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	06/02/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not allow the resident the right to formulate an advance directive. Specifically, for 1 out of 14 sampled residents, a resident that did not have a Physician Orders for Life-Sustaining Treatment (POLST) or Advance Directive was documented as full code in their medical record. Resident identifier: 32. Findings included: Resident 32 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, acute respiratory failure with hypoxia, chest pain, pleural effusion, chronic obstructive pulmonary disease, asthma, atrial fibrillation, type 2 diabetes mellitus with complications, secondary hypertension, and shortness of breath. Resident 32's medical record was reviewed. A physician's order dated 10/8/24, documented that resident 32 was a full code, full treatment, and a trial period of artificial nutrition. On 10/8/24 at 5:16 PM, an admission Progress Note documented . POLST status: . was blank. An Advanced Directive or POLST form were unable to be located in the medical record. On 5/28/25 at 1:15 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the POLST form was completed on admission. The DON stated once the POLST form was completed the staff would turn them into her and she would give them to the Medical Director (MD) to be signed. The DON stated the Resident Advocate would audit the POLST form monthly. On 5/29/25 at 1:44 PM, an interview was conducted with the Administrator (ADM). The ADM confirmed that he was unable to locate resident 32's POLST form. The ADM stated that he had the MD signed a new POLST form for resident 32. The facility policy Residents' Rights Regarding Treatment and Advance Directives was reviewed. The policy was implemented on 4/11/25. Policy: (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directives. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. 4. The facility will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. 5. The facility will identify or arrange for an appropriate representative for the resident to serve as primary decision maker if the resident is assessed as unable to make relevant health care decisions. 6. The facility will define and clarify medical issues and present them to the resident or legal representative as appropriate. 7. During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives. 8. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. 9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined, for 1 out of 14 sampled residents, the facility did not make prompt efforts to resolve grievances the resident may have or maintain evidence demonstrating the results of all grievances. Specifically, a resident reported that his wallet and all personal documents were missing and requested assistance with obtaining new identification (ID) cards and the facility did not maintain evidence demonstrating the grievance investigation and decision. Resident identifier: 18. Findings included: Resident 18 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included schizophrenia, tremor, stimulant abuse, chronic obstructive pulmonary disease, peripheral vascular disease, and hypertension. On 5/27/25 at 8:54 AM, an interview was conducted with resident 18. Resident 18 stated that his wallet was missing with his identification and Medicaid card. Resident 18 stated that he informed the Resident Advocate (RA) and was told that she would assist him with obtaining new identification. Resident 18 stated that the RA never got back to him about how to get a new ID. Resident 18's medical record was reviewed. On 7/20/22, the personal inventory list documented one wallet in possession of the resident. The list did not document the contents of the wallet. On 9/13/23 at 6:58 AM, resident 18's progress note documented, It was brought to RA's attention that [Resident 18's] wallet was reported stolen in March. The investigation was done properly. [Resident 18] said that there had been some contacts and his ID in the wallet. RA found a caseworker's contact in his admission packet, and added that to his chart. RA asked [Resident 18] if there were any other contacts that he can think of, and he said no. RA is going to replace his wallet and get him a new ID. The grievance binder was reviewed from September 2023 through May 2025. No grievances were identified for resident 18 that pertained to the missing wallet and identification cards. Review of the facility Resident and Family Grievances policy documented that the facility would make prompt efforts to resolve grievances. Prompt efforts to resolve included facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. The policy documented under procedure that The Grievance Officer will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. The policy stated that Evidence demonstrating the results of all grievances will be maintained for a period of no less than 3 years from the issuance of the grievance decision. The policy was implemented on 4/11/25. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 7:51 AM, an interview was conducted with the RA. The RA stated that she had worked at the facility for two years and was in charge of the grievance investigations. The RA stated that she believed resident 18's wallet was replaced but she does not think she replaced his ID. The RA stated that sometimes she kept the ID in her office depending on if the resident requested it. The RA stated that she did not obtain new identification cards for the resident. The RA stated that this was something that she would typically start a grievance investigation for. The RA was observed to review the grievances to locate any investigation for resident 18's missing wallet and ID. The RA stated she did not have a grievance investigation for the missing property. The RA stated that she would assist the resident with obtaining a new ID. The RA stated she would contact the Social Security Administration to obtain a new card and then attempt to get a new state ID. The RA stated the timeframe for initiating a grievance investigation was within a week, and that this was something that should have been resolved. The RA stated that she would reach out to resident 18's case worker to obtain a new Medicaid card and would start the process of obtaining a new birth certificate and Social Security card.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined, for 1 of 14 sampled residents, the facility did not ensure that residents who use psychotropic drugs received a gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Specifically, a resident did not have an attempted GDR for Depakote and the Trazodone did not have a rationale for the clinical contraindication. Resident identifier: 26. Findings included: Resident 26 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, cognitive communication deficit, hemiplegia and hemiparesis of left side, dysphagia, aphasia, and hypertension. Resident 26's medical record was reviewed. Resident 26's physician orders revealed the following: a. On 2/6/24, an order was initiated for Trazodone Oral Tablet 50 milligram (mg), give 50 mg by mouth at bedtime related to insomnia. b. On 2/6/24, an order was initiated for Divalproex Sodium Oral Tablet Delayed Release 125 mg, give 250 mg by mouth two times a day for increased behaviors. On 5/19/25, a Clinical Contraindication GDR for Trazodone was completed. The form documented the target symptom(s) or distressed behavior was insomnia. The form had areas listed for the reason of the contraindication but none of the reasons were checked or indicated. No documentation could be found for an attempted GDR or clinical contraindication for the use of the Divalproex. On 5/29/25 at 2:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that resident 26's behaviors were impatience, wanting assistance immediately, some yelling out at times, and a history of hitting and aggressive behaviors. LPN 2 stated resident 26 had been physically and verbally aggressive and had tried to hit the Certified Nursing Assistants in the past. LPN 2 stated that the Divalproex was for resident 26's behaviors. LPN 2 stated that they monitored resident 26's behaviors on the Treatment Administration Record for agitation every shift. