STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A058	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Ridge Rehabilitation and Nursing	455 South 900 East Salt Lake City, UT 84102

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect each resident's right to be free from neglect for 1 of 19 residents. Specifically, facility staff failed to provide the necessary care and supervision required to maintain a safe environment for a resident with known impulsivity and severe cognitive impairment. This failure occurred when a Registered Nurse (RN) left a medication cart unlocked and unattended, in direct violation of facility policy and the resident's specific care plan interventions dated 9/17/25. This breach in safety protocols allowed the resident to access the unsecured cart and ingest multiple medications not prescribed to him. This resulted in a significant change in the resident's condition, including an altered mental status and life-threatening electrolyte imbalances, which required emergency medical transfer and admission to a Medical Intensive Care Unit (MICU). This will be cited at a harm level. Resident Identifier: 32.Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included human immunodeficiency virus, paranoid schizophrenia, and schizoaffective disorder.Review of resident 32's medical record was completed on 6/1/26 through 6/4/26.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 32 had a Brief Interview of Mental Status (BIMS) score of 0 which indicated severely impaired cognition. On 3/13/26 at 12:10 PM, an Event Note Template revealed the following: Event Date/Time: 3/4/26 @ [at] 1130 [11:30 AM] Event Description: Staff found medication cards in residents [sic] room, staff immediately notified nursing and management. A medication error occurred involving the above-named resident. The resident accessed the medication cart after it was left unlocked and unattended. The resident was able to obtain and self-administer medications without staff supervision. Shortly thereafter, the resident exhibited signs of altered mental status (AMS), including confusion and decreased level of awareness. The resident also demonstrated an unsteady gait, increasing fall risk . A thorough search of the resident's room was conducted, which resulted in the discoveryof [sic] multiple medication cards in the resident's possession .DON [Director of Nursing] and provider were notified immediately. Emergency medical services (EMS) were activated due to change in condition. Resident was transferred to the emergency department for further evaluation and treatment . Root cause: Resident was able to access unlocked and unattended medication cart and took med cards and pills . Preventative Measures in Place Prior to Incident: Educated staff to ensure back is never turned to resident while pulling medication, re educated [sic] nurses that they are not to leave meds with residents, med audits will be completed on all nurses.A review of the inpatient admission notes from 3/4/26 through 3/12/26 revealed the following: [resident 32] was brought in by EMS [Emergency Medical Services] from his care facility after they found empty sheets of blister packs for abilify 2mg [milligrams], Eliquis 5mg, desmopressin dose unknown, atorvastatin 40 mg, metoprolol XL100 mg, doxycycline 20 mg, melatonin dose unknown, and zofran dose unknown. It is unclear how much of any of these medications he may have taken, could have taken none, could have taken several of each individual medication. Apparently these were in bubble packs on a cart near his room. This was not discovered unto [sic] some time after ingestion but timing is unclear. He was admitted to MICU [Medical Intensive Care Unit] for management of (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 0600 Level of Harm - Actual harm Residents Affected - Few	hyponatremia, (initially 117) with increased urine output likely 2/2 [secondary] to that ingestion. Patient was placed on a 1:1 sitter, sodium has been uptrending without intervention to 130, and patient's home medications for schizophrenia have been restarted. Still holding BP [blood pressure] meds due to some softer BP readings . Upon my interview [resident 32]was awake and alert but minimally interactive. He reported having right arm pain and right foot numbness. When asked why he was in the hospital he did endorse taking medications but did not respond when asked if this was in an effort to self harm or commit suicide, additionally, he was unable to answer whether or not he was having thought [sic] of self harm/suicidal ideation/ homicidal ideation. A review of the resident's medical record indicated that Resident 32 did not have active medication orders for the following:Abilify 2 mgEliquis 5 mgDesmopressinAtorvastatin 40 mgMetoprolol XL 100 mgDoxycycline 20 mgMelatoninZofranOn 2/21/25, a care plan for resident 32 was initiated and the focus was, Resident has mental health diagnoses of anxiety and schizophrenia and requires the use of psychotropic medications with an intervention added on 9/17/25, resident is extremely impulsive, position medication cart so the nurses back is never towards the residents.On 3/4/26 the facility initiated a Critical Incident Response Plan. The Quality Assurance and Performance Improvement (QAPI) Performance Improvement Plan (PIP) Action Plan documented the following: The facility failed to ensure medications were securely stored and failed to maintain a hazard-free environment when a medication cart was left unlocked and unattended. As a result, a resident accessed and ingested medication, resulting in actual harm that required transfer and admission to the hospital. Identified Concern: Failure to Maintain a Hazard-Free Environment (F689). Medication cart left unlocked and unattended. Resident was able to independently access and remove medication. Lack of adequate supervision to prevent access to hazardous substances. Failure to Secure Medications (F761) Medications were not stored in a locked compartment. Controlled access safeguards were not maintained. Failure to follow facility policy regarding medication cart security. Potential Risk to Patient. Resident ingested medication not prescribed to them. Sent out for emergency transfer to hospital for evaluation and treatment. Required hospital admission, with possibility of adverse outcome. Systemic Risk to Other Residents. Potential for additional residents to access unsecured medications. Possible pattern of noncompliance if carts are routinely left unsecured. Inadequate staff education and/or competency validation regarding medication security. Root Cause Identified: The root cause of this incident was a systemic failure in the facility's medication management and oversight processes, including staff noncompliance with medication cart security policy and ineffective competency validation and supervisory monitoring to ensure sustained adherence to required medication storage standards.On 3/16/26 at 1:21 PM, a MD Progress Note revealed the following, Note Text: admission history and physical cc [chief complaint]: Are you going to give me meds HPI [History of Present Illness]: [Resident 32] is a [AGE] year old male with a history of HIV [Human Immunodeficiency Virus] and paranoid schizophrenia who was admitted to the [name redacted] hospital 3/4 [2026] after ingesting meds that were not prescribed to him. He was admitted to the MICU [medical intensive care unit]. He had a sodium level of 117. His condition stabilized and then he was admitted to the psychiatric unit as he told hospital staff he wanted to die at the time he took the meds. He told the psychiatrist he was no longer suicidal.On 6/4/26 at 11:37 AM, an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated that if she ever saw the medication cart unlocked she would lock it or stay near it until the nurse returned. CNA 3 stated that as a CNA she knows not to leave the medication cart unlocked and unattended because it only takes seconds for something to happen, especially in a facility that takes care of residents with mental health needs. On 6/4/26 at 11:52 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that when the medication cart is unattended it should always be locked. LPN 1 stated that the population of residents served in the facility would make it very unsafe to leave any type of medication unattended.On 6/4/26 at 1:23 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that when resident 32's room was being (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	cleaned, multiple medication blister packs were found. The RDCS stated it was discovered that the Registered Nurse (RN) had left the medication cart unlocked and unattended, at which time resident 32 removed multiple blister packs from the cart. The RDCS stated that resident 32 presented with an altered level of consciousness, EMS was notified, and the resident was transported to the emergency department. The RDCS stated that the RN's employment with the facility was terminated due to a violation of facility policy regarding leaving a medication cart unlocked and unattended.