STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A066	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Cottonwood Rehabilitation and Nursing	3094 South State Street South Salt Lake, UT 84115

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 5 out of 19 sampled residents, that the facility did not maintain medical records on each resident that were complete; accurately documented; readily accessible; and systematically organized. Specifically, a resident's assessment was labeled with another resident's name, a resident's laboratory results were located in another resident's medical records, and a resident's shower sheet had another resident's name listed on the form. Resident identifiers: 5, 13, 15, 27, and 38. Findings included:1. Resident 13 was admitted to the facility on [DATE] with diagnoses which included disorder of brain, major depressive disorder, epilepsy, post-traumatic stress disorder, and insomnia. The Shower Preference form located in resident 13's medical chart had resident 38's name printed on top and signed by resident 13. On 10/8/25 at 1:59 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that the shower preference sheet should have had resident 13's name printed on it and not resident 38's name. LPN 1 stated that the printed name should be the correct name prior to the resident signing the form. LPN 1 stated that the shower sheet should have been corrected prior to placing the form in resident 13's chart. 2. Resident 38 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, unspecified psychosis, anxiety disorder, post-traumatic stress disorder, chronic pain, bipolar disorder, stimulant abuse, borderline personality disorder, and insomnia. On 10/6/25 through 10/8/25, resident 38's medical records were reviewed. Review of a form labeled Consents/Authorizations, dated 5/21/25, documented resident 15's name on the form. The form was located inside resident 38's medical records. On 10/07/25 at 12:22 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the document of consents/Authorizations for resident 15 was located in the wrong chart and that was her responsibility. The DON then stated that the signature on the consent form was resident 38's but that it had resident 15's name on the form. The DON was witnessed to cross out resident 15's name and hand write resident 38's name on the form. 3. Resident 5 was admitted to the facility on [DATE] with diagnoses which consisted of bipolar disorder, dementia, hypertension, insomnia, and drug induced subacute dyskinesia. On 10/6/25 through 10/8/25, resident 5's medical records were reviewed. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 5's laboratory results revealed a thyroid stimulating hormone (TSH) result, dated 6/3/25, for resident 27 that was located inside resident 5's medical records. On 10/8/25 at 9:29 AM, an interview was conducted with LPN 1. LPN 1 stated that resident 27's lab result should not be located inside resident 5's medical record. LPN 1 stated that both resident 5 and resident 27 had scheduled laboratory tests on 6/3/25. On 10/08/25 9:33 AM, an interview was conducted with the DON. The DON was informed of resident 27's TSH lab result that was located in resident 5's medical record. The DON stated that it was her again, and was observed to remove the lab result from resident 5's hard chart.

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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 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. **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 eupporic [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: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 calm and pleasant and takes medications without issue. The side effects witnessed or endorsed this time. From previous note/encounters: she continues to wander the halls mumbling in talking to herself. She appears to be responding to internal stimuli but does not appear distressed or bothered. She's pleasant and friendly and smiles often. Staff report that she takes medications without issue and there are no obvious forms of side effects. d. On 6/26/24 at 8:15 AM, the psych follow up provider note documented, *** HPI ***She continues to be psychotic and delusional and has bizarre beliefs. However, she continues to be pleasant and does not appear to be distressed. e. On 7/10/24 at 8:15 AM, the psych follow up provider note documented, ** HPI ***'I remember you, and did you know that I have a son now'. She continues to make bizarre comments and statements that are delusional in nature. However she is very pleasant and cooperative and does not endorse any feelings of distress or concerns. f. On 7/11/24 at 12:58 PM ,the psychosocial note documented, Resident irrelevantly talks non-stop and mumbles at times. Resident wanders but can easily be redirected for a short time. Resident keeps re-arranging [sic] her clothes on her bed for no reason. Resident is incoherent and has illogical flow of ideas, she talks about her [NAME] children who's [sic] father is [NAME] (for a moment) but in the same conversation she said that [NAME] is her son born after [NAME], and that they all live downstairs. Then out of nowhere she suddenly talks about a lady named [NAME] who she said is running this facility. Resident is pleasant and smiling during the conversation and can