STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465183	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Fork Rehabilitation and Nursing	151 East Center Street Spanish Fork, UT 84660

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 - 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** Based on observation, interview, and record review, it was determined for 1 of 16 sampled residents, that the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, the resident sustained four falls with no new interventions implemented and one of those falls resulted in a head laceration that required ten staples. This was identified at a Harm level. Resident identifier: 4.Findings included:Resident 4 was admitted to the facility on [DATE] with diagnoses which included Huntington's disease, aphasia, anxiety disorder, post-traumatic stress disorder, and nondisplaced intertrochanteric fracture of left femur.On 11/18/25 at 10:26 AM, resident 4's door was observed to be closed, and no noises could be heard from the outside of the room. The surveyor entered the room and resident 4 was laying sideways at the foot of the bed with her head and torso on the bed and her bare feet were hanging off the side of the bed touching the floor; she was awake, moving her arms around, and making noises. The room was observed to be dim, no staff were in the room, the bed was in the lowest position, and a fall mat or call light were not observed in resident 4's room. There were no personal items within her reach.On 11/19/25 at 8:07 AM, resident 4's door was observed to be closed, and no noises could be heard from the outside of the room. The surveyor entered the room and resident 4 was awake and calm laying sideways at the foot of the bed with her head and torso on the bed and her bare feet were hanging off the side of the bed touching the floor. The room was observed to be dim with soft music playing, no staff were in the room, the bed was in the lowest position, and no fall mat or call light was observed in resident 4's room. There were no personal items within her reach.On 11/24/25 at 10:01 AM, resident 4's door was observed to be closed and no noises could be heard from outside of the room. The surveyor entered the room and resident 4 was laying in her bed with the blanket on top of her, the bed was in the lowest position, the privacy curtain was drawn closed, the room was dim, and no call light was observed.Resident 4's medical record was reviewed from 11/17/25 through 11/24/25.A Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident 4 had short and long-term memory problems and severely impaired decision making skills regarding tasks of daily life. It further indicated resident 4 needed substantial/maximal assistance to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and to transfer to and from a bed to a chair or wheelchair.A Care Plan Report initiated on 6/19/25 indicated a Focus of [Resident 4] continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting to injury prevention and quality of life. Risk for falls remains high but current plan priorities safety with the least restrictive measures. It indicated a Goal of, [Resident 4] will be free of falls with injury through the review date. It further indicated the following Interventions:Anticipate and meet the resident's needs. Keep frequently used items within reach. Date Initiated: 6/19/25Follow facility fall protocol if a fall occurs. Date Initiated: 6/19/25Provide resident with high low bed to improve safety. Date Initiated: 10/14/25Staff shall assist to provide the resident with a safe environment to reduce the risk for falls: even floors free (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 0689 Level of Harm - Actual harm Residents Affected - Few	from spills and/or clutter; adequate, glare-free light; handrails on walls in the hallway. Date Initiated: 6/19/25Staff to assist resident with a gait belt while transferring or ambulating. Date Initiated: 6/19/25Toilet riser to be placed on toilet to assist resident with toilet transfers for safety. Date Initiated: 6/19/25A Morse Fall Scale dated 6/20/25 at 8:03 AM indicated resident 4 was at a High Risk for Falling, had impaired gait, and overestimated or forgot her limits with her own ability to ambulate.A Health Status Note dated 7/6/25 at 11:59 AM indicated, The CNA (Certified Nursing Assistant) came and got me saying resident was sitting on the floor in her room. By the time I got in there she had gotten herself into bed. I asked her if she had any pain or if she hit her head she said no.An Event Note Template dated 7/11/25 at 8:46 AM indicated an Interdisciplinary Team (IDT) review of the resident being found sitting on the floor in her room on 7/6/25 at 8:50 AM. It further indicated, .Risk Factors and Root Cause Identification: Huntington's disease with impulsiveness. Preventative Measures in Place Prior to Incident: Checking on resident, New Interventions: Resident continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting to injury prevention and quality of life. Risk for falls remains high but current plan priorities safety with the least restrictive measures.An Event Note Template dated 8/18/25 at 6:16 AM indicated, .Event Description: