STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465179	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Neurorestorative	13747 South Redwood Road Riverton, UT 84065

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that all residents were free from physical restraints. Specifically, 1 resident was restrained during oral care. Resident Identifier: 1. Findings include: The surveyor reviewed the facility's grievance log. The grievance log revealed that on March 3, 2025, the facility received an incident report from the school that Resident 1 attended, regarding a possible abuse event that happened on February 28, 2025 with Respiratory Therapist (RT) 1 and Resident 1. The following summary was documented in the log: Resident 1 was visibly upset during oral care that RT 1 was performing. Resident 1 was attempting to cover their face during these cares. Registered Nurse (RN) 1 offered assistance, and RT 1 declined assistance. RT 1 instead, put Resident 1's hands between RT 1's knees in order to continue oral care. The abuse coordinator for the facility was contacted once the incident report was received. After the incident, RT 1 was removed from the hall with pediatric patients; education was given to all RT's that Resident 1 required two people to perform trach and oral care. Education was provided to RT 1 regarding Resident 1's care needs, patient refusals, and the need to accept help when offered in similar situations. The surveyor reviewed Resident 1's medical records, and the following entries were observed: 1. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident 1's cognitive skills for daily decision making were severely impaired. Resident 1 was dependent on staff for eating, oral hygiene, and personal hygiene. 2. A Care Plan Focus dated 5/31/2023 revealed that when cares are being performed, Resident 1 has a history of swinging her arms and being combative. She has been prescribed Clonidine for agitation/restlessness. Interventions in place included listening to resident input regarding preferences for daily routine, medications, and other related interventions. 3. Resident 1's medical orders were reviewed; it should be noted that they did not include any form of restraints. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 30, 2025, an interview was conducted with RN 4. RN 4 stated that she witnessed the incident with RT 1 and Resident 1. RN 4 stated that she went to get Resident 1 for school and noticed RT 1 in the room performing oral care. RN 4 stated she noticed RT 1 was being aggressive with Resident 1 and offered to help, and RT 1 said she did not need help. RN 4 stated that RT 1 was aggressive when she grabbed both of Resident 1's arms and put them between her thighs, and Resident 1 could no longer move. RN 4 stated that Resident 1 looked to be in distress. RN 4 stated that from the view she observed that Resident 1 would not have been able to move her hands away, and it looked as though RT 1 was restraining Resident 1. RN 4 stated that she notified a nurse in the facility as well as her employer of what she witnessed. On April 29, 2025, the surveyor attempted to interview RT 1. RT 1 was unavailable for an interview. On April 30, 2025, an interview was conducted with RT 2, RT 3 and RT 6. The RT's stated that if a resident is moving their hands in a way that could inhibit care being performed they will have a second person come to help and give a pediatric resident a toy or distract them. The RT's stated that if the resident was nonverbal they would stop and try again later, they would not hold a resident's hands down. The Staff stated that if a resident is resistant or combative during care the staff would document that as a refusal and that they never restrain residents. On April 30, 2025, an interview was conducted with RN 5. RN 5 stated that when performing care for Resident 1 they will remind her to have safe hands, to keep her hands down and away from her face during cares. RN 5 stated that they will gently touch her wrist to remind her and that Resident 1 does not like her hands touched, that it causes agitation, and prefers her wrists to be touched. RN 5 stated that Resident 1 cannot see very well except for one eye and that they will provide a lot of communication to help her stay calm during cares. RN 5 stated that they do have to keep her hands away from her face during cares to keep her safe but never restrain Resident 1's hands, staff will just provide the constant reminders for safe hands. On April 30, 2025, an interview was conducted with the Respiratory Therapy Director (RTD). RTD stated that when she found out about the incident with Resident 1 and RT 1, she spoke with RT 1, and that RT 1 stated Resident 1 was swatting at her so she put Resident 1's hands between her knees to keep them out of the way. RTD stated that is not how the RT's are trained to provide care. RTD stated that after the incident, the