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 2:47 PM, an interview was conducted with the Corporate Resource Nurse (CRN) and the Director of Nursing (DON). The CRN stated that she filled out resident 26's clinical contraindication form for the Trazodone, the provider then signed it, and the DON needed to fill in the form. The CRN stated that the GDR was discussed during the psychotropic meetings. The CRN stated that she filled out the GDR form for those resident's that needed a GDR and the physician brought those forms to the psychotropic meeting. The DON stated that the physician should document a rationale for the clinically contraindication to the GDR. The DON stated that the physician note dated 3/17/25, documented that resident 26 was prescribed Depakote for behaviors. The DON stated that they did not attempt a GDR for the Depakote and it was used for agitation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined, for 1 of 14 sampled residents, the facility did not ensure that all alleged violations involving abuse and neglect were reported immediately, but not later than 2 hours after the allegation was made to the administrator, the State Survey Agency (SSA), and Adult Protective Services (APS). Specifically, the facility investigations for a residents allegation of sexual abuse and an elopement did not have a documented date that APS was notified. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, unspecified convulsions, diabetes mellitus, asthma, hypothyroidism, restless leg syndrome, and dysphagia. Resident 1's facility abuse investigations were reviewed. On 5/2/24 at 2:47 PM, the facility Form 358 documented that the local Police Department (PD) notified the facility that they found resident 1 wandering one street north of the facility and he seemed confused. The local PD reported that they transported resident 1 to a local area hospital for evaluation. The form documented that APS was notified at 3:15 PM, but no date was documented for the notification. On 12/6/24 at 8:00 PM, the facility Form 358 documented that resident 1 reported to the floor nurse that he had rectal pain and that he had been raped. The form documented that resident 1 was unable to recall a timeline or sequence of events, was unable to provide details of the alleged perpetrator, and was unable to provide details of the event. The form documented that APS was notified at 9:15 PM, but no date was documented for the notification. On 5/28/25 at 12:08 PM, an interview was conducted with the Administrator (ADM). The ADM stated that the previous ADM conducted the investigations and documented the APS notification. The ADM stated that he did not have any other documentation for the APS notification. The ADM stated that he reached out to the previous ADM to see if he had documentation of APS notification. The ADM also stated that he had submitted a Government Records Access and Management Act request to APS for copies of the notification verification.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and record review, it was determined, for 2 of 14 resident's sampled, the facility did not ensure that the resident's transfer or discharge was documented in the resident's medical record and the information was communicated to the receiving provider included contact information for the practitioner responsible for the care of the resident; resident representative contact information; Advanced Directive information; all special instructions or precautions for ongoing care; a comprehensive care plan goals; and all other necessary information to ensure a safe and effective transition of care. Specifically, the resident's medical record did not contain documentation of what information was sent to the receiving provider for a transition of care. Resident identifiers: 7 and 15. 1. Resident 7 was admitted to the facility on [DATE] and was re-admitted to the facility on [DATE] with diagnoses which included Human Immunodeficiency Virus, generalized anxiety disorder, paranoid schizophrenia, and viral hepatitis C. Resident 7's medical record was reviewed. On 2/28/25 at 7:38 AM, a Health Status Note documented, Resident has been very anxious this AM, pacing around the facility and calling several people on the phone. He called 911 and requested to go to [local area hospital] complaining of brain pain. Resident showed no S/S [signs and symptoms] of Acute distress and did not mention any issues to staff before calling 911. Sent resident with EMS [emergency medical services] to [name of hospital]. Resident 7's medical record revealed no documentation of a transfer/discharge summary or what information was sent to the receiving provider. 2. Resident 15 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included type 1 diabetes mellitus, generalized anxiety disorder, chronic kidney disease stage 3, complete traumatic amputation of two or more left toes, bipolar disorder, and suicidal ideations. Review of resident 15's record was completed on 5/27/25 through 6/2/25. On 1/25/25 at 2:47 PM, a transfer to hospital summary note revealed that the patient reported feeling dizzy to the nurse, nurse went and assessed him, blood sugar 430, blood pressure (BP) 100/70, respiration rate (RR) 14, temperature (T) 97.0, heart rate (HR) 58, oxygen saturation 70 at room air (RA), patient quickly became pale and unresponsive, continue with HR, 911 was called to the facility, staff stayed with patient monitoring him, places oxygen via nasal cannula at 5 liter (L), saturations eventually went up to 90 at 5L, patient became somewhat more responsive, alert/oriented to self and situation, patient was able to follow simple commands of squeezing nurse's hand, no facial asymmetry noted. Paramedics transfer resident to hospital. Medical Doctor (MD) notified of the incident. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 at 5:11 PM, a health status note revealed the following. Patient reported to nurse the feeling of collapse and right side weakness, he stated he could not walk due to the weakness, he states not feeling those symptoms before. Nurse assessed patient for other symptoms to rule out possibility of stroke, no signs of facial drooping or asymmetry, equal strength of hands, no confusion, patient alert and oriented to person, place, time, and situation consistent with baseline, patient talkative, wheeling himself on manual wheelchair with both hands, BP 180/95, RR 18, T 97.0, HR 88, and oxygen 97% RA, per patient request he would like to go to the emergency department for further assessment, house MD has been notified. Resident 15's medical record revealed no documentation of a transfer/discharge summary or what information was sent to the receiving provider. On 5/29/25 at 9:29 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that she would notify the physician of the resident's change in condition and then she would contact EMS for a transfer to the hospital. LPN 2 stated that she would notify management and the family of the transfer. LPN 2 stated that she would give report to EMS and provide them with copies of a transfer/discharge sheet, order summary, recent physician note, recent labs, and a copy of the Physician Orders for Life Sustaining Treatment (POLST). LPN 2 stated that she would document in a progress note the resident's change in condition, who was contacted and what assessment and treatment that she provided. LPN 2 stated that she would also document what paperwork was sent with the resident to the receiving provider. LPN 2 stated that there was a progress note template that had a spot for what documentation was sent to the receiving provider. On 5/29/25 at 10:50 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the process for a transfer was to print the discharge/transfer report, the order summary, and a face sheet which contains the POLST information to send with EMS. The DON stated that the nurse should document in a progress note the event details and need for transfer, any orders received from the provider, notification of management and Power of Attorney if applicable. The DON stated that the progress note should also include the assessment and any recent vital signs. The DON stated that they did not always document what documentation was sent to the receiving provider. The DON stated that if it was not documented they would not know what was sent to the receiving provider, and if a transfer/discharge assessment was not in the chart then it was not completed at the time of the event.