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure that the transfer and discharge process was properly documented and that the required notifications were sent to the Office of the State Long-Term Care Ombudsman. Specifically, for 3 of 19 residents who were reviewed, the facility failed to maintain evidence that a copy of the written transfer notice was sent to the Ombudsman at the time of the transfer. Resident Identifiers: 2, 20, and 40.1. Resident 20 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included acute respiratory failure with hypoxia, schizophrenia, and acquired absence of lung. A review of resident 20's progress notes revealed the following hospital transfers:4/24/26 at 5:13 AM, a health status note documented, Resident was c/o [complaining of] 10/10 burning stomach pain. He started vomiting. He notified me that yesterday he had dark red stool. He stated he wanted to go to the hospital. He left via EMS [emergency medical services] to [name readacted]. Provider notified.5/11/26 at 4:37 AM, a discharge summary documented, Resident discharge location: [name redacted] HospitalResident 20's medical record was reviewed from 6/1/26 through 6/4/26. There was no documentation in the record that the facility had sent a copy of the written transfer notice to the Ombudsman.2. Resident 40 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included unspecified intracranial injury without loss of consciousness and dementia with mood disturbance.A review of resident 40's progress notes revealed the following hospital transfers:10/20/25 at 5:18 AM, a transfer to hospital summary documented, Resident was observed yelling throughout the night, more than usual.Staff immediately called 911, and the resident was transported via EMS to [name redacted] Hospital in Salt Lake for further evaluation and treatment. The provider, Director of Nursing, Administrator, and family were notified.11/13/25 at 9:46 AM, a discharge summary documented, Discharge/transfer location:: [name redacted] ED [emergency department], Mode at transportation at time of discharge/transfer:: [name redacted] EMS, Reason for Transfer/discharge: Labored breathing, Rhonchi and wheezing throughout lobes. Decreased responsiveness11/25/25 at 12:37 PM, a discharge summary documented, Discharge/transfer location:: [name redacted] ED, Mode at transportation at time of discharge/transfer:: [name redacted] EMS, Reason for Transfer/discharge: Fell out of WC [wheelchair] Onto [sic] dining room floor receiving a laceration above left eyebrow.Resident 40's medical record was reviewed from 6/1/26 through 6/4/26. There was no documentation in the record that the facility had sent a copy of the written transfer notice to the Ombudsman.3. Resident 2 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes, unspecified dementia, major depressive disorder, borderline personality disorder, and sepsis.On 6/1/26 at 10:39 AM, an interview was conducted with resident 2. Resident 2 stated that she had been transferred to several emergency rooms since she was admitted to the facility. A review of resident 2's progress notes revealed the following hospital transfers:On 7/16/25 at 11:16 PM, a health status note documented, Resident approached me wanting to go to the ER [emergency room] for pain unrelieved with current analgesics. She is c/o [complaining of] pain on her left hip that radiates down to her stump. Resident wanting an mri [magnetic resonance imaging] and to go to hospital. [Name redacted] notified and [name redacted] . On 8/17/25 at 10:27 AM, a discharge summary documented, Patient is complaining of nausea and vomiting. Patient is refusing to take any prescribed medications, insulin, blood glucose checks, or vitals. Patient is requesting to be transferred to the hospital due top [sic] her nausea.On 9/22/25 at 11:35 PM, a transfer to hospital summary documented, Resident called 911 and was transferred to [local hospital] due to complaints of sharp, burning pain in the bladder area and right leg. On 9/28/25 at 5:44 PM, a discharge summary documented, Pt [patient] requested to go to the ER for her persistent N/V [nausea and vomiting] and pain. Pt assessed and neurological status is normal, Respirations normal, and BG [blood glucose] is (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	236. Providers notified. On 10/6/25 at 12:30 AM, an alert note documented, pt went to the ED [emergency department] due to break through pain that was not managed with the medication she is currently prescribed. she came back after two hours and is now going to bed.On 10/14/25 at 12:30 AM, a transfer to hospital summary documented, Resident reported experiencing significant pain in her back and bladder and stated she wanted to go to the hospital. Resident refused PRN [as needed] pain medication when offered. Staff explained that she would need to wait for the physician's order for hospitaltransfer [sic], but the resident declined and independently called 911. On 10/17/25 at 10:43 PM, a health status note documented, The resident reported experiencing pain in her right foot on a scale of 8/10 and requested a lidocaine external patch. Provider was notified, and an order was placed for the patch. after an hour of using the patch, resident returned, stating that her pain had not improved and that she would call 911.the Resident decline [sic] to take her PRN pain pill and insisted on being sent to the hospital. Staff explained that she should wait for the providers advice, but refused and proceeded to call 911.On 10/20/25 at 1:50 AM, a transfer to hospital summary documented, Resident reported significant pain during urination and expressed a desire to go to the hospital. PRN pain medication was offered but refused by the resident. Staff explained that a physician's order would be required for hospital transfer; however, the resident declined to wait and independently called 911.On 10/25/25 at 12:50 AM, a nurses note documented, Late Entry: At 0020 [12:20 AM] 0n [sic] 10/25/25, resident came asking for BG check two hours after administering her 35 unit glargine. The BG level was 415. Staff informed resident to wait for the providers order since resident requested .