STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A070	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyonlands Care Center	390 West Williams Way Moab, UT 84532

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 - Immediate jeopardy to resident health or safety 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** 45470 Based on observation, interview, and record review, it was determined that, for 3 of 9 sampled residents, the facility failed to keep residents free from abuse. Specifically, a registered nurse interacted with a resident with unzipped and open pants and touched the resident under the blankets in the abdominal/pelvic area. Additionally, two other residents came forward after the incident with allegations of inappropriate interactions involving the same nurse. Resident identifiers: 1, 2, and 4. It was determined the provider's non-compliance with the requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to the State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect, and Exploitation, F600, at a scope and severity of J. However, based on the facility's corrective actions and a review of its current compliance in this regulatory area, the deficiency was determined to be past noncompliance. The IJ began on March 31, 2025, when Registered Nurse (RN) 1 interacted with Resident 1 with unzipped and open pants and touched the resident under the blankets in the abdominal/pelvic area. RN 1 was subsequently arrested, and two other residents came forward and alleged inappropriate interactions by RN 1. The provider was officially notified verbally and in writing of this finding on May 5, 2025 at 1:00PM. The facility developed and implemented a corrective action plan before the survey start date. The facility's corrective action plan, which was developed and implemented by April 7, 2025 included the following measures: Terminating the nurse involved, interviewing all current residents to identify any potential abuse victims, and conducting physical and psychosocial assessments of the three residents identified as victims. Furthermore, the facility provided mental health services to all residents and trained all staff on abuse prevention. Newly identified abuse allegations were also appropriately reported to the relevant authorities. The health facility investigations team verified that all these interventions were completed before the survey start date. Findings Include: 1. Resident 1 was admitted to the facility on [DATE] with a diagnosis of dementia. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A facility reported incident submitted on April 1, 2025 to the State Survey Agency (SSA) by the by the facility's Administrator, who was also the abuse coordinator, included the following information: On March 31, 2025 at 8:30 PM, a camera set up in Resident 1's room showed RN 1 standing at the bedside of the resident who was lying down. RN 1 was facing Resident 1, and RN 1's back was to the camera. RN 1 unzipped his pants and then zipped them back up. The incident report revealed that in another camera shot, RN 1 reached under Resident 1's covers in the lower abdominal region and did not explain what he was doing. RN 1 was suspended immediately, and the facility started an investigation. Resident 1 was assessed, and no physical injury or mental anguish was noted. The surveyor reviewed the facility's investigation report submitted to the SSA on April 6, 2025, by the facility's Administrator. The Administrator documented, sexual abuse of a vulnerable resident substantiated and verified by evidence collected during the investigation. Perpetrator suspended immediately upon learning of the allegations and terminated the same day after paperwork was completed. He is incarcerated and in his termination letter he was informed that he is not allowed on Canyonlands Care Center grounds again. We feel the current threat is alleviated for the victim and all residents. The facility's investigation report included a plan to prevent recurrence and keep the residents safe. The Administrator documented, We will continue to assess and interview all residents and ensure their safety. We will monitor the resident involved in this situation for any signs of stress, emotional, cognitive, physical injury, or distress, We will continue to work with the residents family to see if they notice any new moods or behaviors and work with them on approaches they want to implement to maintain highest level of cognitive, emotional and physical function. We will retrain our staff on the definitions of abuse, abuse recognition, abuse reporting. Continue with cameras in all common areas and monitor as needed. Encourage any families with nanny cams to report to Administration what they see. Follow regulatory protocols for alleged abuse. Keep residents and residents families involved in all resident careplanning with quarterly careplan