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined, for 1 of 14 sampled residents, the facility did not develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframe's to meet the resident's medical, nursing, and psychosocial needs that were identified in the comprehensive assessment. Specifically, the resident's care plan did not address the resident's bowel elimination pattern. Resident identifier: 4. Findings included: Resident 4 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which consisted of schizophrenia, Parkinsonism, generalized anxiety disorder, obsessive-compulsive disorder, major depressive disorder, congestive heart failure, peripheral vascular disease. On 5/27/25 at 9:35 AM, an interview was conducted with resident 4. Resident 4 stated that within the last two months he had experienced some constipation and went a long time without a bowel movement (BM). Resident 4's medical record was reviewed. Resident 4's physician orders revealed orders for Milk of Magnesia suspension for the treatment of constipation. The May 2025 Medication Administration Record documented that the Milk of Magnesia was not administered during the month. Review of resident 4's bowel elimination pattern for the last 30 days revealed: a. On 5/8/25 through 5/13/25, the task documented no BM. The resident went six days without a BM. b. On 5/23/25 through 5/25/25, the task documented no BM. The resident went three days without a BM. On 10/1/18, resident 4 had a care plan initiated for Activities of Daily Living (ADLs) self-care performance deficit related to schizophrenia. The care plan documented under toileting that resident 4 used a urinal for bladder elimination. The care plan did not address resident 4's bowel elimination pattern nor treatment for constipation. The care plan focus area for toileting was last updated on 7/27/23. On 5/29/25 at 8:14 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the bowel and bladder elimination would be addressed in the care plan under ADLs for toileting. The DON stated that the care plan currently only addressed the resident's urinary elimination.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined, for 1 of 14 sampled residents, the facility did not ensure that all residents received the treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choice. Specifically, a resident had complaints of constipation that were not treated with the facility bowel protocol. Resident identifier: 4. Findings included: Resident 4 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which consisted of schizophrenia, Parkinsonism, generalized anxiety disorder, obsessive-compulsive disorder, major depressive disorder, congestive heart failure, peripheral vascular disease. On 5/27/25 at 9:35 AM, an interview was conducted with resident 4. Resident 4 stated that within the last two months he had experienced some constipation and went a long time without a bowel movement (BM). Resident 4 stated that he used to take Milk of Magnesia (MOM) for constipation. Resident 4 stated that his last BM was on Saturday. Resident 4's medical record was reviewed. Resident 4's physician orders revealed the following: a. On 3/29/24, an order was initiated for MOM Suspension 400 milligrams (mg)/5 milliliters (ml), give 30 ml by mouth as needed for Constipation. b. On 11/26/24, an order was initiated for MOM Oral Suspension 400 mg/5 ml, give 30 ml by mouth every 24 hours as needed for constipation use on day 3 of no BM. Resident 4's May 2025 Medication Administration Record (MAR) documented that the MOM was not administered during the month. Review of resident 4's bowel elimination pattern for the last 30 days revealed: a. On 5/8/25 through 5/13/25, the task documented no BM. The resident went six days without a BM. b. On 5/23/25 through 5/25/25, the task documented no BM. The resident went three days without a BM. On 10/1/18, resident 4 had a care plan initiated for Activities of Daily Living self-care performance deficit related to schizophrenia. The care plan documented under toileting that resident 4 used a urinal for bladder elimination. The care plan did not address resident 4's bowel elimination patter nor treatment for constipation. The care plan focus area for toileting was last updated on 7/27/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility bowel protocol documented that any resident who had gone six full nursing shifts or three days without a bowel movement needed to have the bowel protocol initiated. The protocol documented that after six shifts without a BM staff were to administer Step 1 of the protocol, MOM 30 ml by mouth. The nurse on shift must document whether milk of magnesia was effective or not in producing a bowel movement before shift's end. The protocol Step 2 documented that if the MOM did not produce a BM within 12 hours or the resident refused the next nurse on shift needed to administer a Dulcolax suppository 10 mg rectally. The nurse on shift must document whether the suppository was effective or not in producing a bowel movement before shift's end. The protocol Step 3 documented that if the Dulcolax did not produce a BM within 12 hours of administration the next nurse on shift needed to administer a Fleets enema rectally. The nurse on shift must document whether the enema was effective or not in producing a bowel movement. If no bowel movement was produced, the nurse on shift needs to contact the medical director for further instructions prior to the shift's end. On 5/29/25 at 7:59 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated she did not know where the bowel protocol was located but she thought they had standing orders for the protocol. LPN 2 stated that after three days without a bowel movement they were to administer treatment per the bowel protocol. LPN 2 stated that the Director of Nursing (DON) assisted with tracking of resident bowel movements. On 5/29/25 at 8:07 AM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated that she would monitor the resident's bathroom activity and would check the toilet if she did not assist the resident with toileting. CNA 3 stated that resident 4 was independent with toileting and she would just ask him if he had a bowel movement. CNA 3 stated that if the resident did not have a BM she would notify the nurse. CNA 3 stated that she documented the residents bowel movements in the electronic medical record. On 5/29/25 08:14 AM, an interview was conducted with he DON. The DON stated that they had a bowel protocol that should be implemented if a resident did not have a BM after three days. The DON stated that they had a standing order for MOM for constipation and the nurses and herself tracked resident bowel movements. The DON stated that she generated a report and conducted a daily audit of all resident bowel movements. The DON stated that if there were no documented bowel movements she would ask the staff to check with the resident if they were continent and ask if they had a BM. The DON stated if the resident was not able to inform the staff of their BM then they would implement the bowel protocol. The DON stated that the nurse would inform her if the resident did not have a BM and then they would document in the medical record what treatment was provided. The DON stated that resident 4 did not like to take the MOM. The DON stated that it should have been documented in the MAR if the MOM was administered or refused. The DON reviewed resident 4's MAR and stated that she did not see that the MOM was refused. The DON stated that she did not see any other documentation in the nurse progress notes about a refusal or that resident 4 had a BM. The DON stated that per the bowel protocol the nurse should have administered the MOM on day three of no BM, administered a Dulcolax suppository on day four of no BM, and administered a Fleets enema on day five of no BM. The DON stated that after all treatment had been administered and were not successful they should have notified the provider.

