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	07/11/2024

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

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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 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** 33215 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 15 sampled residents, a resident that did not have a Physician Orders for Life-Sustaining Treatment (POLST) or Advance Directive was documented as do not resuscitate (DNR) in their medical record. Resident identifier: 19. Findings included: Resident 19 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, dementia with psychotic disturbance, bradycardia, history of falling, diastolic heart failure, atrial fibrillation, type 2 diabetes mellitus, major depressive disorder, and chronic kidney disease. Resident 19's medical record was reviewed on 7/10/24. A physician's order dated 3/26/24, documented Order Summary: DNR. Advanced Directive Status: Verified By Medical Record Only. Order Type: Advanced Directive. An Advanced Directive or POLST were unable to be located in the medical record. A care plan Focus dated 4/2/24, documented I am DNR and I don't have any known allergies. The goal documented I will be as comfortable as possible through the review date. The intervention initiated on 4/2/24, documented Please follow POLST when there is one, obtain Hospice referral when condition is appropriate, and Family and resident agree. On 4/4/24 at 1:46 PM, a Nursing Note documented Note Text: [Resident 19] went to her admit appointment with [name redacted] today. The doctor scheduled the Lasix and the prn [as needed] order will continue for 7 more days. A CMP [Comprehensive Metabolic Panel] will be drawn in one week. She also discontinued the mirtazapine. The social worker is working on getting a POLST form filled out. (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	On 7/10/24 at 2:18 PM, an interview was conducted with the Social Service Worker (SSW). The SSW stated that she had resident 19 complete a POLST because the SSW did not have one on file. The SSW stated that she would be sending the POLST to the doctor to sign. The SSW stated that upon admission she would complete the initial interview and get the resident to the facility. The SSW stated that she would complete all the admission paperwork with the resident and family. The SSW stated she would ask for a POLST and if the resident did not have a POLST she would ask the resident to take one to their doctor on their admission visit. The SSW stated that if needed she would help the resident fill out the POLST and the SSW would take the POLST to the resident's doctor to sign. The SSW stated she would try to get the POLST completed the first three to four days after admission. The SSW stated the facility tired to get the resident admission appointment within three to four days after their admission. The SSW stated if the resident was a local resident they would already have the admission appointment set up. The SSW stated that out of state residents would need to get established with a doctor and that might take a little longer. On 7/10/24 at 3:03 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated if a resident did not have a POLST the resident would be a full code. RN 1 stated that if a resident did not have a POLST or Advanced Directive she would look into it but it would default to full code. On 7/11/24 at 9:14 AM, an interview was conducted with the Administrator. The Administrator stated that a POLST would be initiated on admission. The Administrator stated the staff would ask the resident if they already had Advanced Directives and if not the staff would help the resident with that process. The Administrator stated that sometimes the delay was on the resident or the doctor. The Administrator stated if the staff know what they want with their code status the staff would help the resident and educate. The Administrator stated if the resident did not have a POLST the resident would default to a full code status.

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	46A070	A. Building B. Wing	07/11/2024

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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** 30563 Based on observation, interview, and record review, the facility did not ensure that all residents were free from abuse. Specifically, for 3 out of 15 sampled residents, allegations of abuse were not investigated to determine if abuse occurred when a staff member reported to management that a residents family member was observed to approach another resident and stand over a resident speaking loudly. In addition, another incident when residents yelled at each other and one resident threw a wet paper towel at another resident were not reported or investigated. Resident identifiers: 20, 22, 23, and 33. Findings included: On 7/10/24 at 9:41 AM, an observation was made of camera footage from the facility. The footage was from 4/22/24 at 10:57 AM. Resident 20 was observed standing next to resident 33 who was seated in a recliner with a family member sitting next to her. Resident 20 and 33 were observed to be talking but the audio was not clear to hear what they were talking about. Resident 20 was observed to pick up her stuffed animal from the bedside table that was in front of resident 33. Resident 20 was observed to throw the stuffed animal on the ground. Resident 33's family member was observed to stand up and walk over to resident 33. The family member was observed talking to resident 33 and standing over resident 33 with shoulders back and standing tall. The family member was observed to pick up the stuffed animal off the ground. Certified Nursing Assistant (CNA) 1 was observed to enter the area and re-directed resident 33 away from resident 20 and the family member. Resident 20 was observed to lean toward her family member and put her head on their shoulder. The family member was observed giving resident 33 a side hug. 1. Resident 20 was admitted to the facility on [DATE] with diagnoses which included dementia severity without behavioral disturbance, malignant, anxiety disorder, insomnia, tubulo-interstitial nephritis, and hypertension. Resident 20's medical record was reviewed on 7/8/24 through 7/11/24. Progress notes revealed on 4/22/24 at 5:51 PM, Behavior Note: Earlier today [resident 20] walked up to room [ROOM NUMBER] [resident 23] and picked up the cup she had in the living room. 214 preceded to yell at [resident 20], [resident 20] yelled back. This nurse heard from the hallway. Upon walking up it was observed that [resident 20] had thrown a wet paper towel at 214, [resident 23] redirected from the area. Both residents moved on within a few moments, neither appeared to having lingering upset feelings. It should be noted that there was no documentation regarding the incident viewed on the camera footage. 2. Resident 23 was admitted to the facility on [DATE] with diagnoses which included dementia, type 2 diabetes mellitus, and hypertension. Resident 23's medical record was reviewed on 7/8/24 through 7/11/24. (continued on next page)