express her needs known. She denies any concern. Resident shows little interest or pleasure in doing things, feeling tired/little energy. No current discharge plans this time. g. On 8/7/24 at 10:46 AM, the health status note documented, WEEKLY NURSING ASSESSMENT: COGNITION: Resident alert with confusion. Responsive. Speech often incoherent, but Res able to make needs known. Occ difficulty understanding others r/t [related to] confusion, behavior, refusing to listen. BEHAVIOR & MNGT: Episodes of restlessness, anxiety, delusion, hallucination, outburst, paranoia, mood swing, fixation, repetitive, arguementative [sic] at times. Behavior occ exacerbates but has been manageable and able to redirect with current meds and behavior mngt [management]. h. On 8/23/24 at 9:14 AM, the health status note documented, Late Entry: Note Text: Reported by night nurse that resident found w [with] male resident @ 2am in the BR [bathroom] kissing and male resident touching her breast outside her shirt, Resident not on any distress when found. Police was called ny [sic] the nurse on duty, during the interviewed (sic)- Resident stated male resident 'just a horny guy' then started talking w [with] her delusion thought. Interviewed resident today for fup [follow-up], re- early am incident, resident aware of the sexual behavior w a male resident, stated she's okd [okay] w it and smiling about it. Resident alert w confusion, but able to make needs known and make her own decision and she knows exactly what she wants and not. Resident responsible to self, No POA [power of attorney]. Resident often w delusional thought and mostly sexual- like talking about being pregnant, had sex w different names that resident will say. Resident occ [occasionally] making comments of not having sex life and it's upsetting for her not having sex life. Resident behavior w episodes of exacerbation wc [unknown abbreviation] resident gets more delusional, fixation, paranoia, hallucination, restless, anxiety. Behavior goes on a cycle of being manic to being calmer, but still able to make her needs known, and making her own decision. i. On 9/2/24 at 1:29 PM, the health status note documented, Resident alert, w confusion, episodes of being incoherent. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Behavior been increasing for last 4 to 5 day, l [sic] on manic state, talking and fast pacing most of the time even through the noc [night], hardly been sleeping, yelling, screaming, argumentative, delusion, hallucination, paranoia, restless, anxiety, fast pacing, fixation. Resident talking baout [sic] sexual activity. Behavior been difficult to redirect/ re orient.Md [Medical Doctor] notified, ordered to increase depakote to 500mgpo [milligram by mouth] bid [two times daily] and check level w routine sched [scheduled] labs on Oct. Rn explained order to resident and stated ok. j. On 9/12/24 at 4:50 PM, the health status note documented, Resident alert, w confusion. but able to make needs known. Resident been on hyper state for the last 3 wks, talking/ yelling often, w inapp [inappropriate] verbal/ sexual comments, delusion, hallucination, restless, fast pacing, paranoia, argumentative. Behavior been continuing even at noc. Resident not sleeping much at noc then up about early am. Behavior only able to redirect ffor [sic] less than 2 min then start again. Behavior affecting other residents and complaining w her behavior. Resident had haldol inj [injection] this wk [week] but behavior still continue.Md notified of above, ordered to increased [NAME] [haldol] to 150mg im [intramuscular] q [every] 14 days, increase Seroquel to 300mg po [by mouth] bid. Rn explained order to resident and agreed w it. On 8/7/24, the MD note documented, .Delusional with tangential speech. Believes she is [NAME] and just gave birth to twins. Requires frequent redirection by staff due to poor insight and memory. On 3/20/24, the resident had a court order for mental health treatment. The court order documented that the subject had a civil commitment order that required the resident to abide/comply with the providers plan for continued treatment for their mental health condition. The order was to stay in place unless terminated by the court or the provider. The order was in effect and last reviewed on 8/6/25. On 6/16/23, the Pre-admission Screening and Resident Review (PASRR) Level II documented that resident 30 was unable to care for herself and needed daily management of her medical and psychiatric needs. The assessment documented a long history of schizophrenia including auditory hallucinations, disorganization, and avolition. The assessment documented that resident 30 was chronically delusional/conversations had delusion content at baseline. Her thought was tangential, disorganized and delusional. She told stories about a man, none of which made sense. On 4/13/23, resident 30 had a care plan initiated for Alteration in thought process related to poor safety judgement, confusion, incoherent, behaviors, anxiety, restless, delusions, hallucination, paranoia, outburst, and mood swings. Interventions identified on the care plan included the following: assess the resident's level of consciousness, approach calmly, orient resident as needed, redirect attention as needed, provide prompting, monitor and record behavior, assist with problem solving and decision