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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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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, it was determined, for 1 of 14 sampled residents, the facility did not ensure that the resident received adequate supervision and assistance devices to prevent accidents. Specifically, the facility did not provide adequate supervision to prevent a resident elopement from the facility on two occasions. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, unspecified convulsions, diabetes mellitus, asthma, hypothyroidism, restless leg syndrome, and dysphagia. On 5/27/25 at 9:18 AM, an interview was conducted with the resident 1. Resident 1 stated that he tried to go outside once in a while but he was not supposed to go out by himself. Resident 1 stated that the doors to the facility were locked. Resident 1's facility abuse investigations were reviewed. On 5/2/24 at 2:47 PM, the facility Form 358 documented that the local Police Department (PD) notified the facility that they found resident 1 wandering one street north of the facility and he seemed confused. The local PD reported that they transported resident 1 to a local area hospital for evaluation. The form documented under details of the incident that the facility had received visitors for church throughout the day. A gate at the facility was left left [sic] slightly open by vistors [sic]. The gate requires a code to enter. [Resident 1] exited through the gate. The form was submitted to the State Survey Agency on 6/2/24 at 4:50 PM. The discrepancies between the date submitted and the date documented on the form were reviewed and it was determined that the 5/2/24, date was a data entry error and the incident actually occurred on 6/2/24. The facility Form 359 documented under the summary of interviews that staff reported, Many used the back gate in the court yard that exits near the parking lot. The gate was not secured and locked by visitors. Staff members did not check the entirety of the court yard when hearing the wander guard alarm. The conclusion of the facility investigation was that the allegation was verified. The corrective actions taken were that staff members were trained that they must assist and attend to any resident wearing a wander guard wishing to access the courtyard. Additionally, the staff were trained to ensure that the courtyard gate was securely locked behind them and signs were posted directing visitors to use the front door of the facility. Resident 1's medical record was reviewed. Resident 1's physician orders revealed the following: a. On 5/4/25, an order was initiated for WANDERGUARD: Check function of device daily every day shift for Elopement risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. On 3/8/24, an order was initiated for WANDERGUARD: To be used at all times d/t [due to] elopement risk. Device located on BACK OF RESIDENT'S WHEELCHAIR. Verify placement of wanderguard q [every] shift. If resident removes wander guard please initiate Q15 min [minute] checks. c. On 3/6/24, an order was initiated for Monitor attempts made by resident to exit seek. Notify management if resident is exit seeking. Supervise resident during these attempts to ensure patient safety. Document number of attempts made and create a progress note. Resident 1's progress notes revealed the following: a. On 3/5/24 at 7:00 PM, the Health Status Note documented, Patient hanging around nurse station wanting to use the phone. RN [Registered Nurse] hands him the patient phone and he dials the number on a paper in his hand. When RN is counting cards and getting report, Patient vacates the room. Soon the ADM [Administrator] and Aide come in side with this Patient. He states 'I wanted to leave.' ADM states she saw him outside the gate and redirected him back into the facility. Aide was out there too and helped with this. RN called non-emeregent [sic] Police line and explained the situation and asked for a policeman to come calm this patient. Then let the patient talk to the police. Later he took his meds [medications], as the police came in. Wanderguard attached to patient W/C [wheelchair] as the patient cuts it off his leg. Dr [doctor] and DON [Director of Nursing] notified 1857 [6:57 PM] Family [name omitted] notified 3/6/24 0730 [7:30 AM]. 15 minute checks continue. b. On 3/9/24 at 3:06 PM, the Alert Note documented, Patient continues on alert charting for exit seeking. Patient requested to go outside to the patio for a few minutes, staff assisted patient and stayed with him, offered some coffee, he appears to be content, close patient watching out the window constantly which is not usual on him, no attempt to leave at the time. c. On 5/16/24 at 6:37 PM, the Alert Note documented, Data entry error - Note Text: Resident is on alert charting for elopement. Resident kicked gate with alarm on it open again today. Resident said he wanted to go find a phone and call the police. Redirected resident inside and assisted him with calling the police for a well checkup. Resident was satisfied after phone call and went back to him room to watch TV. 15 minute checks completed and ongoing. No other elopement attempts this shift. No injuries noted. Notified management. It should be noted that this note was struck out. d. On 5/19/24 at 8:08 PM, the Health Status Note documented, Incomplete Documentation - Note Text: Patient exit seeking a lot this shift, Hanging around the door, alarm ringing a lot. Did take his meds, Then said I was trying to kill him. RN tried to redirect, Patient Insistant [sic] on calling 911, and leaving. Wanting a Dr. for his 'deformity' (Breastbone). Fixated. Finally he kicked the locked door open. It probably opened from the time of 15 seconds of ringing alarm. RN Walked with him down the inner ramp. talking to him. Finally figured if he called 911 he'd be happy. Nurse dialed non emergent number from office phone but Patient DID ALL the talking. 30 minutes later 5 police men came and RN briefed them prior to entry to building. The official in charge talked to him, reinforced stay here and get a Dr. Tomorrow . Dr [name omitted]. Patient calmer after they left. he watched tv for a couple hours, then watched the road for an hour. Then went to bed after 1030 [10:30 PM]. Pt. [patient] Slept all night. It should be noted that this note was struck out. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 6/2/24 at 3:42 PM, the Health Status Note documented, [City name] police officer informed the nurse that [Resident 1] was found heading ones [sic] street north of the facility. The resident was currently safe at the [name of hospital omitted] hospital getting evaluated. Nurse last saw [Resident 1] in his room and in the activity room shortly before getting a call from the officer. The local church provides services to the residents on Sundays. The church visitors were seen talking to [Resident 1] while leaving. The visitors left the gate opened while exiting. This gate is very secure and requires a code to enter/exit. [Resident 1] exited the gate. Nurse received the information from the police officer and contacted the IDT [Interdisciplinary Team] members. Nurse walked to the gate and saw that it was partially open. Nurse secured gate. Nurse assessed resident when resident arrived back at facility. No injuries noted. No signs of physical injury, emotional distress, or mental anguish. f. On 6/2/24 at 3:42 PM, the Alert Note documented, received call from officer. officer stated that pt was found at 400 s [South] and 900 e [East] and transport pt to the [local hospital] ER [Emergency Room]. received call from ER, they are going to do workup on pt and arrange transportation back to facility. notified MD [Medical Doctor], DON, administrator. On 3/28/24, the wander/elopement evaluation documented a score of 12, which would indicate a high risk for elopement or wandering. The evaluation documented, Resident has attempted to leave facility occasionally when he agitated about something. He has a wander guard and 15 minute checks completed. He has contacted 911 and police in the past several times. Redirection, education and re-orientation provided. On 5/16/24, resident 1's wander/elopement evaluation documented a score of 25. The form documented, Resident has hx [history] of elopement. Resident ambulates using a wheelchair. Resident has severe cognitive impairment. Resident overestimates own ability. Resident uses wanderguard d/t elopement risk. Review of resident 1's care plan documented a focus area for delusional thoughts and Resident elopement on 3/5/24. Wander guard placed on back of resident's wheelchair d/t resident's poor safety awareness. Interventions identified on the care plan included: Encourage resident to stay in common areas of building for observation if needed; Monitor location every 15 min when resident refuses his wanderguard or was not wearing his wanderguard; Document wandering behavior and attempted diversional interventions in behavior log; Resident to wear wandergaurd to mitigate risk for elopement; and Resident's elopement attempts were triggered by paranoia/delusional thoughts that result in resident wanting to leave the facility. On 5/27/25 at 8:48 AM, an observation was made of the back gate. The gate had a sign posted that stated, Stop Please make Sure The Gate Is Locked Thank you!!! On 5/27/25 at 10:13 AM, an observation was made of Certified Nursing Assistant (CNA) 2 to disengage the wander guard alarm on the back patio. CNA 2 stated that it alarmed when a resident with a wander guard was close. On 5/27/25 at 12:15 PM, an observation was made of resident 1. Resident 1 walked close to the doorway leading out to the courtyard. Resident 1's wander guard alarmed and the Licensed Practical Nurse 3 turned it off. The resident did not exit the door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 10:06 AM, the State Surveyor observed the back gate closed and verified that the lock was secured. On 5/28/25 at 11:21 AM, an interview was conducted with CNA 4. CNA 4 stated that resident 1's behaviors were paranoia over his medication and giving him the wrong pills. CNA 1 stated that when resident 1 was paranoid he would want out of the facility. CNA 4 stated that if resident 1 could not get the help he wanted he would attempt to leave the facility or would want the ambulance called. CNA 4 stated that she was not aware of resident 1 exiting the facility. CNA 4 stated that she had brought resident 1 inside from the courtyard, and recalled that he was attempting to kick the fence. CNA 4 stated a few weeks ago resident 1 was threatening to throw a chair at the door to get out. CNA 4 stated that resident 1 had a wander guard located on his wheelchair because he could not ambulate. CNA 4 stated that the courtyard door locked at night and it was currently propped open by an air conditioning unit. CNA 4 stated that the day resident 1 was outside in the courtyard was before the courtyard door automatically locked. CNA 4 stated if resident 1 got close enough to a door the wander guard would alarm. CNA 4 stated if they heard the wander guard alarming they were to quickly locate the door, inspect to see what caused it to alarm, and then turn it off. On 5/28/25 at 12:22 PM, an interview was conducted with the DON. The DON stated that the resident had delusions and paranoia. The DON stated that resident 1 had exit seeking behaviors where he would verbalize wanting to leave and then attempting to push the door open. The DON stated that resident 1 had a wander guard located on his wheelchair, but that the resident was able to ambulate with the use of a walker. The DON stated that resident 1 had two instances where he eloped, one time he was found outside and brought back in and the other time he was picked up by the police and taken to the hospital. The DON stated that resident 1 was alert and oriented times two to person and place, but when he was delusional he was only oriented to self. The DON stated that resident 1 had short term and long term memory deficits. On 5/28/25 at 12:41 PM, an interview was conducted with the ADM and the DON. The ADM stated that on 3/5/24, the resident went to the nurse station and then exited the facility through the back patio. The ADM stated that the courtyard door locked when residents with wander guards approached and the doors automatically locked between 8:00 PM and 6:00 AM. The ADM stated that the resident had an order for the wander guard at the time of his first elopement on 3/5/24. The ADM stated if the door was propped open it would alarm to alert the staff. The ADM stated that when the wander guard alarmed the staff should immediately respond and assess the situation and determine if a resident was outside. The ADM stated that the side gate in the courtyard had a lock on it that would have to be disengaged with a code on the keypad. The ADM stated that if all systems were working the door should have locked, the alarm should have sounded, and the back gate should have been locked. The DON stated that the wander guard was previously on resident 1's leg and the progress note documented that he cut it off. The DON stated that the order was updated to place the wander guard on the wheelchair. The ADM stated he was not aware of the resident previously removing his wander guard. The ADM stated that the elopement in June 2024 he was involved in the investigation but was the DON at that time. The ADM stated that the June elopement occurred on a Sunday. The nurse received a call from the police that the resident was found on the street and was currently at the hospital being evaluated. Due to the timing they determined that the local church service left the gate open. The ADM stated that visitors from the church had access to the gate code to disengage the lock. The ADM stated that an intervention from that elopement was that every visitor had to sign a log and were provided education on shutting the gate after exiting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 3:19 PM, a follow-up interview was conducted with the ADM. The ADM stated that he spoke with the previous ADM and reviewed the incident notes. The ADM stated that he came up with a timeline of events for the March 2024 elopement. The ADM stated that on 3/1/24, resident 1 cut his wander guard off and every 15 minute checks were implemented. The ADM stated that the nurses made attempts to place the wander guard back on resident 1 but were unsuccessful. The ADM stated that on 3/5/24 at 7:00 PM, resident 1 exited the side gate of the courtyard. The ADM stated that the previous ADM found resident 1 in front of the facility. The ADM stated that at the time the resident was found outside the facility the wander guard was not on his person but was instead attached to his wheelchair. The ADM stated that on 6/2/24, resident 1 exited the facility by opening the unlocked south gate. The ADM stated that the gate was functional but not secured. The ADM stated that after the elopement in June 2024 the gate was reinforced with a new lock and the hinge mechanism was replaced so it would automatically close when released. The ADM stated that they also had the wanderguard system vendor check the system for proper functioning. The ADM stated that they made changes to the system which included that the door locked from 8:00 PM to 8:00 AM, the facility door lock engaged when the wanderguard was in close proximity, and the facility door would constantly alarm when the wanderguard was outside the set parameters.