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	46A070	A. Building B. Wing	07/11/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note dated 4/2/24 at 5:53 PM revealed, Earlier today room [ROOM NUMBER] [resident 20] heard yelling with [resident 23] in the living room after 218 had picked up her cup from the table. Upon entering the room this nurse noted that 218 had thrown a wet paper towel at [resident 23], they continued yelling at one another. 218 redirected away from the situation, both residents calmed within moments of the interaction. There was no follow-up alert charting. 3. Resident 33 was admitted to the facility on [DATE] with diagnoses which included dementia, muscle weakness, and chronic kidney disease. Resident 33's medical record was reviewed on 7/8/24 through 7/11/24. There was no documentation of the incident with resident 20 on 4/22/24. On 7/9/24 at 1:21 PM, an interview was conducted with the Therapeutic Recreational Therapist (TRT). The TRT stated she was also a CNA. The TRT stated resident 20 wandered around the facility and stopped to talk with residents and staff. The TRT stated resident 20 was alert to person and family sometimes. The TRT stated resident 20 liked to walk with people and other times told people to go away. The TRT stated some residents had a difficult time with resident 20 because resident 20 had been known to yell at other resident. The TRT stated staff intervened as quickly as possible and re-directed her. The TRT stated resident 20 had verbal and physical altercations with other residents in the past but could not remember who or when. The TRT stated she reported any of those interactions to the nurse and the Administrator because she did not know if it could be an abuse concern. The TRT stated she would report any hitting, scratching, biting, or purposefully running into another resident. The TRT stated mental abuse was a fine line. The TRT stated she did not try to determine if situations were abuse or not and that was why she reported everything to Administration. On 7/9/24 at 2:00 PM, an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that resident 20's needs were anticipated by staff. The MDS coordinator stated resident 20's wandering patterns were tracked by the staff, for example when and where the resident was wandering. The MDS Coordinator stated that once in a while other residents were irritated by resident 20, for example when she walked up and stood close to them. The MDS Coordinator stated residents had been angry and asked resident 20 what she was doing and she sometimes yelled back at them. The MDS Coordinator stated staff needed to keep a close eye on resident 20 because staff knew she irritated other residents. The MDS Coordinator stated if there were raised voices, then staff always looked for resident 20 because she was probably irritating another resident. The MDS Coordinator stated some residents were more irritated by resident 20 than others. The MDS Coordinator stated the male residents usually did not understand why resident 20 stood close to them. The MDS Coordinator stated most of the male residents were in the 100 hallway and resident 20 resided in the 200 hallway. The MDS Coordinator stated resident 23 had raised her voice at resident 20 before and resident 20 threw something at resident 23. The MDS Coordinator stated that was something that would be investigated as potential abuse. The MDS Coordinator stated the Administrator and Director of Nursing (DON) conducted abuse investigations. The MDS Coordinator stated when conducting an abuse investigation the camera footage was reviewed. (continued on next page)

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	46A070	A. Building B. Wing	07/11/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 4:27 PM, an interview was conducted with the Administrator. The Administrator stated she was the abuse coordinator. The Administrator stated when an abuse allegation was reported to her and there were cameras throughout the facility so the camera footage was reviewed. The Administrator stated the camera footage was reviewed to see if it met the criteria of willful injury or if it was a stay out of my space type thing. The Administrator stated resident 20 was a sweetheart and would not hurt a fly. The Administrator stated some residents might yell back at her, like resident 23. The Administrator stated if the resident did not make physical contact with each other it was not abuse. The Administrator stated verbal abuse would be if residents used derogatory names toward each other. The Administrator stated abuse was the willful infliction of injury for physical abuse. The Administrator stated residents yelling at each other was not verbal abuse. The Administrator stated any verbal interaction would need to be looked at to determine if there was abuse or not. The Administrator stated she did not have any allegations of abuse since the previous survey to investigate. On 7/10/24 at 9:19 AM, a follow-up interview was conducted with the Administrator. The Administrator stated she reviewed the definitions of abuse and she looked for willful intent to harm when reviewing the camera footage. The Administrator stated residents that had dementia, could not help their actions but the interaction could still be willful. The Administrator stated there were no current residents that targeted each other. The Administrator stated she reviewed the camera footage from the incident between resident 20 and resident 23. The Administrator stated it looked like resident 20 had a napkin rolled up and she tossed it into resident 23 lap. The Administrator stated if staff observed the incident and there was no harm, then staff did not need to contact Administration. The Administrator stated if staff felt there was something questionable, that Administration needed to review then it was reviewed. The Administrator stated there would be a care plan for residents after an incident. The Administrator stated an incident report would be completed if the resident was super aggressive and then alert charting would be completed. The Administrator stated if staff felt it was an occasional argument with no harm of any sort then there would not be an incident report or alert charting. The Administrator stated alert charting was completed in the psychotropic's area, daily nursing notes, alert notes, or behavior charting. The Administrator stated resident 20 and resident 23 had so many good interactions but only the negative ones were documented. The Administrator stated the incident between resident 20 and resident 23 was ruled out to not be abuse within two hours. The Administrator stated she did not have documentation on how abuse was ruled out besides it was an interaction and there was no harm. On 7/10/24 at 9:41 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated on 4/22/24, she witnessed resident 20 cleaning up resident 23's spilled coffee on an over bed table. LPN 2 stated she heard resident 23 and resident 20 yelling at each other. LPN 2 stated she re-directed the residents away from each other and checked to make sure they were okay. LPN 2 stated she reported to the DON and Administrator to make sure no one was hurt and then put a behavior note in each residents medical record. LPN 2 stated if there had been an injury or abuse then she would have filled out an incident report, called the families, notified the physician's, and notified the Administrator and DON about the incident. LPN 2 stated she did not witness the incident between resident 33's family member and resident 20. LPN 2 stated the incident was reported to her and she assumed that the DON investigated it and took care of the notifications. (continued on next page)