meetings. Five 10-second video clips from the 3/31/2025 incident between RN 1 and Resident 1 were provided to the surveyor by the facility. In one video clip, RN 1 stood at Resident 1's bedside. Resident 1 was observed in bed on her back. RN 1's back was to the camera, he was facing the resident, his lower legs touched the mattress, and his hands were in front of him and not visible. RN 1 was then observed to step backward away from the bed. RN 1's pants were observed to be open. RN 1 then slightly pulled his pants up and buttoned them. During the clip, Resident 1 appears to lift her knees under the blanket and pull the blanket up towards her chest when RN 1 steps away from the bed. In another video clip, RN 1 was observed kneeling at Resident 1's bedside, with his ungloved hand and forearm under the blanket near the resident ' s abdomen/pelvis, while the blanket remained covering the resident. RN 1 proceeded to stand up with his hand still under the blanket and moving. During the clip, Resident 1 is observed raising her arm, sliding her hand down the back of RN 1's arm, and holding onto his forearm when he stands up. The surveyor could not interview Resident 1 due to Resident 1's severe cognitive impairment. Resident 1 had a diagnosis of dementia and a Brief Interview for Mental Status (BIMS) score of 04, which indicates severe cognitive impairment. The surveyor conducted a telephone interview with Resident 1's daughter on April 9, 2025 at 2:52 PM. Resident 1's daughter stated that the video footage was disgusting and that she believed her mother was preyed on because she has no memory and is unable to remember or vocalize anything. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On May 5, 2025 at 11:00 AM the surveyor attempted to interview RN 1. RN 1 stated that he did not want to answer any questions. The surveyor completed a review of Resident 1's medical record. No documented evidence was found to explain a care need that would have required RN 1 to have his hand near Resident 1's abdomen or pelvis as observed in the video footage from March 31, 2025. 2. While investigating the incident that occurred between RN 1 and Resident 1 on March 31, 2025, the facility staff interviewed Resident 2 on April 2, 2025. The Administrator documented in an incident report submitted to the SSA that Resident 2 reported that approximately two months before their interview, RN 1 rubbed her back and started getting lower and lower, and the resident told him to stop. Resident 2 further reported that RN 1's zipper was halfway down, and he had his hands in his pants. The surveyor interviewed resident 2 on April 10, 2025 at 9:31 AM. Resident 2 stated that on an unknown date and time, after completing an assessment or skin check, RN 1 dropped his pants to mid-thigh and started playing with himself. Resident 2 stated there was a sound outside of her room, and RN 1 covered himself, and it was over. Resident 2 stated, I didn't know what to do, and It freaked me out .I'm having trouble dealing with it. Resident 2 further stated, It hurts to go to BINGO now .I don't feel comfortable going to BINGO. 3. While investigating the incident that occurred between RN 1 and Resident 1 on March 31, 2025, the facility staff interviewed Resident 4 on April 3, 2025. The Administrator documented in an incident report submitted to the SSA that in their interview with Resident 4, she reported that she had an uncomfortable back and neck rub given by RN 1 and stated, To go clear to the nipple for a neck rub is going too far. The surveyor interviewed resident 4 on April 10, 2025 at 9:13 AM. Resident 4 stated that RN 1 would put a patch on her neck at night for neck pain, and that at the end of March 2025, he had a tube of cream that he applied and rubbed into her neck. Resident 4 stated she did not have an order for cream to be applied to her neck, and during the neck rub, his hands went down to her upper chest and then down further to her nipples. Resident 4 reported she told the nurse, that's enough, and he replied, ok. Resident 4 stated she did not report the incident because I thought I could handle it. Resident 4 stated she feels safe now, but I didn't like it and I was angry. The surveyor interviewed the Director of Nursing (DON) on April 29th, 2025 at 1:25 PM. The DON stated that resident 2 and resident 4 had some on and off memory issues, but were mostly alert and oriented. The DON stated that this was the first time either resident had made an allegation of sexual abuse. 4. The facility reported to the SAA in December 2024 that a resident reported an allegation of inappropriate physical touch by RN 1. The facility reported the incident to the SSA, Police, and Adult Protective Services. The facility completed an investigation and the incident was unable to be substantiated. The resident had a rash that required assessment and RN 1 documented an assessment was completed.