM 1 stated the tropical fruit blend was in light syrup and the sugar content of 1/2 cup would be 20 grams. On 5/27/26 at 10:45 AM, a follow-up interview was conducted with resident 54. Resident 54 stated that he could hardly eat any of the food because it was too sweet. Resident 54 stated that he selected the food items off the menu but what came was not that good.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **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 that the antibiotic stewardship program included antibiotic use protocols and a system to monitor antibiotic use. Specifically, for 2 out of 42 sampled residents, the facility prescribed antibiotic therapy to treat a Urinary Tract Infection (UTI) without obtaining a culture and sensitivity report to identify the organism and the antibiotic that organism was susceptible to. Resident identifier: 74 and 75.Findings included:1. Resident 74 was admitted to the facility on [DATE] with diagnoses which included methicillin susceptible staphylococcus aureus infection classified elsewhere and a urinary tract infection. On 3/4/26, resident 74 had a urinalysis with culture obtained. The urinalysis documented an abnormal value of urine nitrite (positive) and a trace amount of blood in the urine. The urinalysis documented no to culture indicated. The lab result form had a hand written order for Macrobid 100 milligram (mg) by mouth two times a day for 5 days. Resident 74's March 2026 Medication Administration Record (MAR) documented that resident 74 was administered Macrobid Capsule 100 mg by mouth two times a day for a UTI. The MAR documented that the medication was administered on 3/6/26 through 3/10/26 for a total of 10 doses administered. On 5/28/26 at 10:16 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 74's lab indicated not to do a culture and she did not know why it was not done. The DON stated that the floor nurse should have called the lab to determine why the Culture and Sensitivity was not completed. The DON stated that there was no documentation from the nurse why the culture was not obtained. 2. Resident 75 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection. On 3/2/26, resident 75's urinalysis was obtained. The urinalysis documented abnormal values for urine nitrite (positive), urine protein (greater than 300), and urine ketones (trace). The lab result form had a hand written order for Cefdinir 300 mg by mouth two times a day for 7 days. Resident 75's March 2026 MAR documented that resident 75 was administered Cefdinir Capsule 300 mg by mouth two times a day for UTI. The MAR documented that the medication was administered on 3/3/26 through 3/9/26 for a total of 14 doses administered. On 5/28/26 at 10:16 AM, an interview was conducted with the DON. The DON stated she was not sure why a culture was not obtained for resident 75's urinalysis. The DON stated that there should be a culture to determine the organism to treat. The DON stated without a culture and sensitivity report they could not determine the appropriate antibiotic to treat the organism.The facility policy on Antibiotic Stewardship Surveillance documented that the antibiotic data would be used to guide decisions for individual resident antibiotic prescribing practices. The procedure documented that as part of the antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist (IP). The policy further documented that the IP would review antibiotic utilization and identify specific situations not consistent with appropriate use of antibiotics. Therapy may require further review and possible changes if: i. Organism is not susceptible to antibiotic chosen; ii. Organism is susceptible to narrower spectrum antibiotic;iii. Therapy was ordered for prolonged surgical prophylaxis; or iv. Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. The policy was last updated on 11/15/22.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **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 that residents were offered the pneumococcal immunization unless medically contraindicated or declined. Specifically, for 1 out of 5 residents sampled, the resident signed the pneumococcal immunization form but the form did not indicate an administration or refusal of the vaccine. Resident identifier: 12.Findings included:Resident 12 was admitted to the facility on [DATE] with diagnoses which included aftercare following joint replacement surgery and presence of left artificial knee joint.Resident 12's medical records were reviewed. Resident 12 had a signed copy of the Pneumococcal Vaccine Consent form. The form did not contain a date, a consent for administration of the vaccine, or a declination of the vaccine. On 5/28/26 at 10:12 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that they did not administer the Pneumococcal vaccine to resident 12 and there was no way to determine if she declined the vaccination.