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	46A070	A. Building B. Wing	07/11/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 9:45 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that the Social Service Worker (SSW) showed resident 33's family member the camera footage because the family member was standing over resident 20. The MDS Coordinator stated the SSW, DON, and Administrator had a meeting with resident 33's family member. The MDS Coordinator stated there was an informal investigation into abuse and sometimes the abuse investigations were so smooth no one noticed they were completed. On 7/10/24 at 9:51 AM, an interview was conducted with the SSW. The SSW stated she watched camera footage of an incident on 4/22/24, between resident 33's family member and resident 20. The SSW stated she was notified of the incident the following morning during the morning meeting. The SSW stated a staff member that reported the incident was very concerned that resident 33's family member was out of control with one of the residents. The SSW stated she observed resident 20 standing by resident 33 and her family member. The SSW stated resident 33's family member was irritated by the way he physically carried himself. The SSW stated that resident 20 needed to be acknowledged and then she moved along. The SSW stated if resident 20 did not get attention then she became feisty. The SSW stated her impression of the camera footage was resident 20 was ignored and when resident 20 picked up the stuffed animal it was to get attention. The SSW stated resident 33's family member stood up out of the chair, said words to resident 20, then picked up the stuffed animal off the floor and yelled for staff to come get resident 20. The SSW stated she had a meeting with resident 33's family member and showed the camera footage and the family member stated it was an overreaction and humbly apologized. The SSW stated she monitored resident 20 after the incident and she did not seam to be upset about it. The SSW stated resident 20's reaction in he camera footage was observed closely because staff needed to make sure resident 20 was protected. The SSW stated resident 33 was not as upset after the incident. The SSW stated there was lots of alert charting completed, staff tried to provide resident 20 with one on one supervision because she wandered. The SSW stated the incident was not abuse because of how the receiving party felt about it. The SSW stated if there would have been any physical or verbal interaction, that could be construed as an attack. The SSW stated if resident 20 would have responded as being scared or threatened in any way that would have been abuse. The SSW stated resident 33's body language in the video, was not a change in how she usually was with her family member. The SSW stated resident 20 did not have the comprehension of what was going on and did not appear to be threatened or afraid. The SSW was observed to review resident 20's and resident 33's medical record and stated there was no documentation regarding the incident. The SSW stated the biggest thing was, resident 33's family member was not allowed back into the facility if there were anymore interactions like that with other residents. The SSW stated people did not understand resident 20 and would get frustrated with her. The SSW stated that resident 23 was a grumbler and was upset with others. The SSW stated the same day resident 20 knocked over things of resident 23 and resident 23 yelled at resident 20. The SSW stated resident 20 and resident 23 did not know what was going on the day they yelled at each other. (continued on next page)

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Canyonlands Care Center	390 West Williams Way Moab, UT 84532

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at approximately 10:00 AM, an interview was conducted with LPN 2. LPN 2 stated there was no alert charting after the situation with resident 33's family member and resident 20. LPN 2 stated she communicated with staff that something happened and to be more aware of how resident 20 interacted with others. LPN 2 stated she reported the incident to administration and it was reported the following morning in the morning meeting. LPN 2 stated resident 20 did not realize the situation happened. LPN 2 stated that CNA 1 reported what happened to her that day with resident 20 and resident 33's family member. LPN 2 stated the same day resident 23 was yelling and resident 20 picked up a wet paper towel and threw it at resident 23. LPN 2 stated that resident 20 and resident 23 were both very reactive but easily re-directed. LPN 2 stated she reported the situation to administration because she was worried about the yelling. On 7/11/24 at 8:44 AM, an interview was conducted with CNA 1. CNA 1 stated abuse training had been provided through a computer based system, in-services, and pamphlets distributed from management. CNA 1 stated on 4/22/24, she was walking down the 100 hallway, saw resident 33's family member telling resident 20 to get away. CNA 1 stated she redirected resident 20 out of the area. CNA 1 stated she did not see what happened prior. CNA 1 stated resident 33's family member seamed a little aggressive because of his posture toward resident 20. CNA 1 stated she reported the incident to LPN 2 who was the nurse for the 100 hallway that day and the SSW. CNA 1 stated resident 33's family did not seam to pleased with resident 20, so she wanted to get resident 20 out of the situation quickly. CNA 1 stated resident 20 did not usually make sense when she was talking to other residents. CNA 1 stated other residents had expressed to her that they felt like they were being targeted by resident 20. CNA 1 stated she explained to other residents that resident 20 did not know what she was doing. CNA 1 stated resident 22 expressed to her that he felt like resident 20 was out to get him, and that resident 20 did not belong at the facility. CNA 1 stated resident 22 had gotten upset with resident 20 when she tired to move a table and resident 22 yelled at resident 20. CNA 1 stated another nurse was there when the incident happened and it was reported to the DON, SSW, and the Administrator. CNA 1 stated she was not interviewed or asked any questions about the incident. CNA 1 stated she reported the incident with resident 33's family member and resident 20 because the way the family member came at resident 20. CNA 1 stated the family member's demeanor felt like a get away from me, get away from her. CNA 1 stated also the way the family members voice sounded and he had a fist like he was ready to go like fight someone if he needed to. CNA 1 stated after the incident resident 33 and resident 20 seamed ok. (continued on next page)