abuse coordinator was contacted, RTD educated all staff and made Resident 1 a two person assist for oral care, and educated RT 1. RTD stated that RT 1 should have stopped the care in this particular situation. RTD stated that if you hold a resident's hands down with your hand that is considered a restraint. RTD stated that placing a resident's hand between your knees would not be considered a restraint. RTD stated that in this situation RT 1 should have stopped cares for Resident 1 and considered it as a refusal. A review of the facility policy titled, Restraints- Physical, revealed under the purpose section that a physical restraint is defined as any manual method, physical or mechanical device that is attached or adjacent to the resident's body; and restricts the resident's freedom of movement or normal access to his/her body.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the provider did not ensure that all alleged violations were reported. Specifically, allegations of abuse were not reported to the State Survey Agency (SSA) within the 2 hour timeframe. Resident Identifier: 1 Findings include: The surveyor reviewed the facility's grievance log. The grievance log revealed that on March 3, 2025, the facility received an incident report from the school that Resident 1 attended, regarding a possible abuse event that happened on February 28, 2025 with Respiratory Therapist (RT) 1 and Resident 1. The following summary was documented in the log: Resident 1 was visibly upset during oral care that RT 1 was performing. Resident 1 was attempting to cover their face during these cares. Registered Nurse (RN) 1 offered assistance, and RT 1 declined assistance. RT 1 instead, put Resident 1's hands between RT 1's knees in order to continue oral care. The abuse coordinator for the facility was contacted once the incident report was received. The surveyor completed a review of the SSA's facility reported incident system and could not find that the facility reported this incident. On April 30, 2025, an interview was conducted with the Director of Nursing (DON). When asked if the allegation of abuse was reported to the state the DON stated that they were not sure if the abuse coordinator reported it to the state but that it should be reported to the state as an abuse investigation.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the provider failed to ensure that all residents had appropriate supervision to prevent accidents. Specifically, one resident was given reheated coffee that spilled and caused scalding burns, which required hospitalization in the burn unit. Additionally, another resident fell out of bed and sustained a head laceration that required sutures when a CNA raised the resident's bed and momentarily left the resident unattended, and a third resident fell during a staff-assisted transfer due to the resident's wheelchair not being locked by staff before initiating the transfer. Resident Identifiers: 3, 4, and 5. Findings include: 1. On April 30, 2025, the surveyor interviewed Resident 5. Resident 5 stated that she had an incident where a staff member heated her coffee, but the staff did not check the temperature before giving it to her. Resident 5 stated that she had to go to the hospital for the burns and that she still has redness where she was burned. The surveyor reviewed resident 5's medical records, and the following entries were observed: a. Resident 5's care plan and assessments indicated Resident 5 required staff assistance during hands-on activities and was unable to feed themselves. b. A nurse documented in a nursing note on December 14, 2024, that a Certified Nurse Assistant (CNA) reported that Resident 5 had spilled coffee. The nurse documented that they performed a skin check and redness to the chest, right abdomen, and right hip/buttock was noted. The nurse documented that the Director of Nursing (DON) and the Medical Doctor (MD) were notified of the incident, and the MD said to monitor and clean the site if the blisters open. c. A nurse documented in a nursing note on December 14, 2024, that a follow-up burn injury assessment was completed, and blisters and redness were noted. The nurse notified the DON and the MD. d. A nurse documented in a nursing note on December 15, 2025, that the blisters appeared to be worsening. The nurse notified the MD and the resident's family. The resident was sent to a burn unit at a local hospital. Resident 5's hospital documentation was reviewed and revealed she was admitted to the burn unit due to a 3. 5% total body surface area partial and full thickness burn to the torso, abdomen, and right breast. The resident was admitted to the burn surgery service for wound management, pain management, and possible surgical intervention. On April 30, 2025 an interview was conducted with CNA 1. CNA 1 stated that when a hot beverage is provided to a resident, they must first check the temperature. CNA 1 stated that thermometers were provided to staff along with guidelines for the temperatures. