

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46A066	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER Little Cottonwood Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 3094 South State Street South Salt Lake, UT 84115	

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 - Minimal harm or potential for 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 20 sampled residents, that the facility did not ensure that the resident was free from abuse. Specifically, a resident who lacked the capacity to consent to sexual activity was found engaged in a sexual act with another resident. Resident identifier: 30 and 41. Findings included: 1. Resident 30 was admitted to the facility on [DATE] with diagnoses which consisted of Schizoaffective disorder bipolar type, cocaine dependence, and drug induced subacute dyskinesia. On 10/6/25 at 9:47 AM, an interview was conducted with resident 30 while the resident was ambulating down the hallway. Resident 30 stated that she did not want to die, and someone was going to kill her. Resident 30 then stated that someone programmed her to act the way she does. Resident 30 stated that she did not want to leave the facility because she had friends at the facility and that she did not have any problems with any of the other residents. Resident 30's thoughts and speech were tangential during the interview. On 10/6/25 at 10:17 AM, an observation was made of resident 30 in the dining room. Resident 30 was observed pointing at different men in the dining room and stated that they wanted to be with her. Resident 30 was observed to yell at no one to leave her alone. The facility abuse investigation documentation was reviewed. The Form 358 documented that the nurse on shift, Registered Nurse (RN) 1, Around 0200 [2:00 AM] hours on 08/23/2024. [RN 1] the Nurse on Duty noticed that [Resident 41's] walker was outside of the main bathroom, so [RN 1] went to see what was going on. When [RN 1] got there, he found [Resident 41] kissing one female resident [Resident 30] with his right hand on her left breast, on top of her clothing. [RN 1] said that [Resident 30] was not in any distress and smiling about it when the two residents were found kissing and touching. [RN1] also said that the police interviewed [Resident 30], and she said she's fine with it, she smiled and stated, 'he's just a horny guy'. Then [Resident 30] started talking about her delusional thoughts which is within normal with her. (sic) The form documented the immediate actions taken were that RN 1 separated both of the involved residents and the nurse notified the police department. The facility abuse investigation concluded that the allegation was Not Verified due to The facility deemed the incident to be a consensual sexual behavior after the internal investigation due to [Resident 30] response such as smiling and expressing that she's totally fine with the incident without any complaint nor in any distress. On 10/6/25 through 10/8/25, resident 30's medical records were reviewed. On 7/12/24, resident 30's quarterly Minimum Data Set (MDS) assessment documented a Brief Interview for Mental Status (BIMS) score of 00, which indicated a severe cognitive impairment. The assessment documented that resident 30's depression screening (PHQ-9) score was 11, which would indicate moderate depression. The assessment documented that resident 30 had hallucinations and delusions. On 9/12/25, the quarterly MDS documented a BIMS score of 00, PHQ-9 score 12, and had hallucinations and delusions. Resident 30's progress notes revealed the following: a. On 5/15/24 at 8:15 AM, the provider note documented, HPI [history of present illness] ***Patient does endorse episodes of psychosis at this time. Has recognized episodes of auditory, visual and/or tactile hallucinations since previous encounter. Continues to take medications without issue and does not endorse side effects. Staff have not recognized any significant events since last visitation. Delusional content persists, however remains unconcerned and euphoric [sic]. From previous note/encounters: She continues to smile and laugh easily, but has little insight due to delusional ideas She does have some Erotomanic delusions referring to a [NAME], of which he does not exist. From previous note/encounters:[AGE] year old female who currently resides at a SNF [skilled nursing facility], due to inability to care for self She present as delusional and psychotic stating I am the queen of Switzerland, and overall a poor historian She presents with bizarre content and does appear to be responding to internal stimuli. She has odd beliefs and struggles to participate in her examination as a result ***Psychiatric Exam: Behavior: cooperative and eye contact is good. Mood: euthymic. Thought Processes: shows loosening of associations and is tangential. Thought Content: delusions. Appearance: clean. Perception: auditory hallucinations. b. On 6/7/24 at 6:36 PM, the nursing note documented, Speech often incoherent, but Res [resident] able to make needs known. Occ [occasional] difficulty understanding others r/t [related to] confusion, behavior, refusing to listen. BEHAVIOR & MNGT [management]: Episodes of restlessness, anxiety, delusion, hallucination, outburst, paranoia, mood swing, fixation, repetitive. Behavior occ exacerbates but has been manageable and able to redirect with current meds and behavior mngt. c. On 6/12/24 at 8:15 AM, the psych follow up provider note documented, *** HPI***she continues to be desired and display delusional content. However she continues to be relatively</p>		