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	46A070	A. Building B. Wing	07/11/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 11:42 AM, an interview was conducted with the Administrator. The Administrator stated she looked at the camera footage and resident 20 was standing by resident 33 and the family member. The Administrator stated resident 20 was asked to leave by resident 33's family member and then resident 20 started to play with a toy that was on the bedside table. The Administrator stated resident 20 was observed to lightly toss the toy on the ground. The Administrator stated the family member stood up and got big in stature and appeared irritated with resident 20. The Administrator stated CNA 1 was observed in the camera footage re-directing resident 20 away from resident 33. The Administrator stated that she immediately set-up a meeting with resident 33's family member to educate about not getting upset with resident's because it was their home. The Administrator stated the meeting was the next day. The Administrator stated the family member was educated if there were any problems, then staff needed to be alerted. The Administrator stated the family member felt bad after watching the clip, now the family member and resident 20 were friends. The Administrator stated she did not see anything willful or the intent to hurt by the family member. The Administrator stated the incident was not reported to the State Survey Agency because abuse was ruled out within two hours. The Administrator stated every morning nursing progress notes were reviewed for all residents in the facility. The Administrator stated camera footage was reviewed if there were any reported incidents. The Administrator stated she did not have documentation regarding how abuse was ruled out within two hours. The Administrator stated she ruled out the incident as nothing. The Administrator stated if there was a potential abuse situation, then the staff completed an incident report. The Administrator stated there was no incident report completed or alert charting. A note titled Abuse Reporting Reminder was located at the 200 hallway nurses station. The note revealed This is a very important subject that I need all your help with since I'm not here 24 hours. I only have 24 hours to report alleged abuse or abuse of any kind to the state authorities. This includes Resident to Resident Abuse and Staff to Resident Abuse. Abuse is defined as 'Willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.' If there is any Resident to Resident altercation where contacts made, I need to know immediately so I can start my investigation and instruct you on what you need to do. We are a controlled setting so first and foremost we need to keep the residents involved apart and the nurse needs to assess both residents. If the resident to resident contact appeared in the common area we can watch the cameras to see exactly what happened. If a resident reports getting abused by another resident in a residents room and its unwitnessed by staff, you can interview and assess the residents. If a staff member witnesses it, have them write a statement immediately. If you are a CNA or housekeeper, tell the Charge Nurse and ten call or text me. [number removed] If you are the Nurse, please call or text me as soon as you have an understand of the event. Time is of the essence for our facility to abide by all abuse regulations. If the resident is injured, I only have 2 hours to call the State, the Police and the Ombudsman. If uninjured, I have 24 hours. If there is anything questionable, I need to be notified immediately. Even if you just want to talk through a situation, call or text anytime. (continued on next page)

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	46A070	A. Building B. Wing	07/11/2024

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I am the abuse coordinator, I take my job very seriously. [DON] and [SSW] also help with this but I am the one to immediately notify. [phone number removed]. Thanks for your help with this. I appreciate all you do to help keep our residents safe, healthy and happy. [signed by the Administrator and phone number removed] The facility Abuse Prevention Program policy and procedure dated December 2016 was reviewed and revealed the following: Policy Statement Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Policy and Interpretation and Implementation As Part of the resident abuse prevention, the administration will: 1. Protect our resident from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family member, legal representatives, friends, visitor, or any other individual. 2. 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect or mistreatment of our residents. 4. 5. Implement measures to address factors that may lead to abusive situations. 6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframe's as required by federal requirements; 8. Protect residents during abuse investigations; 9. 10. (Cross refer to F609)

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	46A070	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on interview and record review, the facility did not ensure that residents were free from physical or chemical restraints imposed for purposes of discipline or convenience and that were not required to treat the resident's medical symptoms. Specifically, for 1 out of 15 sampled residents, a Registered Nurse (RN) gave a resident an unprescribed 25 milligram (mg) dose of Trazodone in addition to the resident's prescribed nightly dose of 25 mg of Trazodone. Resident Identifier: 17. Findings Included: Resident 17 was admitted to the facility on [DATE] with diagnoses including aspiration of fluid, respiratory failure, amnesia, nocturia, constipation, and occlusion and stenosis of right posterior cerebral artery. Resident 17's medical record was reviewed from 7/8/24 through 7/11/24. On 5/10/24, resident 17's quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 14, indicating no cognitive impairment. Resident 17's progress notes revealed the following: a. On 2/25/24 at 6:56 PM, an alert note documented, [Resident 17] was given at least one extra dose of trazadone [sic]. Monitor for altered LOC [level of consciousness] and other adverse affects for 72 hours. Complete a nursing note Qshift [every shift]. b. On 2/25/24 at 7:02 PM, a nurse note documented, [Resident 17] appeared more tired than usual this morning. She stated 'I just can't wake up.' Otherwise, Alert and oriented. She has been going to the restroom on her own without issues. She ambulated outdoors in the garden and came to the dining area for dinner. No signs of distress throughout the day. O2 sats [oxygen saturations] above 90%. c. On 2/26/24 at 10:39 PM, a nurse note documented, No a/e [adverse effects] noted from administration of additional trazadone [sic] this shift. d. On 2/27/24 at 5:39 PM, a nurse note documented, [Resident 17] has been very tired today. She had a fall early this morning and it seems to have taken a lot of energy. She has been accepting of care. Resident 17's Incident Reports revealed that on 2/25/24 at 9:00 AM, At 0800 [8:00 AM] this morning it was reported to the Administrator and DON [Director of Nursing], by 2 nurses, that resident may have received an extra dose of Trazadoe [sic] last night and potentially another night. Med [medication] error protocol initiated. Review of the facility investigation documentation for resident 17 revealed the following: (continued on next page)

