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	11/07/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 47431 Based on interview and record review it was determined for 1 of 20 sample residents the facility did not ensure that each resident received adequate supervision and services to prevent accidents. Specifically, a resident was transferred on a utility cart causing a fall resulting in bruising and abrasions. Resident identifier: 42 Resident 42 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included infantile spinal muscular atrophy, type I Werding-[NAME], dysphagia, other lack of expected normal physiological development in childhood, abnormalities of gait and mobility, tracheostomy status, mandibular hypoplasia, and chromosomal abnormality. Review of records was completed on 11/4/24 through 11/7/24. On 10/16/24 at 10:59 PM, a Daily Skilled Charting note for Resident 42 revealed the following. At approximately 2000 [8:00 PM]; CNA [certified nurse assistant] witnessed the patient fall and hit her forehead and nose on the carpet in the hall. (Skin issues listed above) CNA, RT [respiratory therapist], and RN [registered nurse] all provided comfort to the patient. Neuro-checks have been implemented; VS [vital signs] have been stable so far. Pain at that time was 7/10 that was managed with PRN [as needed] Tylenol and ibuprofen; effective. A small ice pack was also place periodically on her forehead for pain/swelling control and comfort. Provider has been notified via phone/text. No new orders at this time; continuing to monitor the patient throughout the shift. Due to the hour of night; report will be passed to day shift to notify family as the patient is stable. On 10/17/24 at 9:10 AM, a Nursing Progress note for Resident 42 revealed the following. RN spoke to ADON [Assistant Director of Nursing] about incident with pt [patient] fall and RN called Mother of pt to update on pt having a fall last night. Mother did not answer, so RN left a message updating mother. RN left message that pt had fall and has a bruise and a scrape on her nose and forehead. And that RN is performing Neuro checks and that all of her vs and responses have been within baseline of pt. And that Admin [administration] will follow up with mother. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 9:57 AM, a Late Entry Nursing Progress note for Resident 42 revealed that, DON [Director of Nursing] and ADON consulted with MD [Medical Doctor] regarding pt's [patient's] fall last noc [night]. MD consulted safe and healthy families regarding imaging and it was not recommended to get imaging at this time as the risks outweighed the benefits. Pt is acting at baseline, neurochecks have remained stable. Staff will continue to monitor. On 11/06/24 at 3:04 PM, an interview with CNA 5 was conducted. CNA 5 stated that on the evening of resident 42's fall he was stocking the rooms with supplies while using a utility cart. CNA 5 stated that when he finished, he would give resident 42 a ride on the cart which he had done a few times. CNA 5 stated the last time he gave resident 42 a ride, the cart collapsed she fell to the floor causing a goose egg to her head. CNA 5 stated that the facility needs better equipment, after the cart collapsed, he noticed it was held together with electrical tape. CNA 5 stated this happened a few feet from the nursing station and the nurse and RT witnessed the event. CNA 5 stated that Resident 42 usually gets transported by her wheelchair. CNA 5 stated that after the incident he was told he needed to do some training, mainly Fall Risk Assessment. CNA 5 stated that management informed him that he is not allowed to work with the kids or any pediatric unit for at least a year. CNA 5 states that the accident was preventable, if he did not put resident 42 on the cart. On 11/7/24 at 10:59 AM, interview conducted with RN 5 who stated most of the kids have wheelchairs to get around, some were ambulatory. RN 5 stated that as the kiddos got older, they could use a slide sheet or Hoyer to help move them into their chairs. RN 5 stated it was never appropriate to transport the children on a cart or any other equipment used in the facility not directly used for transporting children. It was only safe to transport them in their own wheelchairs. RN 5 stated they should only use safe approved seats with seatbelts to keep the kids safe. On 11/06/24 at 2:10 PM, an interview was conducted with ADON. ADON stated that there was video footage for the incident involving resident 42 and the accident was completely preventable. ADON stated that CNA 5 put resident 42 on the utility cart, which is used to transport supplies, and started pushing her around when she fell off the cart. ADON stated that resident 42 had a bump on the front of her head and a scrape on the tip of her nose. ADON stated the MD was called immediately and neuro checks were started. MD called the trauma team at the hospital and was advised to monitor during the evening. ADON stated the MD followed up with the hospital's trauma team the next morning and was advised to transport resident 42 to the emergency department to have a scan done. Scan came back with negative findings. ADON stated that CNA 5 was previously educated about safe transporting due to him carrying residents on his shoulders. CNA 5 was put on suspension and prior to his return he needed to complete several training courses regarding safe transportation. ADON stated that CNA 5 has been reassigned to another area of the facility and is no longer able to be assigned in the pediatric unit.