[sic] short acting insulin. Resident insist (sic) on not waiting for the on-call provider's order. She immediately called 911 to be sent to the hospital. Pt was asymptomatic and denied any symptom related to hyperglycemia.On 11/3/25 at 12:10 AM, a transfer to hospital summary documented, Resident complained of intense right leg pain and stated a desire to go to the hospital. PRN pain medication was offered but declined. Staff explained that hospital transfer required a physician's order, but the resident opted not to wait and independently called 911. EMS [emergency medical services] responded, and the resident was transported to [name redacted] for further assessment and care.On 11/11/25 at 7:30 PM, a transfer to hospital summary documented, At approximately 19:25 [7:25 PM], the resident called 911, reporting nausea and stating that she did not feel well. Emergency Medical Crew arrived, and the resident was transported from the room via stretcher. On 11/12/25 at 2:32 PM, a nurses note documented, pt reported nausea and abdominal pain. gave prn zofran and reglan. pt reported no relief. encouraged fluids. pt requested to be sent to ER. NP [nurse practitioner] was in building and assessed pt. pt still requested to be sent out. pt reported feeling like she was in DKA [diabetic ketoacidosis].On 11/25/25 at 10:50 PM, a transfer to hospital summary documented, Resident reported experiencing intense left leg pain and expressed a desire to be transferred to the hospital. PRN pain medication was offered but the resident declined. Staff explained that a hospital transfer would require a physician's order; however, the resident chose not to wait and independently contacted 911. The resident was transported. On 12/18/25 at 6:45 AM, a health status note documented, Resident returned from [name redacted] with EMS. AAO [awake, alert, and oriented] to person, place, time and situation. No SOB [shortness of breath], chest pain or acute distress.On 12/28/25 at 8:45 PM, a health status note documented, Late Entry: Resident returns from ED visit. No new orders were given.On 2/8/26 at 12:08 AM, a transfer to hospital summary documented, Resident c/o 10/10 right knee pain. She iitially [sic] stated that all prns would not be effective and she wants to go to the hospital. She then did agree to take tylenol but then stated she wanted to go to the hospital. Spoke with provider and called EMS.On 2/8/26 at 11:37 PM, a health status note documented, Patient continued to complain of knee pain following an unwitnessed fall outside. Patient is alert and oriented x4. Patient was sent to [name redacted] Hospital. On 2/13/26 at 11:30 PM, a transfer to hospital summary documented, Resident stated she wants to go to the ER due to UTI [urinary tract infection] s/s [signs and symptoms] and pain.On 2/19/26 at 9:35 PM, a transfer to hospital summary documented, Resident left via ambulance to (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[name redacted] hospital d/t [due to] right knee pain. Provider approved transfer.On 2/21/26 at 12:36 AM, a transfer to hospital summary documented, Resident was taken to the [name redacted] hospital vis [sic] ambulance. Provider notified.On 3/2/26 at 9:47 PM, a health status note documented, Resident called 911 and was transported to [name redacted] Hospital via ambulance on stretcher.Resident 2's medical record was reviewed from 6/1/26 through 6/4/26. There was no documentation in the record that the facility had sent a copy of the written transfer notice to the Ombudsman.On 6/4/26 at 12:50 PM, an interview was conducted with the Administrator (ADM). The ADM stated that staff filled out a discharge summary before residents were transferred to the hospital. The ADM stated that he was unable to locate any notifications that were made to the Ombudsman in regards to hospital transfers, but it was part of their process.

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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** Based on observation, interview, and record review, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. Specifically, 4 out of 19 residents, resident 32 obtained medications independently from an unsecured, unlocked medication cart. This will be cited at a harm level. In addition, the facility failed to implement new or revised interventions after consecutive falls. Resident 40 will also be cited at a harm level. Resident Identifiers: 2, 26, 32, and 40.HARM1. Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included human immunodeficiency virus, paranoid schizophrenia, and schizoaffective disorder.Review of resident 32's medical record was completed on 6/1/26 through 6/4/26.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 32 had a Brief Interview of Mental Status (BIMS) score of 0 which indicated severely impaired cognition. On 3/13/26 at 12:10 PM, an Event Note Template revealed the following: Event Date/Time: 3/4/26 @ [at] 1130 [11:30 AM] Event Description: Staff found medication cards in residents [sic] room, staff immediately notified nursing and management. A medication error occurred involving the above-named resident. The resident accessed the medication cart after it was left unlocked and unattended. The resident was able to obtain and self-administer medications without staff supervision. Shortly thereafter, the resident exhibited signs of altered mental status (AMS), including confusion and decreased level of awareness. The resident also demonstrated an unsteady gait, increasing fall risk . A thorough search of the resident's room was conducted, which resulted in the discoveryof [sic] multiple medication cards in the resident's possession .DON [Director of Nursing] and provider were notified immediately. Emergency medical services (EMS) were activated due to change in condition. Resident was transferred to the emergency department for further evaluation and treatment . Root cause: Resident was able to access unlocked and unattended medication cart and took med cards and pills . Preventative Measures in Place Prior to Incident: Educated staff to ensure back is never turned to resident while pulling medication, re educated [sic] nurses that they are not to leave meds with residents, med audits will be completed on all nurses.A review of the inpatient admission notes from 3/4/26 through 3/12/26 revealed the following: [resident 32] was brought in by EMS [Emergency Medical Services] from his care facility after they found empty sheets of blister packs for abilify 2mg [milligrams], Eliquis 5mg, desmopressin dose unknown, atorvastatin 40 mg, metoprolol XL100 mg, doxycycline 20 mg, melatonin dose unknown, and zofran dose unknown. It is unclear how much of any of these medications he may have taken, could have taken none, could have taken several of each individual medication. Apparently these were in bubble packs on a cart near his room. This was not discovered unto [sic] some time after ingestion but timing is unclear. He was admitted to MICU [Medical Intensive Care Unit] for management of hyponatremia, (initially 117) with increased urine output likely 2/2 [secondary] to that ingestion. Patient was placed on a 1:1 sitter, sodium has been uptrending without intervention to 130, and patient's home medications for schizophrenia have been restarted. Still holding BP [blood pressure] meds due to some softer BP readings . Upon my interview [resident 32] was awake and alert but minimally interactive. He reported having right arm pain and right foot numbness. When asked why he was in the hospital he did endorse taking medications but did not respond when asked if this was in an effort to self harm or commit suicide, additionally, he was unable to answer whether or not he was having thought [sic] of self harm/suicidal ideation/ homicidal ideation. A review of the resident's medical record indicated that Resident 32 did not have active medication orders for the following:Abilify 2 mgEliquis 5 mgDesmopressinAtorvastatin 40 mgMetoprolol XL 100 mgDoxycycline 20 mgMelatoninZofranOn 3/4/26 the facility initiated a Critical Incident Response Plan. The Quality Assurance and Performance Improvement (QAPI) Performance (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Improvement Plan (PIP) Action Plan documented the following: The facility failed to ensure medications were securely stored and failed to maintain a hazard-free environment when a medication cart was left unlocked and unattended. As a result, a resident accessed and ingested medication, resulting in actual harm that required transfer and admission to the hospital. Identified Concern: Failure to Maintain a Hazare-Free Environment (F689). Medication cart left unlocked and unattended. Resident was able to independently access and remove medication. Lack of adequate supervision to prevent access to hazardous substances. Potential Risk to Patient. Resident ingested medication not prescribed to them. Sent out for emergency transfer to hospital for evaluation and treatment. Required