STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465175	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission at Community Living Rehabilitation Center	10 West 400 South Centerfield, UT 84622

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, for 3 of 24 residents sampled, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency. Specifically, a staff member was arrested for driving under the influence (DUI), had alcohol in the facility vehicle while transporting residents and the State Survey Agency was not notified. Resident identifiers: 6, 10 and 90. Findings included: Resident 6 was admitted to the facility on [DATE] with diagnoses which included dementia, osteoporosis, macular degeneration and chronic pain. Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral palsy, contractor, muscle weakness, cramp and spasm and major depressive disorder. Resident 90 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Lupus, major depressive disorder, dementia, anxiety and history of falling. Resident 6, 10 and 90's medical records were reviewed 6/23/25 through 6/25/25. On 6/23/25 a complaint that was sent into the State Survey Agency was reviewed and documented, On 05/30/2023 the facility had taken four Residents to [local city] for a rafting trip. The Complainant alleged that during this trip [name omitted] a maintenance staff member, [name omitted] an activities staff member and [name omitted] the ADON [Assistant Director of Nursing] had drank alcohol. The Complainant noted she did not drink on the trip. The medical records for resident 6, 10 and 90 were reviewed, no information was found regarding the incident. The incident was not reported to the State Survey Agency. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/25 at 10:10 am, an interview was conducted with the Administrator (ADM). The ADM stated there was absolutely no drinking on the job. There is a zero tolerance policy, and there should be no alcohol in the facility vehicles. The ADM stated the staff were on shift the whole time they were with the residents on the rafting trip and that it absolutely should not have happened. The ADM stated the staff should not drink the entire time they are with the resident on an outing- even if it is overnight. The ADM stated she was not the ADM at the time of the incident but believes it should have been reported to the State Agency.

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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, the facility in response to allegations of abuse, neglect, or mistreatment did not have evidence that all alleged violations were thoroughly investigated. Specifically, for 3 out of 24 sampled residents, allegations of a staff member driving residents while being intoxicated was not investigated or the allegations were not investigated thoroughly. Resident identifiers: 6, 10 and 90. Findings included: Resident 6 was admitted to the facility on [DATE] with diagnoses which included dementia, osteoporosis, macular degeneration and chronic pain. Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral palsy, contractor, muscle weakness, cramp and spasm and major depressive disorder. Resident 90 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Lupus, major depressive disorder, dementia, anxiety and history of falling. Resident 6, 10 and 90's medical records were reviewed 6/23/25 through 6/25/25. There was no documentation found in the medical records of resident 6, 10 and 90 regarding the incident. For the allegation no investigation was provided by the facility. On 6/24/25 at 10:10 am, an interview was conducted with the Administrator (ADM). The ADM stated there was absolutely no drinking on the job. There is a zero tolerance policy, and there should be no alcohol in the facility vehicles. The ADM stated the staff were on shift the whole time they were with the residents on the rafting trip and that it absolutely should not have happened. The ADM stated the staff should not drink the entire time they are with the resident on an outing- even if it is overnight. The ADM stated she was not the ADM at the time of the incident but believes it should have been reported to the State Agency. On 6/24/25 at 10:19 am, an interview was conducted with the Chief Executive Officer (CEO). The CEO stated the incident was not reported to the State Agency because the staff member was stopped for rolling through a stop sign, then they pulled him over because there were alcohol containers in vehicle, not because he was drinking. The CEO stated the only time alcohol is allowed is if it is for residents, not the employees. The CEO stated the staff are not supposed to be drinking any alcohol while working or have alcohol in the facility vans.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Resident 90 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Lupus, major depressive disorder, dementia, anxiety and history of falling. Resident 90's medical record was reviewed 6/23/25 through 6/25/25. Resident 90 had a Physician's order for a urine analysis with culture to be collected on 1/25/25. The urine analysis was documented in resident 90's medical record. The urine culture was not located in the medical record. On 6/25/25 at 10:27 AM, an interview was conducted with the ADON. The ADON stated that the facility relied on the lab to give them the results, but the shift nurse would check with the lab daily to see if the labs were available. The ADON stated if orders get faxed over the nurse will note them and put them in the binder for medical records to scan them into the medical record. The ADON stated that the culture results had been missed and were not in the medical record, she had to call and get the results on 6/23/25. Based on interview and record review, the facility did not file in the resident's clinical record the laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, for 2 out of 24 sampled residents, the resident did not have laboratory results filed in their medical record. Resident identifier: 90 and 30. Findings included: 1. Resident 30 was admitted to the facility on [DATE] with diagnoses which Alzheimer's disease, type 2 diabetes, major depressive disorder, and anxiety disorder. A review of resident 30's records was completed on 6/22/25 through 6/25/25. Resident 30 had a Physician's order for a Lipid panel, Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC), urine microalbumin, and Thyroid Stimulating Hormone (TSH) to be collected on 12/1/24. The Lipid panel, CMP, CBC, and TSH was documented in resident 90's medical record. The urine microalbumin was not located in the