DON [Director of Nursing] heard a loud thud in residents room, nurse went in to assess the noise and noted resident sitting on the floor by her bed crossed leg (sic). Nurse asked resident if she fell and resident replied fall and thumbs up. Risk Factors and Root Cause Identification: Huntington's Disease. Preventative Measures in Place Prior to Incident: resident has refused any interventions. New Interventions: Resident continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting to injury prevention and quality of life. Risk for falls remains high but current plan priorities (sic) safety with the least restrictive measures.It should be noted that there were no new interventions implemented on the care plan after the fall on 8/18/25.A Skilled Progress Note dated 8/29/25 at 7:29 PM indicated, Resident fell on floor around 2300 [11:00 PM]. When examining resident there is a new bump on the back right side of the head. It is not currently open or bleeding.An Event Note Template dated 9/5/25 at 12:40 PM indicated, .Event Date/Time: 8/29/25 @ 2300 [11:00 PM]. Event Description: Resident was found on the floor in her room, it appears that she had fallen. Risk Factors and Root Cause Identification: Resident has Huntington's diseasePreventative Measures in Place Prior to Incident: Resident has had several preventive measures put in place but due to residents huntington's disease she has chorea movement which is uncontrollable and can cause resident to fall due to the movements. At this time the goal is injury prevention and qualityof [sic] life. New Interventions: No new interventions.It should be noted that there were no new interventions implemented on the care plan after the fall on 8/29/25.An Alert Note dated 9/2/25 at 3:45 AM indicated, Pt [patient] had an unwitnessed fall @ around 0205 [2:05 AM] is when she was found. Nurse heard a lot [sic] bang, checked on Pt to find her standing next to her bed, covered in blood. Nurse grabbed gauze to hold in place to the back of her head where the blood appeared to be coming from. Pt was conscious @ time of nurse finding Pt. Nurse went out to find a CNA to come help. CNA was told to hold pressure by nurse, w/[with] more gauze while she called paramedics. Paramedics arrived @ around 0218 [2:18 AM] .Paramedics stated Pt would most likely need stiches [sic], stated laceration was about 1inch in length. Pt gave a thumbs up when asked if she wanted to be sent out to hospital.A Health Status Note dated 9/2/25 at 5:52 AM indicated resident 4 returned from the emergency department and required 10 staples to the back of her head.A Care Plan Report initiated on 9/3/25 indicated a Focus of [Resident 4] is at high risk for falls and injury; with a Goal of Resident will have less episodes of falling and injury; and Interventions that included, Assess for weakness and/or fatigue. Educate resident and/or caregiver(s) on ways to reduce fall risk. Identify safety issues and educate on safety precautions to prevent fall and/or (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	injury.An Event Note Template dated 9/8/25 at 8:15 AM indicated, .Event Date/Time: 9/2/25 @ 0205 [2:05 AM]. Event Description: Nurse heard a loud bang and found the resident standing next to her bed, she was covered in blood and had a laceration to the back of her head. Risk Factors and Root Cause Identification: Huntington's disease. Preventative Measures in Place Prior to Incident: Keep resident comfortable. New Interventions: [Resident 4] continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting toinjury [sic] prevention and quality of life. Risk for falls remains high but current plan priorities safety with the least restrictive measures. Resident was sent to ER [Emergency Room] for staples to the laceration on her head.A hospice Plan of Care Order dated 10/2/25 indicated, Falls. Description: Pt is a high risk for falls and injury. Goal: pt will have less episodes of falling and injury. It further indicated, Activities: 9/9/25- SN [Skilled Nurse] identified safety issues and pt has a soft helmet sn ensure pt is wearing soft helmet for protection. 9/12/25- SN provided education to facility staff on putting the soft helmet on the patient to keep patient from injuring her head when falling. 9/16/25 pt has been wearing a soft helmet to reduce the injuries to her head, staff try to place helmet on pt will wear it for about 20 minutes, Sn educated staff on safety measures to keep pt safe. 9/25/25- SN educated staff and a facility with safety concerns such as ambulating, transfers, safety with showers and dressing patient and to notify us and for any injuries or falls. It further indicated, Huntingtons Disease. Description: Pt has a terminal dx [diagnosis] of Huntingtons Disease.Intervention Type-Assess for cause of altered mental status (e.g. infection, pain, urinary retention, constipation). Activities: 9/5/25- Pt has huntingtons disease which is a neurological disease, she is alert and oriented x2.9/25/25- SN assessed patient for increase in confusion, signs and symptoms of decline with Huntington's disease Sn educated staff and family members on disease progression.An Alert Note dated 10/12/25 at 3:46 AM indicated, Resident had an unwitnessed