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure residents were free of any significant medication errors. Specifically, for 1 out of 20 sampled residents, a resident that was not diabetic was administered Insulin instead of Heparin, was hypoglycemic, and was admitted to the hospital. Resident identifier: 111. Findings included: Resident 111 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included, but were not limited to, anoxic brain damage, neuromuscular dysfunction of bladder, post traumatic stress disorder, major depressive disorder, anorexia, cardiac arrest, chronic respiratory failure, urinary tract infection, Methicillin-resistant Staphylococcus aureus (MRSA), pressure ulcer of sacral region unstageable, hypotension, dysphagia, cachexia, unspecified convulsions, pneumonia, poisoning by unspecified drugs, insomnia, and tremors. Resident 111's medical record was reviewed on 11/5/24 through 11/7/24. On 7/10/24, a physician's order documented Sodium (Porcine) Injection Solution 5000 UNIT/ML [milliliter] (Heparin Sodium (Porcine)) Inject 1 ml subcutaneously every 12 hours for Clot prevention. The Order Summary Report for resident 111 was reviewed. There were no physician's orders for Insulin. On 7/21/24 at 11:22 AM, a Nursing Progress Note documented Note Text: Around 0930 [9:30 AM] pt [patient] appeared uncomfortable and diaphoretic. VS [vital signs] were taken and BP [blood pressure] 106/66, HR [heart rate] 105, RR [respiratory rate] 20, temp [temperature] 97.8, and o2 [oxygen] 98. Blood sugar was checked and was 46. Pt immediately given 4 oz [ounces] of juice and MD [Medical Director] was notified. 1mg [milligram] of Glucagon given per MD orders. Bloodsugar [sic] checked again and was 42. Emergency services called for further assessment. When ambulance arrived pt's BS [blood sugar] had gone up to 66 and all other VS stable. Pt alert and appeared comfortable. Before EMS [Emergency Medical Services] left with pt, BS had increased to 86. Pt's mother was at bedside during this time and is aware. On call ADON [Assistant Director of Nursing] notified. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 7/21/24 at 11:32 AM, the Emergency Documentation from the hospital documented a chief complaint reason for visit of, Accidental drug administration. The medical decision making Emergency Department course documented, Review her previous notes including the notes from her visit a week ago, she had a positive urine at the time though her urine culture just grew mixed organisms. Her sputum culture grew MRSA. She was placed on 10 days of Keflex and so should be still on this medication. Initial glucose on the patient was 110s. We did contact the patient's skilled nursing facility and it sounds like this possibly could have been an overdose on Humulin, the nurse who takes care of the patient really is not sure what she gave. She [sic] patient's labs are significant for leukocytosis to 20, and looking at her labs from a week ago her white count was only 5. Her CMP [comprehensive metabolic panel] was notable for LFTs [liver function tests] that seem to be uptrending fairly significantly over the past week and a half. Because of this because of the white blood cell count and her inability to really localize any complaints a CT [computed tomography scan] of her chest and abdomen was ordered again. Check of the patient's glucose approximately an hour and a half after her arrival was 23. After this she was given half an amp [ampule] of D [dextrose] 50. This blood sugar was checked again 1/2-hour later and it was 57. The additional half amp of D50 was given to the patient. She was started on D10 half-normal saline drip. I spoke with poison control regarding this patient, the hemoglobin actually has a half-life of up to 8 hours and I think given the fact that she has had to have multiple doses of D50 she needs given need to be admitted . CTs of her abdomen were significant for may be some ductal dilatation, her LFTs are elevated but her bilirubin is normal so I have lower suspicion for obvious acute intra-abdominal pathology and particularly pathology related to the gallbladder. On 7/21/24 at 2:32 PM, the History and Physical Reports from the hospital documented a chief complaint of Pt brought in by EMS for potentional [sic] medication error at [facility name redacted] today. Pt may have gotten 100 units of insulin (Humilin [sic] R [regular] Instead of 1 ml of heparin today @0900 [at 9:00 AM]. Pt BS dropped to 40@facility [sic], given glucagon. The history of present illness documented, Patient is a [AGE] year-old female with a history of cardiac arrest, anoxic brain injury who is currently at [facility name redacted] who presents with what sounds like a medication error. At around 9 AM this morning the nurse at the facility gave the patient 1 mL of the medication that she thought was heparin, however could have possibly been 100 units