making, check resident often, notify MD of worsening behavior, and firm approach with set limits. On 7/12/24, resident 30 had a Sexual Activity Capacity to Consent assessment completed. The assessment described the residents cognitive status as alert with confusion and her behavior fluctuated between manic and calm. When resident calm, resident more coherent and make decision (sic) and judgement. The form documented that the resident had repetitive sexual comments but had not initiated any sexual activity. The form documented the resident's psychiatric symptoms of delusions, hallucinations, paranoia, restlessness, anxiety, yelling, outburst and mood swings. The form documented that resident 30 was able to express a consistent choice and understood relevant information. No documentation could be found to demonstrate what relevant information was discussed and understood by resident 30. The assessment documented under Describe risk and / or consequences of their choice: Resident will engaged w other resident in sexual activity. It should be noted that no documentation was found to demonstrate resident 30's understanding of relevant information or what that relevant information included. Additionally, no documentation could be found to demonstrate that resident 30 was able to verbalize the risks or consequences of her choice and what those included. The evaluation determination documented that resident 30 had the capacity to make a decision to engage in sexual intimacy with others. On 10/7/25 at 9:47 AM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 30's behaviors were wandering, pacing, and yelling. CNA 1 stated that when this occurred (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would tell resident 30 to calm down, guide her back to her room, and speak calmly to her. CNA 1 stated that resident 30 had delusions and hallucinations and she would talk to people who were not there. CNA 1 stated that resident 30 did not have any hyper-sexual behaviors. CNA 1 stated that she was not aware of resident 30 having had any sexual conduct with other male residents. CNA 1 stated that if that would occur she would redirect resident 30. She is like a little girl with little girl behaviors. CNA 1 stated she should be notified of any sexual behaviors because she would monitor the resident for those behaviors. CNA 1 stated that it was not like resident 30 to be sexual with anyone and that would be unusual for her. CNA 1 stated that they document behaviors in the ADL charting. It should be noted that resident 30's behavior documentation did not have any behaviors documented by the CNAs. On 10/7/25 at 10:12 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 30's behaviors were that she was married to [NAME] Kennedy; she was of royal blood and very descriptive delusions of how she was pregnant; and she had one of [NAME]'s children. LPN 1 stated that they provided redirection, 1:1 monitoring, and attempted to call her mom when resident 30 had behaviors. LPN 1 stated that most of the time those interventions worked for a short period of time. LPN 1 stated that resident 30 did not have any hyper-sexual behaviors that were actionable, but would talk about it. LPN 1 stated that resident 30 believed the other male residents were her lovers or she wanted them to be her lovers. LPN 1 stated that resident 30 never had any sexual contact or interaction with the male residents at the facility. LPN 1 stated she was not aware of resident 30 having any sexual contact with other residents that included kissing or touching of the genitals. LPN 1 stated that she would separate the residents if they were found engaging in sexual contact; would assess for any injury; and report it to the Administrator (ADM) and Director of Nursing (DON). LPN 1 stated that documentation of any incidents and who was notified would be located in a progress note and an incident report. LPN 1 stated if something like that had occurred she needed to be made aware of it to keep it from happening again. On 10/7/25 at 2:41 PM, an interview was conducted with the ADM. The ADM stated that he and the Resident Advocate (RA) worked together on the abuse investigations. The ADM stated that he typically filled out the form and submitted it to the State Survey Agency (SSA). If he was not present then the RA would submit it on his behalf. The ADM stated he did not indicate sexual abuse as an allegation when it was reported to the SSA because it was consensual sexual behavior. The ADM stated that he would need to speak with the DON to determine why it was determined consensual. I was not present at the time. The ADM stated that the DON let him know that the situation was consensual and the DON would have done an evaluation to make the determination that resident 30 had the capacity to consent to sexual activity. On 10/8/25 at 8:01 AM, an interview was conducted with the DON. The DON stated that resident 30 had confusion but knows what she wants. The DON stated that resident 30 was alert and oriented times 2-3 to person, place and sometimes situation. The DON stated that resident 30 was more confused and delusional now, but had always been delusional. The DON stated that resident 30's delusions were centered around famous people. The DON stated that resident 30 believed she had nine children with [NAME]. The DON stated that a year