STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465184	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Riverwalk	1012 West Jordan River Boulevard Midvale, UT 84047

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility did not inform each resident periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. Specifically, for 2 out of 3 sampled residents, 2 residents did not receive a Skilled Nursing Facility Beneficiary Notice of Non-coverage (SNF ABN) or a Notice of Medicare Non-Coverage (NOMNC) when one was due. Resident identifiers: 60 and 61.Findings included:Resident 60 was admitted to the facility on [DATE] with diagnoses which included myotonic muscular dystrophy, acute respiratory failure, and major depressive disorder.Resident 61 was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease, cervical disc disorder with radiculopathy, fusion of spine cervical region, polyneuropathy, dementia, and anxiety disorder.There were no NOMNC's located in resident 60 and 61's medical record. On 9/10/25 at 12:54 PM, an interview was conducted with the Administrator (ADM). The ADM stated the Resident Advocate should have provided a NOMNC to residents 60 and 61. The ADM stated they do not have to do those that often and only those two had to be completed over the last 6 months.

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 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 and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the reach-in refrigerator were not labeled, food in the walk-in refrigerator was not labeled and/or dated, and food in the walk-in freezer was open to air. Findings included:On 9/7/25 at 8:49 AM, an initial tour of the kitchen was conducted. In the reach-in refrigerator, 2 trays containing bowls of a white substance were covered with plastic wrap, but were not labeled or dated. In the walk-in refrigerator, a container of vanilla low-fat yogurt did not have an open date. During the observation, one of the dietary aides entered the walk-in refrigerator and returned a large container of mayonnaise to the shelf. It was approximately 3/4 empty. There was no open date on the lid. Also, a large plastic container of a red liquid was observed with no label or date on the container. In the walk-in freezer, a box of mixed vegetables was open to air, a box of frozen cookie dough was open to air, and a box of beef patties was open to air. On 9/10/25 at 1:50 PM, a follow up tour of the kitchen was conducted and an interview was conducted with the Dietary Manager (DM). The DM stated he received all the orders, checked the dates and ensured that food items were dated and put away. The DM stated that he provided education to the dietary staff once per month about important procedures in the kitchen. The DM stated the Registered Dietitian (RD) completed weekly audits of the kitchen to ensure it was clean, that food was properly stored and labeled and that the temperatures were correct. The DM stated his expectation of his staff when taking items from the refrigerator and freezer was that they return it and make sure it was labeled, dated and sealed to prevent spoilage. The DM stated that he checked to make sure food items were properly stored.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined, for 3 of 39 sampled residents, 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, staff did not use personal protective equipment (PPE) when administering medications through a peripherally inserted central catheter (PICC) line, staff did not wear PPE when entering resident rooms with contact precautions and PPE was not worn in enhanced barrier precautions (EBP) rooms. Resident identifiers: 11, 41, 85 Findings include:1. On 9/9/25 at 8:15 AM, the west hallway morning medication pass was observed. Registered Nurse (RN) 1 was observed to enter the room of resident 11 with oral medications and exited without the medications. RN 1 stated she had administered the oral medications to resident 11. RN 1 was not observed to have donned gloves or a gown prior to entering the room. Resident 11's door was observed to have a contact precautions sign in place that required all who entered the room to wear at a minimum a gown and gloves. On 9/9/25 at 8:25 AM, RN 1 was observed to again enter the room of resident 11 with no PPE (personal protective equipment) in place and administer additional medications to resident 11. On 9/9/25 at 8:45 AM, RN 1 was observed to enter the room of resident 85. The door to resident 85's room was observed to have a contact precautions sign attached to the wall next to the door. RN 1 was observed to sit resident 85 up in bed, touch her mug, adjust her bedding and wiped the resident's mouth. RN 1 was not observed to don gloves or a gown prior to administering the resident's medications. RN 1 was then observed to exit the room, no hand hygiene was not used and RN 1 was observed to touch the mouse and the computer on the medication cart. At 8:55 AM RN 1 re-entered resident 85's room without donning any PPE. RN 1 was then observed to remove the cap from the gray line of the PICC and flush the line with Normal Saline and attached intravenous Daptomycin. RN 1 was then observed to remove the cap from the white line of the PICC, flush the line with Normal Saline and attached intravenous Tigecycline. RN 1 did not use gloves during the medication administration. On 9/9/25 at 8:56 AM, an interview was conducted with RN 1. RN 1 stated resident 85 was on contact precautions for per PICC line and the staff should all wear a gown and gloves when they provided cares for resident 85's