hospital admission, with possibility of adverse outcome. Systemic Risk to Other Residents. Potential for additional residents to access unsecured medications. Possible pattern of noncompliance if carts are routinely left unsecured. Inadequate staff education and/or competency validation regarding medication security. Root Cause Identified: The root cause of this incident was a systemic failure in the facility's medication management and oversight processes, including staff noncompliance with medication cart security policy and ineffective competency validation and supervisory monitoring to ensure sustained adherence to required medication storage standards.On 6/4/26 at 1:23 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that when resident 32's room was being cleaned, multiple medication blister packs were found. The RDCS stated it was discovered that the Registered Nurse (RN) had left the medication cart unlocked and unattended, at which time resident 32 removed multiple blister packs from the cart. The RDCS stated that resident 32 presented with an altered level of consciousness, EMS was notified, and the resident was transported to the emergency department. The RDCS stated that the RN's employment with the facility was terminated due to a violation of facility policy regarding leaving a medication cart unlocked and unattended.2. Resident 40 was admitted to the facility on [DATE],readmitted on [DATE], and discharged [DATE] with diagnoses which included unspecified intracranial injury without loss of consciousness and dementia with mood disturbance.Review of resident 40's medical record was completed on 6/1/26 through 6/4/26.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 40 had a Brief Interview of Mental Status (BIMS) score of 0 which indicated severely impaired cognition.A review of resident 40's care plan focus dated 6/7/24 documented, [Resident 40] is at risk for falls r/t [related to] UNSPECIFIED INTRACRANIAL INJURY WITHOUT LOSS OF CONSCIOUSNESS, SEQUELA; MIXED RECEPTIVE-EXPRESSIVE LANGUAGE DISORDER; UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH MOOD DISTURBANCE.A review of resident 40's medical record revealed the following:a. On 8/18/25 at 10:09 AM, an event note documented, on 7/10/25 at 12:30 PM, the resident was found on the floor in the dining room by another resident. Interventions for this fall included: The current plan of care reviewed will continue to follow.b. On 8/18/25 at 10:09 AM, an event note documented, on 8/10/25 at 6:04 PM, Certified nurse assistant (CNA) notified the nurse that the resident had an unwitnessed fall. Upon the arrival the nurse witnessed the resident on the floor lying on their left side and was on top of their fall mat.Interventions for this fall included: Reviewed care plan, interventions remain in place.c. On 9/8/25 at 4:59 PM, an event note documented, on 8/28/25 at 3:00 PM, CNA notified the nurse that the resident had rolled over his bed and was found on the floor mattress.Interventions for this fall included: Reviewed care plan, interventions remain in place.d. On 9/8/25 at 3:06 PM, an event note documented, on 9/3/25 at 6:30 PM, a CNA found resident 40 lying on the floor beside the bed.Interventions for this fall included: Reviewed care plan, interventions remain in place.e. On 9/17/25 at 4:06 PM, an event note documented, on 9/9/25 at 10:18 AM, CNA found resident on his hands and knees on floor mat next to bed.Interventions for this fall included: maintain the current plan of care.f. On 9/18/25 at 10:24 PM, an alert nursing note documented, patient is on alert charting due to a witnessed fall. Interventions for this fall included: It should be noted no interventions were located for this incident.g. On 9/23/25 at 11:35 AM, an event note documented, on 9/12/25 at 4:20 PM, Resident had an unwitnessed fall at 4:14 PM. Residents were yelling and staff (continued on next page)

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Maple Ridge Rehabilitation and Nursing	455 South 900 East Salt Lake City, UT 84102

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	came running to find the patient on his left side lying on the ground. The patient's head was not on the ground nor were there any signs he hit his head according to fellow residents and the normal skin assessment findings.Interventions for this fall included: Referred resident to be seen by psych Nurse Practitioner she recommended order changes Medical Doctor approved and orders have been updated.h. On 9/23/25 at 11:38 AM, an event note documented, on 9/12/25 at 4:20 PM, the nurse had just got done giving another patient medication, then the nurse came back to the med cart and looked up and the patient was crawling out of his chair and fell on the floor. The nurse then picked the patient up and put him back in his wheelchair Interventions for this fall included: refer resident to wheelchair supplier to evaluate the need for a new wheelchairi. On 9/23/25 at 11:40 AM, an event note documented, on 9/20/25 at 5:14 PM, the resident had an unwitnessed fall at 5:15 PM. Staff heard thud and ran over to see the patient on the floor on his right side. The patient had a laceration to right eyebrow which was bleeding. A bandage was put on the wound after being cleaned. Interventions for this fall included: the resident had 2 falls within the same nature in 2 days, refer resident to wheelchair supplier to evaluate the need for a new wheelchair. j. On 9/30/25 at 10:47 PM, an alert note documented, the resident sustained a witnessed fall this evening. He slid from his wheelchair to the floor, coming to rest in a seated position. There was no head impact, and no injuries were noted upon assessment. The resident was assisted back into his wheelchair without difficulty. Interventions for this fall included: It should be noted no interventions were located for this incident.k. On 10/3/25 at 10:44 AM, an health status note documented the patient is on alert charting following a witnessed fall.Interventions for this fall included: It should be noted no interventions were located for this incident.l. On 10/5/25 at 12:07 PM, an alert note documented the patient on alert charting for fall yesterday. Interventions for this fall included: It should be noted no interventions were located for this incident.m On 11/5/25 at 12:36 PM, an event note documented, on 9/26/25 at 7:45 PM, the nurse was giving medications to another client and then the nurse heard another client say [resident 40] is on the floor. The nurse then came out and helped the patient back into his wheelchair and did a head to toe assessment. The patient did not have any new wounds. The patient was placed on neuro checks and alert charting.Interventions for this fall included: medication review with psych Nurse Practitioner.n. On 11/5/25 at 12:41 PM, an event note documented, on 9/27/25 at 2:52 PM, the patient experienced a witnessed fall from his wheelchair. The patient fell forward, hitting forehead on the floor. No loss of consciousness observed. Staff immediately assisted the patient back into the wheelchair. Interventions for this fall included: medication review with psych Nurse Practitioner.o. On 11/5/25 at 12:51 PM, an event note documented, on 10/4/25 at 7:30 AM, nurse heard a thud, then came out of another resident's room and then the nurse picked up the patient, then cleaned up his eyebrow that had been split open. The patient was taken to the hospital. Interventions for this fall included: Resident was sent to the emergency room for a computed tomography (CT) scan and treatment for laceration.p. On 11/9/25 at 7:50 PM, an incident note documented the Resident experienced an unwitnessed fall this evening in the hallway. The Resident was found lying on his left side on the floor, reportedly falling from his wheelchair. Interventions for this fall included: It should be noted no interventions were located for this incident.q. On 11/25/25 at 12:03 PM, an alert note documented the resident was on the dining room floor near his wheelchair. The resident was awake responding with a low muffle sound and