fall. Resident is on neuro checks. No s/s [signs or symptoms] associated with the fall observed.An Event Note Template dated 10/22/25 at 3:37 PM indicated, .Event Date/Time: 10/11/25 @ 0655 [6:55 AM]. Event Description: Resident was on the floor all the way underneath her bed,Risk Factors and Root Cause Identification: Huntington's disease. Preventative Measures in Place Prior to Incident: resident has had several interventions in place but does not keep them in place. New Interventions: [Resident 4] continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting toinjury [sic] prevention and quality of life. Risk for falls remains high but current plan priorities safety with the least restrictive measures.It should be noted that there were no new interventions implemented on the care plan after the fall, or falls, on 10/11/25 or 10/12/25.An Alert Note dated 10/30/25 at 7:45 AM indicated, I entered the residents room, and found her lying on the side of her bed on the flor [sic]. This was an unwitnessed fall. Neuro checks were started.No new neurological findings were present.An Event Note Template dated 11/4/25 at 9:35 AM indicated, .Event Date/Time: 10/30/25 @ 0745 [7:45 AM]. Event Description: Resident was found lying on her side by the bed, she was unable to describe what she was doing. Risk Factors and Root Cause Identification: Huntington's disease with Chorea. Preventative Measures in Place Prior to Incident: Checking on resident. New Interventions: [Resident 4] continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting toinjury [sic] prevention and quality of life. Risk for falls remains high but current plan priorities safety with the least restrictive measures.It should be noted that there were no new interventions implemented on the care plan after the fall on 10/30/25.On 11/25/25, additional documentation was provided by the Administrator (ADM) through email which included one-hour checks completed on several occasions for resident 4. It included documentation of hourly checks for 24 hours on:5/18/25 through 5/21/25,5/24/25,5/26/25 through 5/27/25, and5/29/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	through 6/1/25.It should be noted that there were no falls documented in resident 4's progress notes within these timeframes.On 11/19/25 at 11:00 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 4 had Huntington's disease and could not hold still. RN 1 stated resident 4 had been found on the floor several times and that she would not really know if she hit her head when the resident fell. RN 1 stated resident 4 grabbed areas that hurt her, like when she had a migraine she would grab her head. RN 1 stated resident 4 would sit on the side of the bed but that she needed assistance to get to her wheelchair. RN 1 stated resident 1 did not have a call light so they had to listen out for her. RN 1 stated fall interventions included her room being close to the nurse's station and a low-to-ground bed.On 11/19/25 at 11:19 AM, an interview was conducted with the CNA 2. CNA 2 stated resident 4 was always on supervision and that they checked on her every 2 hours to see if she was wet or needed a brief change. CNA 2 stated she did rounds and checked on all of her residents every 2 hours. CNA 2 stated she does not have a call light because she could put the cord around her neck. CNA 2 stated she was assigned to resident 4 today and that she was always listening for her and that she checked on her every 15 to 20 minutes because she falls [it should be noted that an observation was completed on 11/19/25 from 1:09 PM to 1:56 PM, and no CNA's or nursing staff were observed to go into resident 4's room for 36 minutes]. CNA 2 stated she would try to get up on her own but she was unable to walk. CNA 2 stated the resident did not have an alarm on the bed and had no fall mat. CNA 2 stated when items were placed in resident 4's bed, she would throw them off.An observation was made of resident 4's room on 11/19/25 from 1:09 PM to 1:56 PM. A CNA was observed to bring resident 4 into her room via wheelchair and shut the door. At 1:20 PM, the CNA left resident 4's room and shut the door. At 1:36 PM, Housekeeping was observed to knock and go into resident 4's room and then leave and shut the door at 1:37 PM. At 1:43 PM, resident 4's roommate came out of the room, shut the door, and then returned to the room at 1:44 PM, went in, and shut the door. At 1:56 PM the Assistant Director of Nursing (ADON) knocked on resident 4's door and entered the room and then left the room and shut the door at 1:56 PM. An interview was conducted with the ADON at 1:56 PM, she stated that staff checked on resident 4 to see if she needed to go to the bathroom or if she was having any pain. The ADON stated resident 4 was on the verge of sleep. The ADON stated she checked on resident 4 every so often because her office was right next to her room and that the assigned CNA was supposed to check on her too.On 11/24/25 at 10:58 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated she did not know if resident 4 was a fall risk but that she had had some falls. LPN 1 stated resident 4 stood up on her own but definitely needed assistance. LPN 1 stated resident 4's bed was low to the