PICC line. RN 85 stated she did not use any PPE when she administered the antibiotics and she should have worn at least gloves when she administered her medications. On 9/10/25 at 10:39 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses were expected to follow physician orders and administer them as they were ordered, they were expected to contact the provider for clarification, if they had a question. The DON stated in regard to PICC lines the nurses were always supposed to use hand hygiene, wear appropriate PPE, flush to ensure patency, attached the appropriate antibiotic, disconnect and flush and attach a new cap. The DON stated if the resident had a PICC line the nurse were expected to wear a gown and gloves. The DON stated that the nurses were required to wear gloves and\ appropriate PPE if they were in a contact isolation room, doing cares or administering medications. 2. Resident 11 was admitted to the facility on [DATE] with diagnoses which included paraplegia, urinary tract infection, pressure ulcer stage 4 right and left buttock, methicillin-resistant staphylococcus aureus (MRSA) and sepsis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/7/25 at approximately 9:30 AM, an observation was made of room [ROOM NUMBER] where resident 11 resided. There was a sign outside the room that revealed contact precautions and EBP. The contact precautions sign revealed Everyone must clean their hand, including before entering and when leaving the room. Providers and Staff must also put on gloves before room entry discard gloves before room exit. Put on gown before room entry discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use disposable equipment. Clean and disinfect reusable equipment before use on another person. On 9/7/25 at 10:11 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated resident 11 had EBP precautions because he had a wound and catheter. LPN 1 stated there was a contact precautions outside the room because the facility ran out of EBP signs. On 9/7/25 at 11:58 AM, an observation was made of room [ROOM NUMBER]. The Certified Nursing Assistant (CNA) coordinator was observed to enter room [ROOM NUMBER] with no PPE. The CNA coordinator was observed to take resident 11's meal in and put it on the overbed table with no PPE. Resident 11's medical record was reviewed on 9/7/25. A physician's order dated 8/15/25 revealed resident 11 was to have contact precautions and staff needed to put on gloves and gown before entering and discard before exiting. On 9/10/2025 at 2:08 PM, an interview was conducted with the DON. The DON stated if a resident was on contact isolation all staff members were required to wear a gown along with gloves, at the very least, when entering the resident's room. The DON stated anyone who broke the entry point of the room should have worn PPE and those residents on contact isolation should have a contact isolation sign outside of their door. The DON stated staff were made aware of those residents who were on isolation through report and on admission an assessment was completed to determine if they have anything contagious. The DON stated resident 11 had an active ESBL (Extended Spectrum Beta-Lactamases) infection in his urine that was being treated with intravenous Gentamycin and he was on contact precautions. The DON stated anyone who entered his room should have worn a gown and gloves regardless of why they were in the room, even if it was just to pass food trays. 3. Resident 41 was admitted to the facility on [DATE] with diagnoses that included non-intracerebral hemorrhage intraventricular, ankylosing spondylitis of multiple sites in the spine, apraxia, dysphagia, severe protein-calorie malnutrition, hemiplegia and hemiparesis. On 9/9/25 at 9:57 AM, an observation was made of Certified Nursing Assistant (CNA) 1. CNA 1 entered resident 41's room without donning personal protective equipment (PPE) to change his brief. CNA 1 awakened resident 41 and told him she was going to check his brief and change it. CNA 1 closed the curtain to provide privacy. CNA 1 was observed to be wearing a gown. On 9/9/25 at 10:02 AM, an interview was conducted with CNA 1 as she exited resident 41's room. CNA 1 stated resident 41 was totally dependent on staff for his care. CNA 1 stated resident 41 was a 1 person assist for brief changes. CNA 1 stated staff check resident 41's brief every hour, but change him every 2 hours if he did not need it sooner. CNA 1 stated resident 41 was not on any enhanced precautions. CNA 1 stated she had been working at the facility for about a week and asked about it when she started. CNA 1 stated she was told resident 41 was not on any enhanced precautions. When asked if she knew what enhanced barrier precautions were, CNA 1 glanced at the sign outside of resident 41's door and stated, yes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 41's medical records were reviewed between 9/7/25 and 9/11/25. Resident 41's physician orders for enteral feedings. A review of resident 41's care plan revealed: [Resident 41] requires enhanced barrier precautions r/t [related to] feeding tube. With a goal of remaining free of transfer infection of an MDRO [multi-drug resistant organism]. The interventions were staff wearing gown and gloves per facility protocol for dressing, bathing, transferring, hygiene, changing linens, changing briefs, assisting with toileting, device care, feeding tube care, and wound care. On 9/9/25 at 10:45 AM, an interview was conducted with CNA 2 who stated enhanced barrier precautions were for residents who had a foley catheter, open wounds, were