ago resident 30 was more stable than she was currently. The DON stated that resident 30 had said she was okay with the incident that occurred with resident 41. The DON stated that she did not really know why resident 30 was court ordered for treatment but assumed it was because she did not want to be at the facility and wanted to go home. The DON then stated that resident 30 was deemed not capable to care for herself and needed assistance with medication management. The DON stated that resident 30's mother had stated that resident 30 was non-compliant with her medications. The DON stated that resident 30 had moments of clarity with confusion, but was able to make her own decisions. The DON stated that when she questioned resident 30 about the incident that occurred on 8/23/24 the resident gave the same explanation of the events, was content with it, and was happy with it. The DON stated that resident 30 was fine with the other resident touching her. The DON stated that resident 30 had episodes of mania, with some sexual behaviors such as believing she was having sex with famous people and having children with them. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated that resident 30 never made sexual comments about other residents. The DON stated that when she evaluated resident 30 for the capacity to consent to sexual activity she asked resident 30 if she knew that she could get hurt if she invited other people to touch her. The DON stated that resident 30 stated she understood. The DON stated that at the time of the evaluation resident 30 was able to recall what she did prior to being admitted to the facility and that she had been admitted to a psychiatric inpatient unit. The DON stated that resident 30 understood that she could not go home. The DON stated that during the sexual capacity to consent evaluation she told resident 30 that her sexual activity and verbal comments were inappropriate and could invite other people to do stuff with her. The DON stated that she asked resident 30 if she was okay with that and could she handle that, i.e. the sexual activity. The DON stated that resident 30 replied that she was alright with that behavior. It should be noted that the evaluation did not specify what risks were associated with sexual activity and if resident 30 was able to understand those risks and the consequences of them. Additionally, the evaluation did not demonstrate that resident 30 had the cognitive ability to consent to sexual activity, only that she appeared to want the contact. The DON stated that the RA signed the evaluation form with her but was not present during the evaluation. The DON stated that no one else was present with her during resident 30's evaluation for capacity to consent to sexual activity. The DON stated that resident 30 had delusions with moments of clarity at the time of the evaluation. The DON stated that resident 30's cognitive ability had declined since the incident.

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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 out of 20 sampled residents, that the facility did not ensure that alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and the State Survey Agency (SSA). Specifically, an allegation of sexual abuse was not reported to the state survey agency for approximately 12 hours after the incident occurred. Resident identifiers: 30 and 41. Findings included: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 through 10/8/25, resident 30's medical records and the facility abuse investigation were reviewed. 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. The Form 358 documented that the SSA was notified of the incident on 8/23/24 at 2:13 PM. It should be noted that this was 12 hours after the incident occurred. On 10/07/25 at 2:41 PM, an interview was conducted with the Administrator (ADM). The ADM stated that he and the Resident Advocate (RA) worked together on the abuse investigations. The ADM stated that he typically filled out the form and submitted it to the State Survey Agency (SSA). If he was not present then the RA would submit it on his behalf. The ADM stated he did not indicate sexual abuse as an allegation when it was reported to the SSA because it was consensual sexual behavior. On 10/08/25 at 1:54 PM, a follow-up interview was conducted with the ADM. The ADM stated that the incident was not reported to the SSA immediately because there was no harm or serious bodily injury. [Cross-refer F600]

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Number of residents sampled: 20Number of residents cited: 0 Based on interview and record review, it was determined the facility did not ensure that any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, was competent to provide nursing and nursing related services; and completed a training and competency program, or a competency evaluation program approved by the State. Specifically, a Nurse Assistant (NA) was employed at the facility on a full-time basis, for approximately 9 months without completion of training and competency evaluation program. Findings included:On 10/6/25, a list of employees with their start date was requested from the facility Administrator.NA 1's employee file was reviewed and documented with a start date of 10/17/23, as a housekeeper.On 10/8/25 at 1:17 PM an interview with the