did not make eye contact. The resident held his head up approximately 25% from the floor. Assessed for injuries as staff supported the resident's head. The resident received a laceration just above left eyebrow with mild bleeding that was controlled. Called EMS and reported with them about the resident incident.Interventions for this fall included: It should be noted no interventions were located for this incident.On 6/4/26 at 12:55 PM, an interview was conducted with the RDCS. The RDCS stated that it was difficult to come up with new interventions to resident 40's fall care plan. The RDCS stated that they approached resident 40 about a possible room change closer to the nursing station and he had refused. The RDCS stated that it was like resident 40 had locked-in syndrome, there was never enough they could do for him. They did try one on one with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him at one time but that seemed like that caused him more agitation, so they would just try and keep eyes on him at all times. POTENTIAL FOR HARM3. Resident 26 was admitted to the facility on [DATE] and discharged on 5/31/26 with diagnoses which included traumatic hemorrhage of cerebrum.Review of resident 26's medical record was completed on 6/1/26 through 6/4/26.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 26 had a Brief Interview of Mental Status (BIMS) score of 7 which indicated severely impaired cognition.A review of resident 26's care plan focus dated 6/16/20 documented, [Resident 26] is at risk for falls r/t [related to] impaired gait and balance, poor muscle control/coordination that results in spastic movements, dementia with associated cognitive deficits including poor safety awareness and judgment, seizures, cataracts, myopia, refusal of care, noncompliance.a. On 1/7/26 at 12:03 PM, an event note documented, on 12/31/25 at 2:30 PM, The Pt [patient] had an unwitnessed fall at approximately 1430 [2:30 PM] which he states happened in the bathroom. He was found by a CNA [certified nursing assistant] in his bed with blood all over his face.There were no other skin issues found other than above his L [left] eyelid which has a large open wound which would require stitches. The patient is refusing to receive any kind of care including stitches, repeatedly stating no, DON [director of nursing] was present and asked the pt as well and he continued to refuse. Interventions for this fall included: Will review fall incidents and adjust interventions as needed. b. On 3/6/26 at 8:46 AM, an event note documented, on 2/27/26 at 12:15 PM, Resident found on the floor next to the bathroom. Resident when questioned states he didn't fall, but it is apparent he did. Found next to his wheelchair. States the floor is slippery [sic] Resident unable to state what happened other than the floor is slippery.Interventions for this fall included: Educate staff to ensure resident has proper nonslip foot wear. It should be noted that an intervention on 3/28/25 states, Education provided to resident on importance of having shoes on and adequately tied prior to transfers.c. On 3/27/26 at 12:05 PM, an event note documented, on 3/21/26 at 4:20 PM, Found resident in room sitting up on the floor between his WC [wheelchair] and bed. BM [bowl movement] on floor around resident. Resident has history of refusing briefs and assistance with toileting. Resident stated he did not remember what he was doing. Assessed resident for injuries. Small abrasion approximately 1 cm [centimeter] to right hand 3rd knuckle and right lateral foot.Interventions for this fall included: Provide frequent reminders for resident to ask for assistance. It should be noted that an invention on 3/28/25 states, Education provided to resident for utilizing staff to assist with transfers when needed.d. On 4/13/26 at 10:46 PM, a health status note documented, Resident noted to have a bruise on the right forehead. When asked about the injury, the resident stated he does not know what happened and does not recall the cause.It should be noted no interventions were located for this incident.e. On 5/8/26 at 1:49 PM, an event note documented, on 4/24/26 at 4:20 PM, Cut near his eye.Refused treatment to clean wound.Pt [patient] stated that he fell off his bed and received that cut near his eye from the floor.Interventions for this fall included: Anticipate and meet resident's needs. Be sure call light is within reach and encourage resident to use it for assistance as needed. It should be noted that an invention on 4/26/25 states, Be sure [resident 24's] call light is within reach and encourage the resident to use it for assistance as needed.f. On 5/8/26 at 1:59 PM, an event note documented, on 4/27/26 at 11:30 AM, Resident had an unwitnessed fall at 1135 [11:35 AM] today. He was found in his room on the floor by the CNA [certified nursing assistant]. He appeared to have a large open wound on the left side of his forehead, no other injuries noted .Pt was unable to state how he fell or what happened to cause the incident.Pt [patient] education was provided for fall precautions.Interventions for this fall included: Anticipate and meet resident's needs. Be sure call light is within reach and encourage resident to use it for assistance as needed.On 6/4/26 at 12:55 PM, an interview was conducted with the RDCS. The RDCS stated that resident 26 would frequently refuse the interventions that had been care planned for him. The RDCS stated that with resident's 26 recent fall on 5/32/26 they moved him closer to the nursing station for an intervention. 4. Resident 2 was admitted to the facility on [DATE] with diagnoses which included, non-pressure chronic ulcer of foot and acquired absence of right foot.A review of resident 2's care (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan focus dated 5/28/25 documented, The resident is at risk for falls r/t [related to] Dementia, diabetes with neuropathy, right diabetic foot ulcer, left below the knee amputation, use of left lower leg prosthetic, anemia, incontinence, use of medications that increase risk for falls, chronic pain. A review of resident 2's medical record revealed the following:On 2/8/26 at 10:25 PM, an incident note documented, Patient had an unwitnessed fall outside while attempting to stand from a chair. Patient denies head strike. No visible injuries noted. Patient reports knee pain. Interventions for this fall included: Encourage resident to ask for help and wait until getting balance when ambulating.On 2/19/26 at 3:44 PM, an alert note documented, Found resident sitting on floor next to bed. Resident said that she was sitting on her bed reaching down to adjust her sock (right leg) and she slid off of the bed landing on her buttox. [sic] Assessed resident for injuries. No bruising, abrasions or new injuries noted.Interventions for this fall included: Educated staff to ensure they are anticipating needs for resident.On 2/20/26 at 8:51 PM, a health status note documented, Resident was found on the floor in between bed and wheelchair. She was in the fetal position on her right side. She stated she was stransferring [sic] from bed to wheelchair and the wheelchair brakes were not on. She c/o [complaining of] right hip and head pain. Neuros started.Interventions for this fall included: Resident was assessed for pain.On 2/21/26 at 12:36 AM, a transfer to hospital summary documented, Resident was taken to the [name redacted] hospital vis [sic] ambulance.Interventions for this fall included: Resident was assessed for pain. It should be noted that this intervention was used for the fall on 2/20/26.On 3/29/26 at 12:40 AM, a health status note documented, Resident had an unwitnesed [sic] fall in her room. She stated the brakes on her wc were not locked and she fell onto her buttocks. She was found on her buttocks in front of her wc. Assessed for pain and injury. Interventions for this fall included: Re-educated resident to ask for assistance and re-educated staff to anticipate needs. It should be noted that these interventions were used for the falls occurring on 2/8/26 and 2/19/26.On 3/29/26 at 1:35 