incontinent, etc. and she stated the staff were required to use PPE when having contact with the residents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that 1 of 39 sample residents who was continent of bladder on admission receives services and assistance to maintain continence. Specifically, one resident who was continent upon admission later became incontinent and was not on a toileting program. Resident identifier: 24. Findings include: Resident 24 was admitted to the facility on [DATE] which included hemiplegia, malignant neoplasm of brain, obesity, hyperlipidemia and mild cognitive impairment. An admission Minimum Data Set (MDS) dated [DATE] revealed resident 24 was always continent of bladder. Quarterly MDS's dated 2/22/24 through 7/3/25 revealed resident 24 was frequently incontinent of bladder and was not on a toileting program (TP). On 1/22/24, an admission Assessment was completed for resident 24. The assessment indicated that the resident was fully continent of urine. Review of resident 24's care plan revealed the following: a. On 1/25/24, the resident was documented as having an Activities of Daily Living (ADL) performance deficit related to incontinence. The care plan also revealed that the resident required up to partial/moderate assist of one staff with toileting. b. On 1/25/24, the resident was documented as being at risk for episodes of bowel [and] bladder incontinence [related to] impaired mobility, ADL's (sic) limitations, [Left] ankle weakness, diuretic use. The care plan revealed that the resident was using disposable briefs.c. On 11/26/24, resident 24 was documented to be using disposable briefs. The care plan did not indicate if a TP was in place for resident 24. Skilled Nursing notes for resident 24 from admission through 2/2/24 indicated that the resident was voiding independently but did require assistance with toilet use. On 2/3/24, staff began documenting in the skilled progress notes that the resident was incontinent of urine. Review of resident 24's progress notes revealed the following: On 1/22/24, the resident was documented as being continent of bladder. On 1/29/24, the resident was complaining of burning with urination and frequency. The physician was notified and ordered facility staff to push fluids and continue to monitor. On 2/3/24, The patient will call for the CNA (Certified Nursing Assistant) every 30 minutes to be transferred to the toilet starting at 1800 6:00 PM). The CNA has repeatedly tried to let the patient know that due to the shift change and the other patients she needs to care for as well that the transfer cannot happen at such a rate. The patient refuses a request to have a brief on so that if the toilet transfer cannot happen as fast as the resident needs to occur avoiding the wet clothes and linens. Once the patient falls asleep the call light is utilizedto (sic) transfer the patient to the toilet if needed has slowed to a manageable pace for the CNA.On 2/6/25, the resident was documented as continuing to have symptoms of a urinary tract infection. No documentation could be located that provided information regarding resident 24's change in continence status. In addition, no documentation could be located regarding the potential use of a TP to restore, if possible, the resident's urinary continence status. On 9/10/25 at 3:49 PM, an interview was conducted with CNA 3. CNA 3 stated that resident 24 was incontinent of urine and wore incontinence briefs. CNA 3 stated that resident 24 was not on a specific toileting program. On 9/10/25 at 3:27 PM, an interview was conducted with CNA 4. CNA 4 stated that resident 24 thinks she is continent but that the resident was actually incontinent of urine. CNA 4 stated that resident 24 was not on a specific toileting program. On 9/10/25 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that facility staff did not document if a resident was on a TP. The DON stated that staff were supposed to encourage continence by frequently offering to toilet residents. The DON stated that upon admission, a resident's urinary continence status was evaluated by a nurse. However, the DON stated he was unsure how the status was communicated to the CNAs. On 9/10/25 the facility policy regarding Urinary Incontinence was reviewed. The policy indicated that as part of the initial assessment, the physician will help identify individuals with impaired urinary continence. The policy also indicated that the physician would identify potentially treatable medical (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and psychiatric conditions related to urinary incontinence, order appropriate diagnostic tests and categorize the incontinence. The policy further indicated that facility staff would identify environmental interventions and assistive devices that facilitate toileting, and based on the assessment would provide scheduled toileting or other interventions to try to improve the individual;s continence status. [Note: It should be noted that the first provider note to be included in resident 24's medical record was not until 4/3/24 by a nurse practitioner, which was approximately 90 days after the resident was admitted . The nurse practitioner did not address resident 24's continence status. Additional progress notes after this date also did not address the resident's continence status per facility policy.]