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that pain management was provided to residents who required such services. Specifically, for 1 out of 14 sampled residents, a resident complaining of pain and requesting to go to the hospital was not provided pain medications, an alternative pain reliever, or nonpharmaceutical pain interventions. Resident identifier: 14. Findings included: Resident 14 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, atherosclerotic heart disease of native coronary artery without angina pectoris. On 5/27/25 at 11:14 AM, resident 14 was observed to tell a Certified Nursing Assistant (CNA) that he was in a lot of pain right now. The CNA stated to resident 14 that she would talk to the nurse. The CNA was observed to tell the nurse that resident 14 was having pain. The nurse stated to the CNA that she would send a message to the Medical Director (MD). Resident 14 was observed to tell the nurse the pain was in his neck and back. The Director of Nursing (DON) was observed to tell resident 14 that X-rays were done not to long ago. Resident 14 stated I need to go to the hospital and get this taken care of. Resident 14 stated that he was in a lot of pain and wanted more than two Tylenol. Resident 14 stated that he wanted six Tylenol because two Tylenol did not help with the pain. The nurse was observed to instruct resident 14 to go lay down in his room. Resident 14 stated he did not want to sit down because he was afraid he would not get back up. On 5/27/25 at 11:22 AM, an interview was conducted with resident 14. Resident 14 stated he was having arthritis pain and he needed something other than two Tylenol to kill the pain. Resident 14 stated he would go to the hospital if he needed to. On 5/27/25 at approximately 12:00 PM, resident 14 was observed walking to the dining room with his cane. Resident 14 stated to the State Surveyor that nothing had been done as of yet and he was still in pain. Resident 14's medical record was reviewed. A care plan Focus dated 5/16/18 and revised on 7/30/23, documented that resident 14 had pain related to headache. Interventions initiated on 5/16/18 and revised on 7/6/21, included: a. The resident's pain is alleviated and relieved by medication and rest. b. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. c. Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects, and impact on function. d. Identify, record, and treat the resident's existing conditions which may increase pain and or discomfort due to headache. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. Monitor and document for probable cause of each pain episode. Remove and limit causes where possible. f. The resident prefers to have pain controlled by Tylenol. It should be noted the care plan was developed for resident 14's headache pain. A quarterly Minimum Data Set assessment dated [DATE], documented that resident 14 had a Brief Interview for Mental Status (BIMS) score of 9. A BIMS score of 8 to 12 would suggest moderate cognitive impairment. On 5/7/25, a quarterly pain assessment documented that resident 14 had pain or hurt at any time in the last five days. Pain frequency was documented as frequent. Pain occasionally had an effect on resident 14's sleep, would frequently interfere with therapy activities, and would occasionally interfere with day to day activities. Resident 14 rated his worst pain over the last five days an eight on a pain scale of zero to ten and pain intensity was moderate. Resident 14 has had vocal complaints and facial expressions of pain over the last five days. Contributing factors to pain listed childhood neck injury and arthritis. Medication and resting helped relieve pain. On 5/26/25 at 10:11 AM, an Orders -Administration Note documented Lidocaine External Patch 4 Apply to Lower Back topically two times a day for Pain Apply during day shift. Keep on for 12hours; Remove at night shift after it has been on for 12 hours. awaitng [sic] pharmacy delivery. The May 2025 Medication Administration Record (MAR) was reviewed: a. A physician's order dated 8/25/23, documented Monitor pain level q [every] shift using 0-10 pain scale. Document ALL interventions being utilized for pain management: 0) No intervention indicated d/t [due to] no pain 1) Scheduled pain medication 2) PRN [as needed] pain medication 3) PRN pain medication offered and refused 4) Repositioning 5) Rest 6) Ice/Heat 7) Other (specify in progress notes) 8) Resident refused all nonpharmacological interventions every shift for PAIN MONITORING. On 5/27/25 at 6:00 AM to 6:00 PM, it was documented on the MAR that resident 14's pain level was 0. The Face, Legs, Activity, Cry, and Consolability scale was 0 and no interventions were utilized. b. A physician's order dated 7/25/24, documented Acetaminophen Extra Strength Tablet 500 MG [milligrams] (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for Pain. It should be noted that resident 14 was not offered acetaminophen for his complaints of pain on 5/27/25, and there was no documentation of a refusal. c. A physician's order dated 5/20/24, documented Biofreeze External Cream 10 % (Menthol (Topical Analgesic)) Apply to Affected areas topically every 8 hours as needed for Pain. It should be noted that resident 14 was not offered Biofreeze for his complaints of pain on 5/27/25, and there was no documentation of a refusal. On 5/28/25 at 11:16 AM, an interview was conducted with resident 14. Resident 14 stated the staff had still not given him anything or done anything about his pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/28/25 at 11:28 AM, an interview was conducted with the DON. The DON stated if the MD was contacted documentation would be in a progress note. The DON stated a message was sent to the MD on 5/27/25, that resident 14 was wanting to go to the hospital for pain and refused Tylenol. The DON stated that the nurse responded that resident 14 was worried if he laid down that he would not get back up. The DON stated three hours later the MD responded and asked if resident 14 was okay and the nurse responded yes. The State Surveyor asked if that was a typical response time for the MD and the DON stated it would depend but with this particular resident he had intermittent complaints with pain. The DON stated they had done X-rays and she believed some of the pain was real and some was delusional. The DON stated that Tylenol was offered often and resident 14 refused it every time. The DON stated there should be a progress note with refusals. The DON stated there had been no other discussion about other pain alternatives for resident 14. The DON stated usually 35 to 40 minutes after resident 14 complained of pain he moved on from the subject.