Director of Nursing (DON) was conducted. The DON stated that NA 1 started in housekeeping, they trained her initially as a hospitality aide, and continued her training to be a CNA. The DON stated that NA 1 completed her clinical nursing assistant training in May 2024. The DON stated that NA 1 still needed to complete her classroom hours before she could take the exam. The DON stated that NA 1 was scheduled and worked as a full-time nursing assistant since January of 2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A066	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Cottonwood Rehabilitation and Nursing	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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not ensure that the resident assessment accurately reflected the resident's status. Specifically, for 3 out of 20 sampled residents, the facility coded a resident as having received insulin during the seven day Minimum Data Set (MDS) observation period when the resident had not received any insulin. Resident Identifiers: 2, 7, and 28.1. Resident 2 was admitted to the facility on [DATE] with diagnoses which included secondary parkinsonism, disorder of brain, schizoaffective disorder, depressive type, personality disorder, and type 2 diabetes mellitus. Review of resident 2's medical record was completed on 10/6/25 through 10/8/25. Resident 2's Quarterly Minimum Data Set (MDS) assessment dated [DATE], was reviewed. The MDS assessment documented that Resident 2 received insulin on one of seven days of the seven-day lookback observation period. Resident 2's Quarterly MDS assessment dated [DATE], was reviewed. The MDS assessment documented that Resident 2 received insulin on one of seven days of the seven-day lookback observation period. Resident 2's Quarterly MDS assessment dated [DATE], was reviewed. The MDS assessment documented that Resident 2 received insulin on one of seven days of the seven-day lookback observation period. Resident 2's order history was reviewed. There were no orders for insulin after 10/1/24. Resident 2's Medication Administration Record (MAR) was reviewed. There was no documentation that Resident 2 had received any insulin after 10/1/24. 2. Resident 7 was admitted to the facility on [DATE] with diagnoses which included disorder of brain, schizoaffective disorder, bipolar type, and type 2 diabetes mellitus. Review of resident 7's medical record was completed on 10/6/25 through 10/8/25. Resident 7's Quarterly MDS assessment dated [DATE], was reviewed. The MDS assessment documented that Resident 7 received insulin on one of seven days of the seven-day lookback observation period. Resident 7's Quarterly MDS dated [DATE], was reviewed. The MDS assessment documented that Resident 7 received insulin on one of seven days of of the seven-day lookback period. Resident 7's order history was reviewed. There were no orders for insulin after 10/1/24. Resident 7's Medication Administration Record (MAR) was reviewed. There was no documentation that Resident 7 had received any insulin after 10/1/24. On 10/8/25 at 1:04 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated that she was the person that completes and submits the MDS reports. The DON stated that none of the residents in the facility were ordered insulin. The DON stated there were three residents (continued on next page)

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	46A066	A. Building B. Wing	10/09/2025

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	that had a physician's order for Ozempic. However, resident 28 orders were recently discontinued. The DON stated that for residents 2 and 7 they were ordered to receive one Ozempic injection once a week. The DON stated that Ozempic was considered an insulin since it was injected and it is like a long-acting thing that controls blood sugar. According to the Ozempic website, Non-insulin Ozempic works with your body's own ability to lower blood sugar and [glycated hemoglobin] A1C. Ozempic helps your body release its own insulin. And it's designed to respond when your blood sugar rises. https://www.ozempic.com/faqs.html 3. Resident 28 was admitted to the facility on [DATE] with diagnoses including, but not limited to disorders of brain, schizoaffective disorder bipolar type, and idiopathic gout. A review of Resident 28's medical record was completed from 10/6/25 through 10/8/25. Resident 28's Quarterly MDS dated [DATE], was reviewed. The MDS assessment documented that Resident 28 received insulin on one of seven days of the seven-day lookback period. Resident 28's Quarterly MDS dated [DATE], was reviewed. The MDS assessment documented that Resident 28 received insulin on one of seven days of the seven-day lookback period. Resident 28's Annual MDS dated [DATE], was reviewed. The MDS assessment documented that Resident 28 received insulin on one of seven days of the seven-day lookback period. Resident 28's order history for the last year was reviewed. Resident 28 did not have any orders or previous orders for insulin. Resident 28's Medication Administration Record (MAR) for the last year was reviewed. There was no documentation that Resident 28 had received any insulin. On 10/8/25 at 7:47 AM, an interview with Licensed Practical Nurse (LPN) 1 was conducted. LPN 1 stated that currently there are no residents in the facility on insulin.