AM, a health status note documented, Resident had and [sic] unwitnessed fall in her room. She stated swhe [sic] was getting onto the toilet and slipped on her pant leg. She stated she hit her head on the sink. Assessed for pain and injury. Interventions for this fall included: Re-educated resident to ask for assistance and re-educated staff to anticipate needs. It should be noted that these interventions were used for the falls occurring on 2/8/26, 2/19/26, and 3/29/26.On 6/3/26 at 9:54 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 2 was a fall risk because she was an amputee. CNA 1 stated that the only fall intervention that she knew of for resident 2 was to keep her room clutter free. On 6/3/26 at 1:45 PM, an interview was conducted with the Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 2 could be a fall risk and that she had fallen in the past. LPN 1 stated that she could not remember if resident 2 had gotten injured from any of her falls. LPN 1 stated that she did not know of any fall interventions that resident 2 had. On 6/3/26 at 2:12 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that resident 2 had a history of falls and was someone who could not care for themselves. The RDCS stated that resident 2 had a few falls where resident 2 grabbed for things and tried to self-transfer. The RDCS stated that resident 2 was able to be educated, but oftentimes over-estimated her abilities. The RDCS stated that fall interventions should not be repeated and assessments were not interventions for falls. On 6/3/26 at 2:28 PM, an interview was conducted with the Administrator (ADM). The ADM stated that if a resident fell then they should have a unique intervention for each fall and interventions should not be repeated even if multiple falls occurred on the same day.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure that the pharmacist's monthly drug regimen review recommendations were documented and acted upon. Specifically, for 1 out of 19 residents reviewed the facility failed to ensure that the pharmacist's March 2026 recommendation to update order from as needed to a scheduled medication was addressed. This resulted in a three-month delay until June 2026 without any medication update. Resident Identifier: 13.Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included radiculopathy, lumbosacral region and major depressive disorder.Review of resident 13's medical record was completed on 6/1/26 through 6/4/26.On 3/16/26, a physician recommendation provided by the pharmacist revealed the following, [Resident 13] has an order for sodium fluoride toothpaste to be used as needed. This toothpaste is recommended to be used daily. Recommend changing the order to scheduled daily instead of as needed. A review of the facility's Medication Regimen Review Policy implemented on 4/11/25 revealed the following: Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.A review of ordered medication reviewed the following:On 2/10/26, Sodium Fluoride Gel 1.1 % 1 application dental every 12 hours as needed for sensitivity was started and discontinued on 6/2/26.On 6/3/26, Sodium Fluoride Gel 1.1 % 1 application dental every day shift for dental care, was started.On 6/4/26 at 12:55 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that the Director of Nursing (DON) was responsible for any follow-up regarding the pharmacist's monthly recommendations, which includes updating any physician orders to reflect the recommendation. The RDCS stated that the previous DON was not following the facility's policy regarding pharmacy recommendations.

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F 0761 Level of Harm - Actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to store all medications in a locked compartment and limit access only to authorized staff. Specifically, for 1 of 19 sampled residents, a resident was able to access the medication cart that was unlocked and unattended in a public hallway, allowing the resident to obtain multiple medications blister packs, and possibly ingest of unauthorized medication. This resulted in a finding of harm. Resident Identifier: 32.Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included human immunodeficiency virus, paranoid schizophrenia, and schizoaffective disorder.Review of resident 32's medical record was completed on 6/1/26 through 6/4/26.On 3/13/25 at 12:10 PM, an Event Note Template revealed the following: Event Date/Time: 3/4/25 @ [at] 1130 [11:30 AM] Event Description: Staff found medication cards in residents [sic] room, staff immediately notified nursing and management. A medication error occurred involving the above-named resident. The resident accessed the medication cart after it was left unlocked and unattended. The resident was able to obtain and self-administer medications without staff supervision. Shortly thereafter, the resident exhibited signs of altered mental status (AMS), including confusion and decreased level of awareness. The resident also demonstrated an unsteady gait, increasing fall risk . A thorough search of the resident's room was conducted, which resulted in the discoveryof [sic] multiple medication cards in the resident's possession .DON [Director of Nursing] and provider were notified immediately. Emergency medical services (EMS) were activated due to change in condition. Resident was transferred to the emergency department for further evaluation and treatment . Root cause: Resident was able to access unlocked and unattended medication cart and took med cards and pills . Preventative Measures in Place Prior to Incident: Educated staff to ensure back is never turned to resident while pulling medication, re educated [sic] nurses that they are not to leave meds with residents, med audits will be completed on all nurses.A review of the inpatient admission notes from 3/4/26 through 3/12/26 revealed the following: [resident 32] was brought in by EMS [Emergency Medical Services] from his care facility after they found empty sheets of blister packs for abilify 2mg [milligrams], Eliquis 5mg, desmopressin dose unknown, atorvastatin 40 mg, metoprolol XL100 mg, doxycycline 20 mg, melatonin dose unknown, and zofran dose unknown. It is unclear how much of any of these medications he may have taken, could have taken none, could have taken several of each individual medication. Apparently these were in bubble packs on a cart near his room. This was not discovered unto [sic] some time after ingestion but timing is unclear. He was admitted to MICU [Medical Intensive Care Unit] for management of hyponatremia, (initially 117) with increased urine output likely 2/2 [secondary] to that ingestion. Patient was placed on a 1:1 sitter, sodium has been uptrending without intervention to 130, and patient's home medications for schizophrenia have been restarted. Still holding BP [blood pressure] meds due to some softer BP readings . Upon my interview [resident 32] was awake and alert but minimally interactive. He reported having right arm pain and right foot numbness. When asked why he was in the hospital he did endorse taking medications but did not respond when asked if this was in an effort to self harm or commit suicide, additionally, he was unable to answer whether or not he was having thought [sic] of self harm/suicidal ideation/ homicidal ideation. A review of the resident's medical record indicated that Resident 32 did not have active medication orders for the following:Abilify 2 mgEliquis 5 mgDesmopressinAtorvastatin 40 mgMetoprolol XL 100 mgDoxycycline 20 mgMelatoninZofranOn 3/4/26 the facility initiated a Critical Incident Response Plan. The Quality Assurance and Performance Improvement (QAPI) Performance Improvement Plan (PIP) Action Plan documented the following: The facility failed to ensure medications were securely stored and failed to maintain a hazard-free environment when a (continued on next page)