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	07/11/2024

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility initial investigation, form 358, documented that an allegation of willful mistreatment occurred on 2/23/24. The form documented that staff became aware of the allegation at 8:00 AM on 2/25/24, and notified facility administration on 2/25/24. The form documented that the night shift nurse, RN 3 reported to the day shift nurse that she gave 50 mg of Trazodone to resident 17 in order to help her sleep. The facility final investigation summary, form 359, documented that the conclusion of the investigation was that the allegation was verified. The form documented, Allegation and admittance verified by perpetrator via text and by camera footage on 2-24-24 after 2200 [10:00 PM]. Perpetrator resigned after being suspended pending investigation. Resident 17's Medication Administration Record (MAR) for the month of February 2024 was reviewed. There were no documented additional doses of Trazodone on the MAR during the dates of the incident. On 7/8/24 at 2:33 PM, an interview was conducted with Resident 17. Resident 17 was unable to recall the incident. On 7/9/24 at 2:20 PM, a voice mail phone message was left for RN 3 after an attempt was made to call her. RN 3 did not return the call or voice mail. On 7/9/24 at 3:07 PM , an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she received her report from RN 3 when coming onto her shift on the morning of 2/24/24. LPN 1 stated that RN 3 told her that she had given resident 17 an extra dose of Trazodone. LPN 1 stated that RN 3 told her she was going to enter an order for the medication. LPN 1 stated that the next morning, RN 3 stated that she had given resident 17 another 25 mg of Trazodone after another nurse had already given resident 17 her prescribed dose of 25 mg of Trazodone. LPN 1 stated that she went over and talked to the nurse over the other unit at the facility, RN 4. LPN 1 stated that herself and RN 4 reviewed resident 17's chart and saw that resident 17 only had orders for 25 mg of Trazodone to be given each night. LPN 1 stated that Trazodone was a medication used to help residents at the facility sleep. LPN 1 stated that residents that received this medication should be monitored for excessive sleepiness. LPN 1 stated that herself and RN 4 reported the incident to the facility Administrator and the DON. LPN 1 stated that after the incident, all staff at the facility received additional training on reporting abuse and medication administration protocols. (continued on next page)

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	07/11/2024

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 8:33 AM, an interview was conducted with RN 4. RN 4 stated that prior to the incident, resident 17 had a history of not sleeping well. RN 4 stated that on 2/24/24, RN 3 told her she had given resident 17 50 mg of Trazodone because she was frustrated with how often resident 17 had been pressing her call bell during the night. RN 4 stated that this was double the prescribed dose of 25 mg. RN 4 stated that RN 3 had asked her not to say anything, and RN 4 filed a request form for resident 17's medical provider to increase the prescribed dosage of Trazodone. RN 4 stated that on 2/25/24, she was told by a Certified Nursing Assistant (CNA) that the CNA had overheard RN 3 tell LPN 1 that she gave resident 17 an additional 25 mg of Trazodone the night of 2/24/24. RN 4 stated that she talked to LPN 1. RN 4 stated that LPN 1 told her that RN 3 had given resident 17 a double dose of Trazodone. RN 4 stated that herself and LPN 1 reviewed resident 17's chart and could not find documentation that extra doses of Trazodone had been administered. RN 4 stated that she notified the Administrator and the DON at 8:00 AM on 2/25/24, through text message. RN 4 stated that on the morning of 2/25/24, resident 17 was extremely sleepy, hard to ambulate, and that she required a one to two person assist. RN 4 stated that this was not resident 17's baseline and that she was typically more independent. RN 4 stated that resident 17 kept stating, I feel so sleepy, I can't wake up. RN 4 stated that she was not aware of any other residents at the facility receiving extra doses of Trazodone or any other medications. On 7/10/24 at 9:32 AM, an interview was conducted with the Administrator. The Administrator stated that on the morning of 2/25/24, she received a call from one of her nurses. The Administrator stated that the nurse told her that she needed to relay what she was told during the morning report. The Administrator stated that the day shift nurse told her that the night shift nurse, RN 3 told the day shift nurse that she had given resident 17 an extra 25 mg dose of Trazodone. The Administrator stated that she suspended RN 3 immediately and that RN 3 resigned immediately after the suspension. The Administrator stated that the incident was reported to the Department of Professional Licensing. The Administrator stated that resident 17 had no recollection of the incident, but that she had staff monitor resident 17 for extra sedation. The Administrator stated that RN 3 would have had to have obtained the extra dose of Trazodone from resident 17's own supply. The Administrator stated that she was able to verify that resident 17 received an extra dose of Trazodone on 2/24/24, from security footage that showed RN 3 obtained another dose of Trazodone. The Administrator stated that the camera footage showed the evening nurse giving the scheduled dose of 25 mg of Trazodone and that it showed RN 3 obtained another dose after coming on shift at 10:00 PM. The Administrator stated that in order for resident 17 to receive an additional dose of Trazodone, there would need to be a physician's order. The Administrator stated that after the incident, she reviewed resident 17's chart. The Administrator stated that the chart did not document any additional administrations of Trazodone other than the prescribed 25 mg dose. The Administrator stated that after the incident, she provided training to all nurses on staff about medication administration protocols and instructed them to not give residents medication that was not prescribed. The Administrator stated that she had not heard of any other residents receiving extra doses of any medications and that she had not received any complaints from residents or staff.