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F 0761 Level of Harm - Minimal harm or potential for 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 observation and interview, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with accepted professional principles, and included the expiration date when applicable. Specifically, for 1 out of 14 sampled residents, an opened multi use vial of Humalog had expired and a multi use vial of aplisol was not labeled with an open or a discard date. Resident identifier: 15 Findings included: On [DATE] at 10:33 AM, an observation was conducted of the medication fridge located at the nurses station with Licensed Practical Nurse (LPN) 1. There was an open multi use vial of Humalog with a date on the box of [DATE]. LPN 1 stated that she was unsure if the date was an open date or a discard date. The Humalog was available for use and belonged to resident 15. The medication fridge also included an open multi use vial of aplisol that was available for use and did not include an open or discard date. On [DATE] at 11:25 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the Medical Director (MD) did not feel comfortable prescribing resident 15 a sliding scale insulin. The DON stated the MD would prescribe a one time order for the Humalog if resident 15 needed it. The DON stated that typically multi use vials were labeled with an open date. The DON stated the Humalog was good for 30 days from the open date and aplisol was good for 30 days after opened.

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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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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. Resident 26 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, cognitive communication deficit, hemiplegia and hemiparesis of left side, dysphagia, aphasia, and hypertension. Resident 26's medical record was reviewed. On 12/26/24, resident 26 had a physician order initiated for a laboratory draw for a Prothrombin Time (PT) and International Normalized Ratio (INR). The laboratory results were not located in resident 26's medical record. On 5/29/25, the facility emailed a copy of the PT/INR laboratory results for the 12/26/24, order. On 5/29/25 at 2:47 PM, an interview was conducted with the Administrator (ADM). The ADM stated that the 12/26/24, INR was printed from the laboratory website and was not located in resident 26's medical record. On 6/2/25 at 7:40 AM, a follow-up interview was conducted with the ADM. The ADM stated that the laboratory process was that the DON created a calendar for the labs with the dates of the draws. The DON would then follow-up on the results and notify the physician of the results. The ADM stated that the DON would then enter any new orders obtained from the physician after reviewing the lab results. The ADM stated that the DON would document in a progress note the lab results and then would upload the results into the medical record. The ADM stated that the results should be uploaded into the medical record within a week of receiving them back from the laboratory. Based on interview and record review, the facility did not file in the resident's clinical record the laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, for 4 out of 14 sampled residents, the residents did not have laboratory results filed in their medical record. Resident identifiers: 12, 15, 22, and 26. Findings included: 1. Resident 12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included respiratory failure, unspecified dementia, muscle weakness, and bipolar disorder. Review of resident 12's record was completed on 5/27/25 through 6/2/25. On 12/6/24 at 11:50 AM, a health status note revealed the following. . Draw [Vitamin] B12, Folate and Iron panel for Anemia. On 12/6/24, a physician's order revealed to draw a Vitamin B12, Folate, and Iron blood panel one time only for Anemia for 1 Day was completed. On 12/7/24 at 9:58 AM, a health status note revealed the following. Received Vitamin B12, Folate, and Iron levels. MD [medical doctor] have been notified . It should be noted that no laboratory results could be located in the medical record. (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident 15 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included type 1 diabetes mellitus, generalized anxiety disorder, chronic kidney disease stage 3, complete traumatic amputation of two or more left toes, bipolar disorder, and suicidal ideations. Review of resident 15's record was completed on 5/27/25 through 6/2/25. On 12/16/24 at 1:54 PM, a MD Progress Note revealed that resident 15 has been having muscle cramps. He wonders if his electrolytes were off. Muscle cramps - will order Basic Metabolic Panel (BMP). On 12/18/24, a physician's order revealed to draw a BMP and a magnesium level. One time, only for 1 day was completed. On 12/20/24 at 12:00 AM, an encounter progress note revealed that labs were reviewed. It should be noted that no laboratory results could be located in the medical record. 3. Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included intracranial injury without loss of consciousness, type 2 diabetes mellitus, mixed receptive-expressive language disorder, dementia with mood disturbance and agitation, and major depressive disorder with psychotic symptoms. Review of resident 22's record was completed on 5/27/25 through 6/2/25. On 12/18/24, a physician's order revealed to draw a complete blood count with differential, comprehensive metabolic panel, and Valproic Acid one time only was completed. On 4/10/25, a physician's order revealed to draw a glycated hemoglobin, thyroid stimulating hormone, Lipid Panel, and Prolactin. One time, only for 1 day was completed. It should be noted that no laboratory results could be located in the medical record. On 5/29/25 at 2:47 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the lab results requested were uploaded to the resident's medical record today.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview, the facility did not employ a clinically qualified full-time dietitian or another clinically qualified nutrition professional to serve as the director of nutrition services. Specifically, the facility did not employ a full-time Registered Dietitian (RD) and the Dietary Manager (DM) did not meet the requirements to serve as the director of nutrition services. Findings included: On 5/27/25 at 8:55 AM, an initial walk-through of the kitchen was completed. An interview was conducted with the DM who stated he had not completed the training required to serve as the DM. The DM stated that he had been working as the DM for two months. The DM stated that the RD did not work at the facility full-time. The DM stated that he was in the process of obtaining his certifications. On 6/2/25 at 8:53 AM, a follow-up interview was conducted with the DM. The DM stated that he was taking his ServSafe test in two days and he would be taking the Certified Dietary Manager course in the next few weeks On 6/2/25 at 8:59 AM, an interview with the Administrator (ADM) was conducted. The ADM stated that he was aware that the DM was not certified as a dietary manager or with ServSafe. The ADM stated when their previous DM resigned, they moved the current DM to the position. The ADM stated that they have enrolled the DM for the certified dietary manager course, and he was taking his ServSafe test soon.