ground, her room was right next to the nurse's station, had no extra cords in the room so she did not get tangled in the cords, and she was consistently checked on but was not sure how often. LPN 1 stated it was everyone's responsibility to check on resident 4. LPN 1 stated resident 4 did not have a call light because of the cord and that she would not know how to push it if she did have one. LPN 1 stated she did not know why resident 4's door was kept shut but that her roommate would usually shut the door. LPN 1 stated they could hear when resident 4 would get up because she was very verbal and flailed before she got up and staff could hear that through the shut door. LPN 1 stated resident 4 did not have a fall mat because she might trip on it and that she did not remember resident 4 ever having a fall mat. LPN 1 stated resident 4 did not have a bed alarm or motion sensor and was not aware of her having those interventions before. LPN 1 stated she thought that resident 4 was checked on every hour and that was good timing to monitor the resident.On 11/24/25 at 11:00 AM, an interview was conducted with CNA 1. CNA 1 stated they check on resident 4 every hour but that the timing changed if she was more agitated. CNA 1 stated today she was checked on every hour but it could be every 30 minutes because she had been more agitated lately.On 11/24/25 at 1:54 PM, an interview was conducted with the DON and Corporate Nurse. The DON stated that resident 4 was a hard one because she has Huntington's disease and constant movement. The DON stated she was very unpredictable and would just stand up and walk toward you. The DON stated, she will just jump out of bed. The DON (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stated when resident 4 got up she could not walk safely and she would fall. The DON stated they tried to put down a fall mat about 4 months ago but they felt it was more of a fall risk. The DON stated she did not think the fall mat trial was documented anywhere in the medical record and that it might have been a conversation. The DON stated resident 4 would remove all items in her bed and that she removed all of her bedding and clothes and would hide stuff. The DON stated that they were trying to keep her safe and that that was a hard thing to do. The DON stated that resident 4 liked to be around people so they would try to keep her out in the common area but if there was too much noise it would make her agitated. The DON stated they kept her door shut to help calm her down because she would get migraines or agitated when there was too much noise. The DON stated resident 4 was not able to communicate but she could give you a thumbs up or down if you asked her if she was having pain. The DON stated she did not know how often staff were doing bathroom checks but the CNAs would check on her every 30 minutes to an hour. The DON stated they all worked together to make sure they took a look at her. The DON stated if the nurses noticed resident 4 was more agitated they would have the CNAs check on her more frequently. The DON stated that resident 4 was very loud and yelling when she got up so staff would hear her when her door was shut. The DON stated the IDT team did identify that her falls happened from midnight to 6:00 AM. The DON stated they were seeing more frequent falls at that time so they provided fall education and ensured staff were doing their rounding on residents.The DON stated that after each fall they meet as a team and discussed what might work for interventions to prevent falls and that they met for resident 4's falls and that there was nothing they could do but try to keep her out of her room and do frequent checks. The DON stated they had not discussed trying a silent alarm or motion detector. The Corporate Nurse stated the nurses would not hear the alarm going off or resident 4 getting out of bed if they were not at the nursing station.On 11/24/25 at 3:04 PM, an interview was conducted with the ADM. The ADM stated that residents with Huntington's were tough to manage at times. The ADM stated that they had resident 4's room close to the nurse's station and checked on her frequently. The ADM stated they had talked about putting some type of sensor but they were concerned that it would cause sensor fatigue for the staff because she moved so much. The ADM stated a pressure alarm was not effective. The ADM stated they tried a helmet but the resident would take it off, tug at it all of the time, and ripped the buckle part off so they ruled it as ineffective and discontinued its use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the food was not served in a sanitary manner and open spices were not dated. Findings included:On 11/24/25 during the tray line of lunch service the following was observed:a. At 11:55 AM, the [NAME] was observed to don gloves and was then observed to push a metal cart out of the way and then pull it back into position with a gloved left hand. The [NAME] was then observed to plate the lunch meal and use the dirty gloved left hand to touch the food as it was placed onto the plate.b. At 11:57 AM, the [NAME] was observed to use a washcloth to wipe off the cutting board near the tray line. The [NAME] was then