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	07/11/2024

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

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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** 30563 Based on observation, interview, and record review, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment were reported immediately, but not later than two hours after the allegation was made. Specifically, for 3 out of 15 sampled residents, management did not report or investigate when a staff member reported to management that a residents family member was observed to approach another resident and stand over a resident speaking loudly. In addition, another incident when residents yelled at each other and one resident threw a wet paper towel at another resident were not reported or investigated. Resident identifiers: 20, 22, 23, and 33. Findings included: On 7/10/24 at 9:41 AM, an observation was made of camera footage from the facility. The footage was from 4/22/24 at 10:57 AM. Resident 20 was observed standing next to resident 33 who was seated in a recliner with a family member sitting next to her. Resident 20 and resident 33 were observed to be talking but the audio was not clear to hear what they were talking about. Resident 20 was observed to pick up her stuffed animal from the bedside table that was in front of resident 33. Resident 20 was observed to throw the stuffed animal on the ground. Resident 33's family member was observed to stand up and walk over to resident 33. The family member was observed talking to resident 33 and standing over resident 33 with shoulders back and standing tall. The family member was observed to pick up the stuffed animal off the ground. Certified Nursing Assistant (CNA) 1 was observed to enter the area and re-directed resident 33 away from resident 20 and the family member. Resident 20 was observed to lean toward her family member and put her head on their shoulder. The family member was observed giving resident 33 a side hug. 1. Resident 20 was admitted to the facility on [DATE] with diagnoses which included dementia severity without behavioral disturbance, malignant, anxiety disorder, insomnia, tubulo-interstitial nephritis, and hypertension. Resident 20's medical record was reviewed on 7/8/24 through 7/11/24. Progress notes revealed on 4/22/24 at 5:51 PM, Behavior Note: Earlier today [resident 20] walked up to room [ROOM NUMBER] [resident 23] and picked up the cup she had in the living room. 214 preceded to yell at [resident 20], [resident 20] yelled back. This nurse heard from the hallway. Upon walking up it was observed that [resident 20] had thrown a wet paper towel at 214, [resident 23] redirected from the area. Both residents moved on within a few moments, neither appeared to having lingering upset feelings. It should be noted that there was no documentation regarding the incident viewed on the camera footage. 2. Resident 23 was admitted to the facility on [DATE] with diagnoses which included dementia, type 2 diabetes mellitus, and hypertension. (continued on next page)

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	07/11/2024

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Canyonlands Care Center	390 West Williams Way Moab, UT 84532

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 23's medical record was reviewed on 7/8/24 through 7/11/24. A behavior note dated 4/22/24 at 5:53 PM revealed, Earlier today room [ROOM NUMBER] [resident 20] heard yelling with [resident 23] in the living room after 218 had picked up her cup from the table. Upon entering the room this nurse noted that 218 had thrown a wet paper towel at [resident 23], they continued yelling at one another. 218 redirected away from the situation, both residents calmed within moments of the interaction. There was no follow-up alert charting. 3. Resident 33 was admitted to the facility on [DATE] with diagnoses which included dementia, muscle weakness, and chronic kidney disease. Resident 33's medical record was reviewed on 7/8/24 through 7/11/24. There was no documentation of the incident with resident 20 on 4/22/24. On 7/9/24 at 1:21 PM, an interview was conducted with the Therapeutic Recreational Therapist (TRT). The TRT stated she was also a CNA. The TRT stated resident 20 wandered around the facility and stopped to talk with residents and staff. The TRT stated resident 20 was alert to person and family sometimes. The TRT stated resident 20 liked to walk with people and other times told people to go away. The TRT stated some residents had a difficult time with resident 20 because resident 20 had been known to yell at other residents. The TRT stated staff intervened as quickly as possible and re-directed resident 20. The TRT stated resident 20 had verbal and physical altercations with other residents in the past but could not remember who or when. The TRT stated she reported any of those interactions to the nurse and the Administrator because she did not know if it could be an abuse concern. The TRT stated she would report any hitting, scratching, biting, or purposefully running into another resident. The TRT stated mental abuse was a fine line. The TRT stated she did not try to determine if situations were abuse or not and that was why she reported everything to Administration. On 7/9/24 at 2:00 PM, an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that resident 20's needs were anticipated by staff. The MDS Coordinator stated resident 20's wandering patterns were tracked by the staff, for example when and where the resident was wandering. The MDS Coordinator stated that once in a while other residents were irritated by resident 20, for example when she walked up and stood close to them. The MDS Coordinator stated residents had been angry and asked resident 20 what she was doing and she sometimes yelled back at them. The MDS Coordinator stated staff needed to keep a close eye on resident 20 because staff knew she irritated other residents. The MDS Coordinator stated if there were raised voices, then staff always looked for resident 20 because she was probably irritating another resident. The MDS Coordinator stated some residents were more irritated by resident 20 than others. The MDS Coordinator stated the male residents usually did not understand why resident 20 stood close to them. The MDS Coordinator stated most of the male residents were in the 100 hallway and resident 20 resided in the 200 hallway. The MDS Coordinator stated resident 23 had raised her voice at resident 20 before and resident 20 threw something at resident 23. The MDS Coordinator stated that was something that would be investigated as potential abuse. The MDS Coordinator stated the Administrator and Director of Nursing (DON) conducted abuse investigations. The MDS Coordinator stated when conducting an abuse investigation the camera footage was reviewed. (continued on next page)