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F 0761 Level of Harm - Actual harm Residents Affected - Few	medication cart was left unlocked and unattended. As a result,, a resident accessed and ingested medication, resulting in actual harm that required transfer and admission to the hospital. Identified Concern: Failure to Secure Medications (F761) Medications were not stored in a locked compartment. Controlled access safeguards were not maintained. Failure to follow facility policy regarding medication cart security.Potential Risk to Patient. Resident ingested medication not prescribed to them. Sent out for emergency transfer to hospital for evaluation and treatment. Required hospital admission, with possibility of adverse outcome. Systemic Risk to Other Residents. Potential for additional residents to access unsecured medications. Possible pattern of noncompliance if carts are routinely left unsecured. Inadequate staff education and/or competency validation regarding medication security. Root Cause Identified: The root cause of this incident was a systemic failure in the facility's medication management and oversight processes, including staff noncompliance with medication cart security policy and ineffective competency validation and supervisory monitoring to ensure sustained adherence to required medication storage standards.On 6/4/26 at 11:37 AM, an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated that if she ever saw the medication cart unlocked she would lock it or stay near it until the nurse returned. CNA 3 stated that as a CNA she knows not to leave the medication cart unlocked and unattended because it only takes seconds for something to happen, especially in a facility that takes care of residents with mental health needs. On 6/4/26 at 11:52 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that when the medication cart is unattended it should always be locked. LPN 1 stated that the population of residents served in the facility would make it very unsafe to leave any type of medication unattended.On 6/4/26 at 1:23 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that when resident 32's room was being cleaned, multiple medication blister packs were found. The RDCS stated it was discovered that the Registered Nurse (RN) had left the medication cart unlocked and unattended, at which time resident 32 removed multiple blister packs from the cart. The RDCS stated that resident 32 presented with an altered level of consciousness, EMS was notified, and the resident was transported to the emergency department. The RDCS stated that the RN's employment with the facility was terminated due to a violation of facility policy regarding leaving a medication cart unlocked and unattended.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility did not provide or obtain laboratory services to meet the needs of the residents. Specifically for 2 out of 19 sampled residents a resident did not have his Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP), Lipid Panel and a Valproic Acid level drawn every 6 months and another resident did not have their monthly CBC lab drawn. Resident Identifiers: 12 and 27.1. Resident 12 was admitted [DATE], readmitted [DATE] with diagnoses including, but not limited to schizophrenia, chronic diastolic (congestive) heart failure, and unspecified intracranial injury. Resident 12's medical record was reviewed from 6/1/26 through 6/4/26.A physician's order dated 9/29/25 stated, Draw CBC [complete blood count] monthly r/t [related to] clozaril use. This order was discontinued 3/6/26.A physician's order dated 3/6/26, stated, Draw CBC monthly r/t clozaril use. This order was still active during the dates the resident's medical record was reviewed. There were no monthly CBC laboratory results in the resident's medical record for the months of June 2025, July 2025, August 2025, February 2026, April 2026, and May 2026.On 6/3/26 at 10:47 AM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that laboratory results should be uploaded under the Documents tab or the Results tab in the electronic medical record. The RDCS stated that if laboratory results were not uploaded under either of these tabs, then it was likely that the facility did not have a record of the labs being completed. 2. Resident 27 was admitted to the facility on [DATE] with diagnoses which included, cerebral infarction, generalized anxiety disorder, adjustment disorder with depressed mood, and insomnia.A physician's orders dated 2/6/24 documented, Routine labs: Draw CBC, CMP [Comprehensive Metabolic Panel], Valproic Acid Level q [every] 6 Months in February and August. Draw Lipid Panel in February.Labs drawn in February 2026 were not located in resident 2's medical record.On 6/3/26 at 11:09 AM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that valproic acid levels should be drawn every 6 months on residents. The RDCS stated that resident 27's valproic acid level was drawn on 5/28/26. On 6/4/26 at 1:17 PM, a follow-up interview was conducted with the RDCS. The RDCS stated that there were standing orders for routine labs. The RDCS stated she had completed an audit of residents and found out that many residents were not getting routine labs drawn. The RDCS stated that she informed the previous Director of Nursing (DON) that resident 27 had not had his labs drawn in February and instructed him to notify the medical provider to see if she still wanted labs drawn. The RDCS stated that there was not a progress note documenting that the previous DON contacted the medical provider. The RDCS stated that the labs drawn in May 2026 for resident 27 were supposed to be the labs that needed to be drawn in February 2026. [Cross refer to F773]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A058	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Ridge Rehabilitation and Nursing	455 South 900 East Salt Lake City, UT 84102

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not obtain laboratory (lab) services only when ordered by a physician; physician assistant; nurse practitioner, or clinical nurse specialist. Specifically for 2 out of 19 sampled residents, a resident had a complete blood count (CBC), comprehensive metabolic panel (CMP), valproic acid level, and lipid level collected without a physician's order. Additionally, a resident had a glycated hemoglobin (HgbA1C), CMP, CBC with differential, prolactin, valproic acid, and lipid panel collected without a physician's order. Resident identifiers: 19 and 27.1. Resident 27 was admitted to the facility on [DATE] with diagnoses which included, cerebral infarction, generalized anxiety disorder, adjustment disorder with depressed mood, and insomnia.On 5/28/26 at 5:32 PM, a health status note documented, Late Entry: CBC w/Diff [differential] and CMP results received and reviewed by provider.It should be noted that an order for lab tests was not located in resident 27's medical record. On 6/4/26 at 1:17 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that there were standing orders for routine labs. The RDCS stated she had completed an audit of residents and found out that many residents were not getting routine labs drawn. The RDCS stated that she informed the previous Director of Nursing (DON) that resident 27 had not had his labs drawn in February and instructed him to notify the medical provider to see if she still wanted labs drawn. The RDCS stated that there was not a progress note documenting that the previous DON contacted the medical provider. The RDCS stated that the labs drawn in May 2026 for resident 27 were supposed to be the labs that needed to be drawn in February 2026. 2. Resident 19 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, unspecified convulsions and diabetes mellitus due to underlying condition with diabetic neuropathy.Review of resident 19's medical record was completed on 6/1/26 through 6/4/26.On 5/28/26 the following laboratory results were located in resident 19's medical chart:Hemoglobin A1C [HgbA1C]CMP CBC with differentialProlactinValproic Acid LevelLipid PanelIt should be noted that an order for lab tests was not located in resident 19's medical record. On 6/4/26 at 12:55 PM, an interview was conducted with the RDCS. The RDCS stated that a physician's order is needed in order to draw labs. The RDCS stated that she was unable to find an order for resident 19 for the labs that were drawn on 5/28/26.