observed to use the same wash cloth and wipe the edges of the plate to remove excess food. The wash cloth was observed to touch the food that had already been plated. c. At 11:59 AM, the same wash cloth was observed to be used to wipe the gloved hands of the [NAME] and then used to wipe the edge of another plate. The wash cloth was observed to touch the food that had already been plated. d. At 12:01 PM, the [NAME] was observed to reposition all of the food on a plate with the dirty gloved left hand. The [NAME] was then observed to wipe her hands with the wash cloth and and then wipe down the cutting board near the tray line.e. At 12:07 PM, the [NAME] was observed to clean her hands with the wash cloth then reposition some egg rolls on a plate using the dirty gloved left hand. f. At 12:08 PM, the [NAME] was observed to wipe around the edge of a plate with the soiled wash cloth while touching the food that had already been plated.g. At 12:13 PM, the [NAME] was observed to reposition the food on the plate with the dirty gloved left hand.h. At 12:21 PM, the [NAME] was observed to push the metal cart out of the way, pick up the meal tickets, and pull the cart back into place with the gloved left hand. The [NAME] was then observed to wipe her hands and wipe the edge of a plate with the soiled wash cloth. The [NAME] was then observed to place her entire left hand on the face of the plate, plate the food, then rearrange the food with the dirty gloved left hand. i. At 12:23 PM, the [NAME] was observed to remove a meal ticket that had fallen into the rice container and placed a spoonful of rice onto a plate. The [NAME] was observed to use her entire right hand to touch the face of a plate, plate the food, and then wiped the edge of the plate and touched the plated food with the soiled wash cloth. During the final kitchen inspection the following spices were observed to not have an open date:An 11 oz (ounce) container of parsley flakes.An 11 oz container of whole bay leaves.An 11 oz container of Italian seasoning.A 6 oz container of onion powder.A 6 oz container of garlic powder.A 6 oz container of Spanish paprika.A 6 oz container of light chili powder.A 6 oz container of whole rosemary leaves.A 6 oz container of ground black pepper.A 6 oz container of Cajun seasoning.A 6 oz container of dill weed.A 6 oz container of crushed red pepper.A 6 oz container of ground cumin. A 6 oz container of celery salt.A 6 oz container of rubbed sage.On 11/24/25 at 12:31 PM, an interview was conducted with the [NAME] who stated that they never dated the spices when they got them, they just opened them and used them. The [NAME] stated the wash cloth should not touch the food but it could be used to clean the plates. On 11/24/25 at 12:35 PM, an interview was conducted with the Dietary Manager (DM). The DM stated the staff should not touch the food with their hands or gloves that may be dirty. The DM stated they had already talked about this specific issue with the cook and that she should not touch the food and that she should change her gloves after she touches the carts. The DM stated that the staff should not wipe the plates with the dirty wash cloth that they used for cleaning. The DM stated they did not label the spices because they used them so quickly but the spices should be labeled.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined, for 1 of 16 sampled residents, that the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment; and the comprehensive care plan failed to describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Specifically, one resident sustained four falls and no new interventions were implemented on the care plan. Resident identifier: 4.Findings included:Resident 4 was admitted to the facility on [DATE] with diagnoses which included Huntington's disease, aphasia, anxiety disorder, post-traumatic stress disorder, and nondisplaced intertrochanteric fracture of left femur.Resident 4's medical record was reviewed from 11/17/25 through 11/24/25.A Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated resident 4 had short and long-term memory problems and severely impaired decision making skills regarding tasks of daily life. It further indicated resident 4 needed substantial/maximal assistance to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed and to transfer to and from a bed to a chair or wheelchair.A Care Plan Report initiated on 6/19/25 indicated a Focus of [Resident 4] continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting to injury prevention and quality of life. Risk for falls remains high but current plan priorities safety with the least restrictive measures. It indicated a Goal of, [Resident 4] will be free of falls with injury through the review date. It further indicated the following Interventions:Anticipate and meet the resident's needs. Keep frequently used items within reach. Date Initiated: 6/19/25Follow facility fall protocol if a fall occurs. Date Initiated: 6/19/25Provide resident with high low bed to improve safety. Date Initiated: 10/14/25Staff shall assist to provide the resident with a safe environment to reduce the risk for falls: even floors free from spills and/or clutter; adequate, glare-free light; handrails