medical record. On 6/25/25 at 8:03 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that for the urine microalbumin lab results for resident 30, she had to ask the hospital to send the results over so she could attach it to the medical record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, chemicals were stored in the dry storage room with food, the thermometer for the freezer was not functional and there was no backup thermomter inside the freezer, and there was an observation of the Dietary Manager not properly wearing a hairnet. Findings included: On 6/22/25 at 12:34 PM, an observation was made of the facility kitchen. In the dry storage room, there was a mop handle that touched an open bag of tortilla chips sitting on top of a crate. The bag of tortilla chips was also touching a bottle of 30% vinegar. At 12:43 PM, the freezer was observed. The display outside of the freezer did not display a temperature. There were no additional thermometers located in the freezer to verify the temperature of the freezer. A temperature log located outside of the freezer documented that the freezer had been measured as 3.1F from 6/1/25 through 6/22/25. On 6/24/25 at 11:42 AM, a follow up observation was made of the facility kitchen. The dry storage room contained peroxide, multi surface cleaner, glass cleaner, mop cleaner, table top cleaner, vinegar, and mop heads. On 6/24/25 at 11:43 AM, the freezer was observed. The display on the outside of the freezer was still not working. There was still not an additional thermometer in the freezer. The temperature for 6/23/25 and 6/24/25 was documented as 3.1F. On 6/24/25 at 11:43, an observation was made of the Dietary Manager (DM) in the kitchen. The DM was observed to be wearing a hairnet. However, several strands of hair were not contained within the hairnet. On 6/24/25 at 12:53 PM, an interview was conducted with the DM. The DM stated that staff in the kitchen should put on a hairnet right when they enter the kitchen. The DM stated that most of the chemicals used in the kitchen were stored in a closet in the dining room, but that some of the most frequently used chemicals were stored in the dry storage room. The DM stated that there was a second thermometer in the freezer. The DM was unable to locate the second thermometer when asked to point it out. The DM stated that the display on the outside of the freezer can be read if a flashlight is shined over it.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 4 of 24 sample residents, that the facility did not maintain medical records on each resident that were complete and accurately documented. Specifically, documentation regarding resident's immunization history was not in the medical record. Resident identifiers: 6, 14, 21 and 30. Findings included: 1. Resident 6 was admitted to the facility on [DATE] with diagnoses which included dementia, osteoporosis, macular degeneration and chronic pain. The immunization record for resident 6 was not located in the medical record. 2. Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included congestive heart failure, chronic kidney disease, morbid obesity and anxiety. The immunization record for resident 14 was not located in the medical record. 3. Resident 21 was admitted to the facility on [DATE] with diagnoses which included dementia, type II diabetes, hyperkalemia and anxiety. The immunization record for resident 21 was not located in the medical record. 4. Resident 30 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, type II diabetes, anxiety and neuropathy. The immunization record for resident 30 was not located in the medical record. On 6/24/25 at 8:30 AM, an interview was conducted with the Administrator (ADM). The ADM stated she was unsure where the immunization records were stored if not in the medical record. On 6/24/25 at 9:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated stated the immunization records were stored in a pharmacy file in her office not in the medical records. The DON stated she was unsure what would happen if the information was needed and it wasn't in the medical record.

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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** 2. On 6/23/25 at 12:20 PM, a Laundry Staff (LS) was observed to push a cart which had resident clean laundry hanging from the railing. There was no cover over the laundry. The LS passed residents and staff members in the hallways as she took the laundry to rooms 120, 121, 122, 123, and 124. On 6/24/25 at 11:24 AM, an observation was made of the LS. The LS carried laundered resident clothing on her shoulder and entered resident room [ROOM NUMBER] and put some clothing into the closet of room [ROOM NUMBER]. The LS was then observed to take the remaining resident clothing into room [ROOM NUMBER] and put it into the closet. On 6/24/25 at 11:40 AM, an interview was conducted with the LS. The LS stated the clothes are washed and then taken to the resident's rooms. The LS stated that she did not cover the laundry when she took it to the residents. The LS stated that sometimes she will have a bundle of laundry and will walk around and disperse it into the resident's rooms. The LS stated that sometimes other residents clothing will enter other residents room. On 6/24/25 at 12:00 PM, an interview was conducted with Plant Operations (PO). The PO stated he was the supervisor for the laundry department and that the clean laundry was not covered when it was taken to the residents. The PO stated the laundry staff should not take other resident's clothing into another resident's room. The PO stated that they were unaware that the laundry needed to be covered. 