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 of 19 sampled residents, that the facility did not ensure that laboratory results were filed in the resident's clinical record. Specifically, the facility did not include 6 monthly physician ordered complete blood counts in a resident's medical record. Resident Identifier: 12Resident 12 was admitted [DATE], readmitted [DATE] with diagnoses including, but not limited to schizophrenia, chronic diastolic (congestive) heart failure, and unspecified intracranial injury. Resident 12's medical record was reviewed from 6/1/26 through 6/4/26.A physician's order dated 9/29/25 stated, Draw CBC [completed blood count] monthly r/t [related to] clozaril use. This order was discontinued 3/6/26.A physician's order dated 3/6/26, stated, Draw CBC monthly r/t clozaril use. This order was still active during the dates the resident's medical record was reviewed. There were no monthly CBC laboratory results in the resident's medical record for the months of June 2025, July 2025, August 2025, February 2026, April 2026, and May 2026.On 6/3/26 at 10:47am, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that laboratory results should be uploaded under the Documents tab or the Results tab in the electronic medical record. The RDCS stated that if laboratory results were not uploaded under either of these tabs, then it was likely that the facility did not have a record of the labs being completed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not maintain medical records on each resident that were complete; accurately documented; readily accessible; and systematically organized. Specifically, for 2 out of 19 sampled residents a resident had an incorrect medical diagnosis and another resident had an incorrect diagnosis for a medication given. Resident identifiers: 6 and 27.1. Resident 6 was admitted to the facility on [DATE] with diagnoses which included peripheral vascular disease, adult failure to thrive, mild cognitive impairment, and major depressive disorder.A review of resident 6's Minimum Data Set, dated [DATE] documented that resident 6 had a diagnosis of Schizophrenia. A review of resident 6's medical record revealed that resident 6 did not have a Preadmission Screening and Resident Review (PASRR) level 2 with a diagnosis of Schizophrenia.On 6/3/26 at 1:29 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that resident 6 was screened out for a PASRR 2 because he did not have any mental health issues. The RDCS stated that she would have to have the schizophrenia diagnosis removed from resident 6's MDS because she was unable to remove them.2. Resident 27 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, insomnia, muscle weakness, dysphagia, generalized anxiety disorder, adjustment disorder with depressed mood, aphasia, cognitive communication deficit, and essential hypertension. A review of resident 27's orders revealed a physician's order started on 7/9/25 for Bromocriptine Mesylate Oral Tablet 2.5 MG (milligrams) Give 20 mg by mouth two times a day for DM (diabetes mellitus). It should be noted that resident 27 did not have a diagnosis for diabetes mellitus.On 6/3/26 at 10:53 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 27 did not have diabetes and did not take any medications for diabetes.On 6/3/26 at 10:56 AM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that resident 27 did not have a diagnosis for diabetes mellitus and was unsure why he was taking bromocriptine. On 6/3/26 at 11:05 AM, a follow-up interview was conducted with the RDCS. The RDCS stated that resident 27 was admitted with the medication for diabetes and she would continue to look into why he was taking the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 that the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 2 of 19 sampled residents, Enhanced Barrier Precautions [EBP] were not being implemented as ordered. Resident identifiers: 2 and 27.1. Resident 2 was admitted on [DATE] with diagnoses which included, non-pressure chronic ulcer of foot, sepsis, and acquired absence of right foot.On 6/1/26 at 9:02 AM, an observation and interview were conducted with resident 2. There was no observed EBP signage or Personal Protective Equipment (PPE) available for use in the resident's room. Resident 2 was observed to have her right foot wrapped in a bandage. Resident 2 stated that she required assistance from staff with showering and staff did not wear a gown when assisting her.A review of resident 2's physician orders started on 3/11/26 documented, ENHANCED BARRIER PRECAUTIONS: PPE required for high direct care resident contact activities. Indication for use: wounds every shift.On 6/3/26 at 9:54 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 2 was mostly continent, but there were times that she did have incontinent episodes and that she needed to have her brief changed. CNA 1 stated that the CNAs performed about 75% of the work when showering resident 2. CNA 1 stated that resident 2 was not on EBP and that she did not wear a gown when assisting resident 2. On 6/3/26 at 1:45 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 2 had a wound on her foot that was being managed by podiatry. LPN 1 stated that resident 2 only needed EBP when her dressing was changed, but that was done at the podiatrist's office. On 6/3/26 at 2:29 PM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that resident 2 should be on EBP because she had a chronic wound. The RDCS stated that staff should be wearing a gown and gloves when providing high contact care and there should be signage on her door.2. Resident 27 was admitted to the facility on [DATE] with diagnoses which included, venous insufficiency, non-pressure chronic ulcer of right lower leg, and non-pressure chronic ulcer of left lower leg.On 6/1/26 at 9:44 AM, an observation was made of resident 27. Resident 27 had swollen legs with red marks and open areas. Resident 27 had red marks and scabs to his upper left arm and shoulder. Resident 27 was bleeding from a scratch behind his right ear and neck. There were no visible bandages on resident 27's open areas of the skin. There was no EBP signage on the door and no PPE available for use in his room.A review of resident 27's physician orders revealed the following orders: Open area on left leg: Cleanse with wound wash and pat dry. Apply collagen, alginate, and cover with border dressing. Date started: 12/6/25 Wound care to left shoulder: cleanse with wound wash, pat dry. Apply skin prep and cover with border dressing. Change daily and PRN [as needed] for soiling or accidental removal. Start date: 1/24/26 Open area on right buttock: Cleans (sic) with wound wash and pat dry. Apply collagen and cover with protective dressing. Date started: 4/14/26 ENHANCED BARRIER PRECAUTIONS: PPE required for high-contact direct care activities R/T [related to] (wounds). Start date: 6/1/26On 6/3/26 at 9:54 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 27 had wounds to his body from scratching. CNA 1 stated that resident 27 needed a Hoyer lift for transferring and was unable to move himself. CNA 1 stated that resident 27 was incontinent. CNA 1 stated that she only wore gloves when assisting resident 27.On 6/3/26 at 10:56 AM, an interview was conducted with the Regional Director of Clinical Services (RDCS). The RDCS stated that resident 27 had chronic wounds and had an active order for EBP. The RDCS stated that resident 27 should have signage that stated he was on EBP. On 6/4/26 at 9:41 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 27 was fully dependent on staff for his activities of daily living. CNA 2 stated that resident 27 used a Hoyer lift and was incontinent. CNA 2 stated that resident 27 had open (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wounds on his legs and left shoulder and had them for some time. CNA 2 stated that resident 27 scratched at his wounds. CNA 2 stated that she needed to wear a gown and gloves when caring for resident 27.