of Humalin [sic] R. About an hour later the patient was getting sweaty, tachycardic and blood glucose was checked and was found to be 40. She was given glucagon. While in the ED [Emergency Department] patients lowest blood glucose level was in the 20's. ED physician asked hospitalist for admission. The assessment and plan documented #) Medication Error #) Hypoglycemia Was accidentally given 100 U [units] Humalin R Lowest BG [blood glucose] was 23. Was given 50 ml dextrose and started on D10 drip Most recent BG was 79 Continue close monitoring with q2h [every two hour] BG checks Continue D10 drip @ 125ml/hr [milliliters per hour]. On 7/22/24 at 8:43 AM, the Progress Notes from the hospital documented Subjective Patient appears comfortable today. blood sugars are much improved. No other issues overnight. Assessment/Plan #) Medication Error #) Hypoglycemia Was accidentally given 100 U Humalin R Lowest BG was 23. She was given D50 last night and then was on a D10 drip overnight. Her blood sugars have been trending up and are now around 140s. I will discontinue the D10 and see how she does. We will start her tube feeds . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 7/23/24 at 12:53 PM, a Nursing Progress Note documented Note Text: Patient returned to facility. She was transferred from [hospital name redacted] via stretcher. Orders were reviewed and implemented. Patient was transferred to bed and positioned properly. On 11/6/24 at 7:30 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that injectable medications were labeled with the resident's name. RN 1 stated the opened injectable medications were labeled with the resident's prescription and expiration date. RN 1 stated that once a medication was opened the nurse would label the medication with an open date. RN 1 stated any overstock of injectable medications were stored in the locked medication room. RN 1 stated that she currently did not have any residents prescribed Heparin. RN 1 stated the facility was really trying to stay away from having Heparin in the facility. RN 1 stated enoxaparin was being prescribed to the residents, since there was less risk associated with the medication. RN 1 stated that the Heparin and Insulin vials look similar and it was easy to mix them up. RN 1 stated that Heparin was not stored in the medication carts. On 11/6/24 at 8:20 AM, an interview was conducted with RN 2. RN 2 stated that she did not have any Heparin stored in her medication cart or in the medication room. RN 2 stated that any insulin that was stored in the medication cart was for specific residents and the box was labeled with the resident's name and order information. On 11/6/24 at 9:00 AM, an interview was conducted with RN 3. RN 3 stated that Heparin was not stored in the medication carts to prevent medication errors. RN 3 stated that any insulin stored in the medication cart or the medication room was labeled with the resident's name. RN 3 stated that the facility had moved away from Heparin and residents were being prescribed Lovenox. On 11/7/24 at 9:58 AM, an interview was conducted with RN 4. RN 4 stated on the day of the medication error the Insulin and Heparin were stored next to each other in the medication cart. RN 4 stated that both vials of medication had orange on them and looked the same. RN 4 stated that right after she had administered the medication to resident 111, she had not noticed what she had done. RN 4 stated that she had went in to resident 111's room about an hour and a half after she had administered the medication and resident 111 did not look right and was sweating. RN 4 stated that she took a set of vital signs and they were all within normal limits, so she got a blood sugar and that was when she noticed that she must have given resident 111 Insulin. RN 4 stated that she notified the MD immediately, administered glucagon to resident 111, and sent resident 111 to the hospital. RN 4 stated that both medication vials were not in their boxes. RN 4 stated the vials of medicine would come in bags and when the vials were removed from the bags and opened staff would put the labels with resident information on the vials. RN 4 stated on the day of the error the vials were labeled with resident information but she did not notice that she had grabbed the wrong vial. RN 4 stated that Heparin did not come in prefilled syringes but Lovenox did. RN 4 stated the Insulin was an intermediate acting Insulin that was administered to resident 111. RN 4 stated that after the error staff were instructed to put a yellow or red sticker on the Insulin vial to identify that the vial was Insulin and the nurses were to double check the medication with another nurse prior to administration. RN 4 stated that resident 111 was not diabetic and there were no orders to do routine BS checks for resident 111. RN 4 stated that resident 111 was to receive Heparin 1 ml and RN 4 had administered 1 ml of Insulin instead. RN 4 stated that she currently did not have any resident that were on Heparin. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 11/7/24 at 10:38 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that when the incident happened the nurse called management and reported that she accidentally gave Insulin instead of Heparin to resident 111. The DON stated that resident 111 was trending hypoglycemic and had signs and symptoms. The DON stated that the Heparin and Insulin were stored together in the top drawer of the medication cart. The DON stated that resident 111's mom was in the room and was aware of what happened and resident 111 was sent to the hospital. The DON stated that after the error a process was put in place to have colored stickers put on the Insulin vials and staff would write the open date on the sticker. The DON stated that staff were also instructed to store Insulin vials in the top drawer on the right side of the medication cart. The DON stated that other injectable medications were to be stored somewhere else in the medication cart but not the top drawer. The DON stated the new process was implemented facility wide. The DON stated if a resident was going to be admitted to the facility on an injectable medication staff would see about an oral substitution. The DON stated that after the incident the nurse completed some additional training, had a record of discussion, and was removed from working with resident 111.

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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** 44640 Based on observation and interview it was determined, 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 out of 20 sampled residents, staff members were observed to not clean the Hoyer lift after each resident use. Resident identifiers: 1, 23 and 55. Findings include: On 11/6/24 at 10:30 AM, an observation was made of Certified Nursing Assistant (CNA) 1. CNA 1 was observed to bring the Hoyer lift out of the room of resident 55 and place it in the hallway. CNA 1 did not clean the Hoyer lift. Resident 55 was observed to be on enhanced barrier precautions. On 11/6/24 at 10:46 AM, an observation was made of the Hoyer [NAME] being taken into resident 23's room by CNA 2. Resident 23 was observed to be in contact isolation along with enhanced barrier precautions. CNA 2 was observed to have a gown, mask and gloves in place. CNA 1 was observed to enter the room with no PPE (Personal Protective Equipment) and assist transferring resident 23 from her bed to chair. CNA 1 was observed to bring the Hoyer machine out into the hallway, the Hoyer machine was not cleaned. On 11/6/24 at 11:19 AM, an observation was made of the Hoyer lift being taken into resident 1's room by CNA 1. Resident 1 was observed to be on enhanced barrier precautions. Hoyer was observed to be brought out of resident 1's room to the hallway, the Hoyer lift was not cleaned. On 11/6/24 at 11:44 AM, an observation was made of CNA 1. CNA took the Hoyer lift into resident 55's room. CNA 1 was observed to bring the Hoyer lift out of the room and place it in the hallway, the Hoyer lift was not cleaned. On 11/6/24 at 11:14 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 23 was on contact precautions for Impetigo. RN 1 stated they believed it had cleared up but they were not completely sure so they were keeping the resident on precautions to be safe. RN 1 stated the staff were to wear all the PPE anytime they did cares or enter the resident's room or if they took the resident anywhere outside of their room. RN 1 stated for resident 23 the staff should wear a gown, mask and gloves when in her room. On 11/6/24 at 11:30 AM, an interview was conducted with CNA 3. CNA 3 stated the Hoyer lift was supposed to be cleaned everytime it was taken out of a resident's room. CNA 3 stated it should be wiped down with bleach wipes after use, especially with all of the residents who are on precautions right now. On 11/6/24 at 11:33 AM, an interview was conducted with CNA 4. CNA 4 stated that they do not always wipe down the Hoyer lift after each use. CNA 4 asked, Are we supposed to? CNA 4 stated they would wipe it down if it had been used in an isolation room but not usually. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/6/24 at 11:49 AM, an interview was conducted with CNA 2. CNA 2 stated that each resident has their own sling, but we also have them in storage. CNA 2 stated that they try to clean the Hoyer lift and then park it in the hallway. CNA 2 stated that they do not always clean it after each resident use. On 11/6/24 at 12:10 PM, an interview was conducted with CNA 1. CNA 1 stated the resident share Hoyer lift slings then they are laundered and stored. CNA 1 stated the Hoyer lifts are kept in the hallways, where they are plugged in. CNA 1 stated they never clean the Hoyer lifts. CNA 1 stated that they had never been instructed to do so. On 11/7/24 at 10:36 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated that with all residents who are on precautions the staff need to be wear what is required, whether it be a gown, mask, gloves and/or glasses when they are working with the residents. The IP stated the CNA's are expected to wipe the Hoyer lifts down when they bring them out of each room. The IP stated the CNA's should definitely be cleaning the Hoyer lift, especially with the enhanced barrier precautions and other isolation precautions that are in place. All of the staff have been educated many times on this subject but it sounds as if more education is needed.