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not provide routine and emergency drugs and biologicals to 1 of 39 sample residents. Specifically, one resident did not have 6 medications available for administration on multiple occasions. Resident identifier: 5. Findings include:Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pulmonary edema, chronic obstructive pulmonary disease, pulmonary hypertension, congestive heart failure, protein calorie malnutrition, chronic respiratory failure, osteoporosis, diabetes mellitus, and chronic kidney disease. Resident 5's medical record was reviewed between 9/7/25 through 9/10/25. Resident 5's May 2025 Medication Administration Record (MAR) was reviewed. The following medications were documented as not being administered per the physician's order: Lactobacillus Rhamnosus oral packet, one packet by mouth one time a day. The medication was not administered on 5/2/25 or 5/3/25. The medication was discontinued on 5/3/25. Lansoprazole oral suspension 3 milligrams (mg) per milliliter (ml), 10 ml by mouth one time a day. The medication was not administered on 5/2/25. The medication was discontinued 5/2/25. LidoPro External Patch 4-4-5 % (Methyl SalicylateLidocaine-Menthol), Apply to affected area topically one time a day in the morning. The medication was not administered on 5/2/25, 5/3/25, or 5/4/25. The medication was discontinued on 5/5/25. Pantoprazole Sodium Oral Packet 40 mg, 40 mg by mouth one time a day. The medication was not administered on 5/2/25.The medication was discontinued on 5/20/25. Advair HFA Inhalation Aerosol 230-21 microgram per actuation (MCG/ACT) 2 puffs inhaled orally two times a day. The medication was not administered on 5/1/25, 5/2/25, 5/3/25, 5/4/25, 5/5/25, 5/6/25, or 5/7/25.Vitron-C Oral Tablet 65-125 MG, one tablet by mouth two times a day. The medication was not administered on 5/2/25 and 5/3/25. The medication was discontinued on 5/3/25. Nursing progress notes were reviewed for the above listed dates. No documentation could be located to indicate why the above listed medications were not administered on the appropriate dates. On 9/10/25 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the pharmacy made deliveries to the facility multiple times a day. The DON also stated that the pharmacy was available to make stat or immediate medication deliveries as well. When asked about the medications that were not administered to resident 5 as documented on the May 2025 MAR, the DON stated that he did not know why the medications were not administered.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that 1 of 39 sample residents' drug regimen was free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate drug therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued. Specifically, a resident received a medication used to treat hypotension outside of prescribed parameters. Resident identifier: 5. Findings include: Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included pulmonary edema, chronic obstructive pulmonary disease, pulmonary hypertension, congestive heart failure, protein calorie malnutrition, chronic respiratory failure, osteoporosis, diabetes mellitus, and chronic kidney disease. Resident 5's medical record was reviewed between 9/7/25 through 9/10/25. Resident 5 had a physician order dated 5/1/25 to administer Midodrine hydrochloride (HCl), 2.5 milligrams (mg) by mouth every 6 hours for systolic blood pressure (SBP) below 100. Resident 5's May 2025 Medication Administration Record (MAR) was reviewed. The following was documented: On 5/2/25 at 6:00 AM, the SBP was 100, however the medication was documented as administered.On 5/2/25 at 6:00 PM, no blood pressure (BP) was documented as having been obtained. On 5/3/25 at 6:00 AM, no BP was documented as having been obtained. On 5/3/25 at 12:00 PM, the SBP was 100, however the medication was documented as administered.On 5/3/25 at 6:00 PM, no BP was documented as having been obtained.On 5/4/25 at 6:00 AM, no BP was documented as having been obtained. On 5/5/25 at 12:00 AM, the SBP was 105, however the medication was documented as administered. On 5/5/25 at 6:00 AM, the SBP was 108, however the medication was documented as administered. On 5/6/25 at 12:00 PM, the SBP was 146, however the medication was documented as administered.On 5/7/25 at 6:00 AM, the SBP was 104, however the medication was documented as administered. On 5/8/25 at 12:00 AM, the SBP was 100, however the medication was documented as administered. On 5/8/25 at 6:00 AM, the SBP was 100, however the medication was documented as administered. On 5/8/28 at 6:00 PM, no BP was documented as having been obtained. On 5/9/25 at 12:00 PM, no BP was documented as having been obtained. On 5/10/25 at 6:00 AM, the SBP was 118, however the medication was documented as administered. On 5/10/25 at 12:00 PM, the SBP was 108, however the medication was documented as administered. On 5/11/25 at 6:00 PM, the SBP was 118, however the medication was documented as administered. On 5/12/25 at 12:00 AM, the SBP was 107, however the medication was documented as administered. [Note: It should be noted that for the above listed errors, multiple nurses administered the medication incorrectly per the staff initials listed on the MAR.] On 9/10/25 at 1:26 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that the electronic health record prompted staff to enter a blood pressure prior to documenting that the Midodrine was administered. The May 2025 MAR was reviewed with RN 2, and RN 2 confirmed that the medication was administered outside of prescribed parameters. On 9/10/25 at 1:50 PM, an interview was conducted with the Director of Nursing (DON). The DON reviewed the May 2025 and confirmed that the medication had been administered outside of prescribed parameters.