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On April 30, 2025, an interview was conducted with the DON. The DON stated that Resident 5 liked to have really hot coffee and would ask staff members to reheat her coffee. A CNA warmed Resident 5's coffee up and then walked away. Resident 5 was able to move the coffee a bit, and it tipped over and fell on her. Nursing was involved, the physician was notified, and Resident 5 went to the hospital. After the incident, a policy was implemented that established a temperature limit for hot liquids provided to residents and required staff to verify the temperature of the liquid before serving it to the resident. 2. The surveyor reviewed resident 4's medical records, and the following entries were observed: a. Resident 4's care plan revealed that resident 4 was at risk for falling off of his bed due to his diagnoses of spastic quadriplegic cerebral palsy. The interventions, which were initiated on March 13, 2025, revealed that resident 4 had a bed and mattress that was lowered to the floor. b. Resident 4's Minimum Data Set from February 24, 2025, revealed that resident 4 required a two person physical assist with transfers. c. A nurse documented in a nurses note on April 14, 2025 at 10:00 AM that resident 4 had a fall from his bed and sustained a laceration to the left top side of his scalp and a scratch near the left eye. The nurse documented that the provider and family were contacted, and the resident was transferred to the hospital. d. A nurse documented in a nurses note on April 14, 2025 at 4:52 PM that resident 4 returned from the hospital with sutures in the left side of his forehead. The facility reported to the state survey agency that CNA 2 had elevated Resident 4's bed to prepare for a transfer before bringing a Hoyer lift into the residents room. CNA 2 had begun to leave the room while Resident 4's bed was elevated, and Resident 4 rolled out of bed. The facility reported that the CNA was able to catch Resident 4's lower body, but Resident 4 sustained a head laceration. The facility reported that education was provided to CNA 2 to leave Resident 4's bed in the lowest position with fall prevention measures in place prior to leaving the bedside. On April 30, 2025, the surveyor interviewed the DON. The DON stated that CNA 2 had raised Resident 4's bed into a high position, and then CNA 2 stepped out to see if a Hoyer lift was in the hall. The DON stated that when CNA 2 stepped away from Resident 4, Resident 4 began to roll out of bed. CNA 2 was able to catch Resident 4's lower half of his body, but Resident 4 sustained a head injury. The DON stated that staff are instructed to bring the Hoyer lift into the room, along with any other necessary equipment, prior to raising a resident's bed in preparation for a transfer. The DON stated staff should not raise a resident's bed and walk away. The DON stated that CNA 2 was trained and knew the protocol. 3. Resident 3's medical record was reviewed, and the following entries were observed: a. Resident 3 had a care plan that revealed Resident 3 required assistance with all activities of daily living due to weakness. An intervention, initiated on November 26, 2024, revealed that Resident 3 required maximum assistance with one staff member for stand pivot transfers, and to use a gait belt. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. A nurse documented in a nurse's note on February 17, 2025 that Resident 3 had a fall during the day shift and was sent to the emergency room per family request. c. A nurse documented in a nurse's note on February 18, 2024 that a CT scan of the resident's pelvis and lumbar spine was performed and there were no abnormalities noted. Facility staff documented in an incident report dated February 17, 2025 that a CNA was transferring Resident 3, and the wheelchair slipped out from under the patient. The incident report revealed that the CNA did not lock the resident's wheelchair. The incident report revealed that a bruise was identified on the resident's right lower back, and no other injuries were noted. On April 30, 2025, the surveyor interviewed Resident 3. Resident 3 stated that she had a fall during a transfer because the CNA did not lock her wheelchair. Resident 3 stated that the wheelchair slid out from underneath her, and she fell on her backside. Resident 3 stated that her back hurt from the fall. Resident 3 stated that the CNA did not work with her after that incident. On April 30, 2025, the surveyor interviewed the DON. The DON stated that the CNA did not ensure that resident 3's wheelchair was locked, and the CNA did not use a gait belt. The DON stated that the CNA was new and had completed the training and knew that he needed to use a gait belt and to lock the wheelchair. The DON stated that the CNA was no longer working at the facility.