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	07/11/2024

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at 4:27 PM, an interview was conducted with the Administrator. The Administrator stated she was the abuse coordinator. The Administrator stated when an abuse allegation was reported to her and there were cameras throughout the facility so the camera footage was reviewed. The Administrator stated the camera footage was reviewed to see if it met the criteria of willful injury or if it was a stay out of my space type thing. The Administrator stated resident 20 was a sweetheart and would not hurt a fly. The Administrator stated some residents might yell back at her, like resident 23. The Administrator stated if the residents did not make physical contact with each other it was not abuse. The Administrator stated verbal abuse would be if residents used derogatory names toward each other. The Administrator stated abuse was the willful infliction of injury for physical abuse. The Administrator stated residents yelling at each other was not verbal abuse. The Administrator stated any verbal interaction would need to be looked at to determine if there was abuse or not. The Administrator stated she did not have any allegations of abuse since the previous survey to investigate. On 7/10/24 at 9:19 AM, a follow-up interview was conducted with the Administrator. The Administrator stated she reviewed the definitions of abuse and she looked for willful intent to harm when reviewing the camera footage. The Administrator stated residents that had dementia, could not help their actions but the interaction could still be willful. The Administrator stated there were no current residents that targeted each other. The Administrator stated she reviewed the camera footage from the incident between resident 20 and resident 23. The Administrator stated it looked like resident 20 had a napkin rolled up and she tossed it into resident 23's lap. The Administrator stated if staff observed the incident and there was no harm, then staff did not need to contact Administration. The Administrator stated if staff felt there was something questionable, that Administration needed to review then it was reviewed. The Administrator stated there would be a care plan for residents after an incident. The Administrator stated an incident report would be completed if the resident was super aggressive and then alert charting would be completed. The Administrator stated if staff felt it was an occasional argument with no harm of any sort then there would not be an incident report or alert charting. The Administrator stated alert charting was completed in the psychotropic's area, daily nursing notes, alert notes, or behavior charting. The Administrator stated resident 20 and resident 23 had so many good interactions but only the negative ones were documented. The Administrator stated the incident between resident 20 and resident 23 was ruled out to not be abuse within two hours. The Administrator stated she did not have documentation on how abuse was ruled out besides it was an interaction and there was no harm. On 7/10/24 at 9:41 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated on 4/22/24, she witnessed resident 20 cleaning up resident 23's spilled coffee on an over bed table. LPN 2 stated she heard resident 23 and resident 20 yelling at each other. LPN 2 stated she re-directed the residents away from each other and checked to make sure they were okay. LPN 2 stated she reported to the DON and Administrator to make sure no one was hurt and then put a behavior note in each residents medical record. LPN 2 stated if there had been an injury or abuse then she would have filled out an incident report, called the families, notified the physician's, and notified the Administrator and DON about the incident. LPN 2 stated she did not witness the incident between resident 33's family member and resident 20. LPN 2 stated the incident was reported to her and she assumed that the DON investigated it and took care of the notifications. (continued on next page)

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	07/11/2024

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 9:45 AM, an interview was conducted with the MDS coordinator. The MDS coordinator stated that the Social Service Worker (SSW) showed resident 33's family member the camera footage because the family member was standing over resident 20. The MDS coordinator stated the SSW, DON, and Administrator had a meeting with resident 33's family member. The MDS coordinator stated there was an informal investigation into abuse and sometimes the abuse investigations were so smooth no one noticed they were completed. On 7/10/24 at 9:51 AM, an interview was conducted with the SSW. The SSW stated she watched camera footage of an incident on 4/22/24, between resident 33's family member and resident 20. The SSW stated she was notified of the incident the following morning during the morning meeting. The SSW stated a staff member that reported the incident was very concerned that resident 33's family member was out of control with one of the residents. The SSW stated she observed resident 20 standing by resident 33 and her family member. The SSW stated resident 33's family member was irritated by the way he physically carried himself. The SSW stated that resident 20 needed to be acknowledged and then she moved along. The SSW stated if resident 20 did not get attention then she became feisty. The SSW stated her impression of the camera footage was resident 20 was ignored and when resident 20 picked up the stuffed animal it was to get attention. The SSW stated resident 33's family member stood up out of the chair, said words to resident 20, then picked up the stuffed animal off the floor and yelled for staff to come get resident 20. The SSW stated she had a meeting with resident 33's family member and showed the camera footage and the family member stated it was an overreaction and humbly apologized. The SSW stated she monitored resident 20 after the incident and she did not seam to be upset about it. The SSW stated resident 20's reaction in the camera footage was observed closely because staff needed to make sure resident 20 was protected. The SSW stated resident 33 was not as upset after the incident. The SSW stated there was lots of alert charting completed, staff tried to provide resident 20 with one on one supervision because she wandered. The SSW stated the incident was not abuse because of how the receiving party felt about it. The SSW stated if there would have been any physical or verbal interaction, that could be construed as an attack. The SSW stated if resident 20 would have responded as being scared or threatened in any way that would have been abuse. The SSW stated resident 33's body language in the video, was not a change in how she usually was with her family member. The SSW stated resident 20 did not have the comprehension of what was going on and did not appear to be threatened or afraid. The SSW was observed to review resident 20's and resident 33's medical record and stated there was no documentation regarding the incident. The SSW stated the biggest thing was, resident 33's family member was not allowed back into the facility if there were anymore interactions like that with other residents. The SSW stated people did not understand resident 20 and would get frustrated with her. The SSW stated that resident 23 was a grumbler and was upset with others. The SSW stated the same day resident 20 knocked over things of resident 23 and resident 23 yelled at resident 20. The SSW stated resident 20 and resident 23 did not know what was going on the day they yelled at each other. (continued on next page)