on walls in the hallway. Date Initiated: 6/19/25Staff to assist resident with a gait belt while transferring or ambulating. Date Initiated: 6/19/25Toilet riser to be placed on toilet to assist resident with toilet transfers for safety. Date Initiated: 6/19/25A Morse Fall Scale dated 6/20/25 at 8:03 AM indicated resident 4 was at a High Risk for Falling, had impaired gait, and overestimated or forgot her limits with her own ability to ambulate.An Event Note Template dated 8/18/25 at 6:16 AM indicated, resident 4 had a fall.Preventative Measures in Place Prior to Incident: resident has refused any interventions. New Interventions: Resident continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting to injury prevention and quality of life. Risk for falls remains high but current plan priorities (sic) safety with the least restrictive measures.It should be noted that there were no new interventions implemented on the care plan after the fall on 8/18/25.A Skilled Progress Note dated 8/29/25 at 7:29 PM indicated, Resident fell on floor around 2300 [11:00 PM]. When examining resident there is a new bump on the back right side of the head. It is not currently open or bleeding.It should be noted that there were no new interventions implemented on the care plan after the fall on 8/29/25.An Alert Note dated 10/12/25 at 3:46 AM indicated resident 4 had an unwitnessed fall.An Event Note Template dated 10/22/25 at 3:37 PM indicated, .Event Date/Time: 10/11/25 @ 0655 [6:55 AM] .Preventative Measures in Place Prior to Incident: resident has had several interventions in place but does not keep them in place. New Interventions: [Resident 4] continues to experience frequent falls despite environmental modification, therapy, assistive devices and medication optimization. Due (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465183	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spanish Fork Rehabilitation and Nursing	151 East Center Street Spanish Fork, UT 84660

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to progression of Huntington's disease with severe Chorea and cognitive decline, the focus of care is shifting toinjury [sic] prevention and quality of life. Risk for falls remains high but current plan priorities (sic) safety with the least restrictive measures.It should be noted that there were no new interventions implemented on the care plan after the fall, or falls, on 10/11/25 or 10/12/25.An Alert Note dated 10/30/25 at 7:45 AM indicated, I entered the residents room, and found her lying on the side of her bed on the flor [sic]. This was an unwitnessed fall.It should be noted that there were no new interventions implemented on the care plan after the fall on 10/30/25.On 11/24/25 at 1:54 PM, an interview was conducted with the DON and Corporate Nurse. The DON stated that resident 4 was a hard one because she has Huntington's disease and constant movement. The DON stated she was very unpredictable and would just stand up and walk toward you. The DON stated, she will just jump out of bed. The DON stated when resident 4 got up she could not walk safely and she would fall. The DON stated they tried to put down a fall mat about 4 months ago but they felt it was more of a fall risk. The DON stated she did not think the fall mat trial was documented anywhere in the medical record and that it might have been a conversation. The DON stated resident 4 would remove all items in her bed and that she removed all of her bedding and clothes and would hide stuff. The DON stated that they were trying to keep her safe and that that was a hard thing to do. The DON stated that resident 4 liked to be around people so they would try to keep her out in the common area but if there was too much noise it would make her agitated. The DON stated they kept her door shut to help calm her down because she would get migraines or agitated when there was too much noise. The DON stated resident 4 was not able to communicate but she could give you a thumbs up or down if you asked her if she was having pain. The DON stated she did not know how often staff were doing bathroom checks but the CNAs would check on her every 30 minutes to an hour. The DON stated they all worked together to make sure they took a look at her. The DON stated if the nurses noticed resident 4 was more agitated they would have the CNAs check on her more frequently. The DON stated that resident 4 was very loud and yelling when she got up so staff would hear her when her door was shut. The DON stated the IDT team did identify that her falls happened from midnight to 6:00 AM. The DON stated they were seeing more frequent falls at that time so they provided fall education and ensured staff were doing their rounding on residents.The DON stated that after each fall they meet as a team and discussed what might work for interventions to prevent falls and that they met for resident 4's falls and that there was nothing they could do but try to keep her out of her room and do frequent checks. The DON stated they had not discussed trying a silent alarm or motion detector. The Corporate Nurse stated the nurses would not hear the alarm going off or resident 4 getting out of bed if they were not at the nursing station.