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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, it was determined, for 1 of 14 sampled residents, the facility did not maintain medical records on each resident that was complete and accurately documented. Specifically, a resident's medication order was entered incorrectly in the medical record. Resident identifier: 15. Findings included: Resident 15 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included type 1 diabetes mellitus, generalized anxiety disorder, chronic kidney disease stage 3, complete traumatic amputation of two or more left toes, bipolar disorder, and suicidal ideations. Review of resident 15's record was completed on 5/27/25 through 6/2/25. On 5/25/25 at 11:22 AM, a physician's order revealed Hydroxyurea Oral Tablet (Hydroxyurea Sickle Cell Disease) Give 25 milligrams (mg) by mouth every 12 hours as needed for Anti-anxiety. On 5/26/25 at 11:24 AM, a nursing progress note revealed that a verbal order was received from the in-house provider to restart hydroxyzine 25 mg by mouth twice a day and as needed. Order in place. It should be noted that no active order for hydroxyzine or a diagnosis for sickle cell disease could be located in resident 15's medical record. On 5/28/25 at 3:34 PM, an observation was made that hydroxyzine 25 mg was in the medication cart available for resident 15. There was no hydroxyurea in the medication cart for resident 15. On 5/29/25 at 2:27 PM, an interview with Licensed Practical Nurse (LPN) 2 was conducted. LPN 2 stated she would double-check the order after she had entered an order, making sure the order was entered in the medical record correctly. LPN 2 stated that when she administered medication to a resident, she would do the six rights of medication administration which were, the right patient, the right dose, the right time, the right amount, the right form, and the right medication. LPN 2 stated that the way she verified the medication was she would take the medication card and verify the medication against the order. On 5/29/25 at 3:10 PM, an interview with the Director of Nursing (DON) was conducted. This State Surveyor (SS) brought to the attention the order of Hydroxyurea 25 mg, to the DON. The DON stated that she had identified the wrong medication that morning and had fixed it, and it was no longer a problem. The SS informed the DON that the wrong order was identified during the survey, prior to being fix. The DON stated that she expected when entering an order for the nurse to verify the medication against the order. The DON stated she also expected the nurse to verify the correct medication was entered into the medical record.

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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, for 1 out of 14 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 disease and infections. Specifically, a resident with a peripherally inserted central catheter (PICC) line and open wounds did not have enhanced barrier precautions (EBP) initiated and a plate guard that dropped to the floor was used on the resident's lunch plate. Resident identifier: 22 Findings included: Resident 22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included intracranial injury without loss of consciousness, type 2 diabetes mellitus, mixed receptive-expressive language disorder, dementia with mood disturbance and agitation, and major depressive disorder with psychotic symptoms. Review of resident 22's record was completed on 5/27/25 through 6/2/25. 1. On 4/25/25, a physician's order revealed the right lateral foot to be cleansed with wound cleanser and pat dry. Apply a small amount of Anasept and alginate, cover with border dressing every day shift. On 5/16/25, a physician's order revealed the right dorsum foot wounds to be cleaned with wound cleanser, apply collagen and cover with bordered gauze every day shift for wound treatment. On 5/16/25, a physician's order revealed the sacrum to be cleaned with wound cleanser, apply collagen and bordered gauze dressing every day shift for wound treatment. On 5/24/25, a physician's order revealed to monitor PICC site to right upper arm every shift for signs and symptoms of infection or extravasation. On 5/24/25, a physician's order revealed to change transparent PICC dressing every seven days and as needed if dressing becomes soiled, wet or dislodged: as needed for intravenous management. On 5/24/25, a physician's order revealed the left lateral foot to have Xeroform gauze with dry sterile gauze over sutures. Cover with kerlix and wrap with ace wrap. Every day shift for incision wound. If entire left foot dressing becomes completely soaked with blood and drainage contact clinic. On 5/27/25 at 9:48 AM, an observation was made that there was no EBP signage or supplies located outside resident 22's room. On 5/29/25 at 1:17 PM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated she did not think there were any residents in the facility on EBP. CNA 2 stated that when she did cares with the residents, she would use gloves. CNA 2 stated that after cares she would sanitize and/or wash her hands. CNA 2 stated that she did not use a gown when doing resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/25 at 1:25 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that she did not have any residents on EBPs. LPN 2 stated that residents with any tubing, catheters, or those with Methicillin-resistant Staphylococcus aureus would be on EBPs. LPN 2 stated that some wounds would need EBP, and she would need to double check if EBP was needed for residents with PICC lines. On 5/29/25 at 3:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated currently there were no residents with EBP in the facility. The DON stated that residents that had wounds and indwelling catheters would qualify to be on EBP. The DON stated that a PICC line would be considered an indwelling catheter. The DON stated staff should don personal protective equipment when doing cares on any resident on EBP. 2. On 5/27/25 at 11:46 AM, an observation was made during the lunch meal service. Resident 22 was sitting at a dining room table with two drinks, flatware, and a plate guard in front of him. On 5/27/25 at 12:09 PM, an observation was made of resident 22 knocking off his drinks and plate guard off the table to the floor while CNA 1 was talking with resident 22. On 5/27/25 at 12:10 PM, an observation was made of the plate guard sitting on a table behind resident 22 after being picked up off the floor. On 5/27/25 at 12:11 PM, an observation was made of CNA 1 setting up resident 22's meal. CNA 1 grabbed the plate guard that had fallen to the floor and placed it on resident 22's plate. On 5/27/25 at 12:29 PM, an interview with CNA 1 was conducted. CNA 1 stated that he thought the plate guard was set away from the drinks that resident 22 knocked off the table. CNA 1 stated that he did not realize that the plate guard he used was picked up off the floor prior to him putting it on resident 22's plate. On 5/29/25 at 3:45 PM, an interview with the Administrator (ADM) was conducted. The ADM stated he expected his staff to retrieve a clean plate guard if it got dropped on the floor. The ADM stated that he also expected that if a plate guard did fall to the floor that it immediately got put in the dirty dishes. The ADM stated that he would not use a plate guard that had dropped on the floor on the resident's plate.