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 1 out 24 sampled residents, there were observations of no implementation of Enhanced Barrier Precautions (EBP) for a resident with wounds and observations of staff carrying clean laundry uncovered throughout the facility. Resident identifiers: 22. Findings included: 1. Resident 22 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease stage 2, acute and subacute infective endocarditis, metabolic encephalopathy, and pressure ulcer of sacral region, stage 3. On 6/23/25 at 9:53 AM, an observation was made that resident 22 had a wound vaccum on left foot and no enhanced barrier precautions were posted outside of resident 22's room. Review of resident 22's records was completed on 6/22/25 through 6/25/25. On 6/11/25, a Physician's order for wound care of Left heel was started. Cleanse with wound wash or normal saline. Apply foam to wound bed and cover with vac drape, suction at 125 millimeters of mercury (mmHg). Change every Monday, Wednesday, and Friday dayshift for ulcer to left heel and as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/24/25 at 11:26 AM, there were no Enhanced Barrier Precautions (EBP) observed to be displayed on any of the rooms in the facility. On 6/24/25 at 11:30 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated we have contact precautions but no barrier precautions. RN 1 stated the nurses communicate the isolation information for each resident through the communication board in the medical record. RN 1 stated that currently they only had one person on contact precautions. RN 1 stated they do not put isolation signage on the resident doors. On 6/24/25 at 11:32 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated he did not not what enhanced barrier precautions were. LPN 1 stated there are not any residents in the facility who are on precautions. LPN 1 stated that they do put signage on the door and it says what is needed to be done for the precautions that the resident is on. On 6/24/25 at 11:35 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she did not know what enhanced barrier precautions were and that they usually do not put signage on the resident's doors. CNA 1 stated she would get told by the off going CNA if a resident was on precautions and none of the residents currently are on precautions. On 6/24/25 at 11:38 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they did not know about Enhanced Barrier Precautions. The DON stated that they honestly had just learned about EBP today from their corporate staff. The DON stated they were planning to go over it with the staff. The DON stated we do have some residents who would qualify to be on EBP, resident 22 has a wound vacuum so he would be one of them. It should be noted, the Centers for Medicare and Medicaid Services Center for Clinical Standards Quality, Safety & Oversight Group (QSO) Reference QSO-24-08-NH on the subject of Enhanced Barrier Precautions in Nursing Homes came out March 20, 2024 and became effective April 1, 2024.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interview and record review it was determined that the facility did not provide training to staff that educated on activities that constituted dementia management, abuse, neglect exploitation and misappropriation of property, procedures for reporting abuse, and resident abuse prevention. Specifically, the facility did not provide ongoing substance abuse training with the facility staff after a staff member was arrested for drinking while driving residents in the facility van. Resident identifiers: 6, 10 and 90. Findings included: On 6/24/25 at 8:54 AM, an interview was conducted with the Therapeutic Recreational Technician (TRT). The TRT stated she was in the facility van with the residents when it got pulled over. The TRT stated she did not know exactly what had happened, she just knew she had to drive the remaining distance back to the facility because the Plant Operations (PO) was arrested. The TRT stated she was on the facility insurance and could drive the residents. The TRT stated there had not been any training done with the staff after the incident with the alcohol. The TRT stated the staff were just told that if they were caught drinking while working they would be terminated. On 6/24/25 at 9:09 AM, an interview was conducted with the Plant Operations (PO). The PO stated after the incident there was not any training or education done with the staff. The PO stated the administration only told him not to drink while the court proceedings were going. On 6/24/25 at 10:19 AM, an interview was conducted with the Chief Executive Officer (CEO). The CEO stated the incident happened right after he started and he was unsure if any training had been done with the drivers. On 6/24/25 at 2:04 PM, an interview was conducted with the Retired Administrator (RADM) who was the acting administrator during the incident. The RADM stated she did not remember doing any training after the incident, she only remembered taking away the driving privileges of the PO. On 6/24/25 at 1:50 PM, an interview was conducted with the Administrator (ADM). The ADM stated they have an All Staff meeting monthly where we go over specific items. The ADM stated they touch on issues that need to be addressed. When a staff member is hired they have policies they need to review and sign - drugs and alcohol are part of that onboarding process. The ADM did not remember if there was specific training done after the alcohol incident. On 6/24/25 at 2:59 PM, an interview was conducted with Transportation/Medical Records (TMR). The TMR stated she was not offered formal training other than coworker showing her how to put the residents into the vehicles. The TRM stated there wasn't really any training as far as she knows. The TRM stated there were no checklist or training for the overnight trips. No one does any audits that she is aware of or checks on them to make sure they are doing it right. On 6/24/25 at 3:14 PM, an interview was conducted with the ADM. The ADM stated there were no audits done on the transportation drivers. The ADM stated they just went based on their driving record, that they didn ' t have any issues, and they were able to maintain a safe environment. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Drug and Alcohol Free Workplace stated that the care community had a vital interest in providing a safe and healthful working and living environment for employees and residents. The unlawful or improper presence or use of controlled substances or alcohol in the work place conflicts with this vital interest. For these reasons, this care community has established, as a condition of employment with this care community, the following drug-free work place policy. The facility policy of Policy on the Prevention of Resident Abuse, Neglect, and Misappropriation of Resident Property was reviewed and documented that all employees will be provided education on abuse, neglect and exploitation during orientation and periodically during their employment. The facility Abuse Prohibition Education and Information Sheet on 7 Components was reviewed and documented that training means we provide training to employees through orientation and ongoing on issues related to abuse prohibition, including aggressive and catastrophic reactions of residents, reporting without fear of reprisal, recognition of burnout, frustration and stress that could lead an employee to be abusive, and understanding exactly what constitutes abuse, neglect, misappropriation of resident property.