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	07/11/2024

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at approximately 10:00 AM, an interview was conducted with LPN 2. LPN 2 stated there was no alert charting after the situation with resident 33's family member and resident 20. LPN 2 stated she communicated with staff that something happened and to be more aware of how resident 20 interacted with others. LPN 2 stated she reported the incident to administration and it was reported the following morning in the morning meeting. LPN 2 stated resident 20 did not realize the situation happened. LPN 2 stated that CNA 1 reported what happened to her that day with resident 20 and resident 33's family member. LPN 2 stated the same day resident 23 was yelling and resident 20 picked up a wet paper towel and threw it at resident 23. LPN 2 stated that resident 20 and resident 23 were both very reactive but easily re-directed. LPN 2 stated she reported the situation to administration because she was worried about the yelling. On 7/11/24 at 8:44 AM, an interview was conducted with CNA 1. CNA 1 stated abuse training had been provided through a computer based system, in-services and pamphlets distributed from management. CNA 1 stated on 4/22/24, she was walking down the 100 hallway, saw resident 33's family member telling resident 20 to get away. CNA 1 stated she redirected resident 20 out of the area. CNA 1 stated she did not see what happened prior. CNA 1 stated resident 33's family member seamed a little aggressive because of his posture toward resident 20. CNA 1 stated she reported the incident to LPN 2 who was the nurse for the 100 hallway that day and the SSW. CNA 1 stated resident 33's family did not seam to pleased with resident 20, so she wanted to get resident 20 out of the situation quickly. CNA 1 stated resident 20 did not usually make sense when she was talking to other residents. CNA 1 stated other residents had expressed to her that they felt like they were being targeted by resident 20. CNA 1 stated she explained to other residents that resident 20 did not know what she was doing. CNA 1 stated resident 22 expressed to her that he felt like resident 20 was out to get him, and that resident 20 did not belong at the facility. CNA 1 stated resident 22 had gotten upset with resident 20 when she tired to move a table and resident 22 yelled at resident 20. CNA 1 stated another nurse was there when the incident happened and it was reported to the DON, SSW, and the Administrator. CNA 1 stated she was not interviewed or asked any questions about the incident. CNA 1 stated she reported the incident with resident 33's family member and resident 20 because of the way the family member came at resident 20. CNA 1 stated the family member's demeanor felt like a get away from me, get away from her. CNA 1 stated also the way the family members voice sounded and he had a fist like he was ready to go like fight someone if he needed to. CNA 1 stated after the incident resident 33 and resident 20 seamed ok. (continued on next page)

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	46A070	A. Building B. Wing	07/11/2024

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 11:42 AM, an interview was conducted with the Administrator. The Administrator stated she looked at the camera footage and resident 20 was standing by resident 33 and the family member. The Administrator stated resident 20 was asked to leave by resident 33's family member and then resident 20 started to play with a toy that was on the bedside table. The Administrator stated resident 20 was observed to lightly toss the toy on the ground. The Administrator stated the family member stood up and got big in stature and appeared irritated with resident 20. The Administrator stated CNA 1 was observed in the camera footage re-directing resident 20 away from resident 33. The Administrator stated that she immediately set-up a meeting with resident 33's family member to educate about not getting upset with resident's because it was their home. The Administrator stated the meeting was the next day. The Administrator stated the family member was educated if there were any problems, then staff needed to be alerted. The Administrator stated the family member felt bad after watching the clip, now the family member and resident 20 were friends. The Administrator stated she did not see anything willful or the intent to hurt by the family member. The Administrator stated the incident was not reported to the State Survey Agency because abuse was ruled out within two hours. The Administrator stated every morning nursing progress notes were reviewed for all residents in the facility. The Administrator stated camera footage was reviewed if there were any reported incidents. The Administrator stated she did not have documentation regarding how abuse was ruled out within two hours. The Administrator stated she ruled out the incident as nothing. The Administrator stated if there was a potential abuse situation, then the staff completed an incident report. The Administrator stated there was no incident report completed or alert charting. A note titled Abuse Reporting Reminder was located at the 200 hallway nurses station. The note revealed This is a very important subject that I need all your help with since I'm not here 24 hours. I only have 24 hours to report alleged abuse or abuse of any kind to the state authorities. This includes Resident to Resident Abuse and Staff to Resident Abuse. Abuse is defined as 'Willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.' If there is any Resident to Resident altercation where contacts made, I need to know immediately so I can start my investigation and instruct you on what you need to do. We are a controlled setting so first and foremost we need to keep the residents involved apart and the nurse needs to assess both residents. If the resident to resident contact appeared in the common area we can watch the cameras to see exactly what happened. If a resident reports getting abused by another resident in a residents room and its unwitnessed by staff, you can interview and assess the residents. If a staff member witnesses it, have them write a statement immediately. If you are a CNA or housekeeper, tell the Charge Nurse and then call or text me. [number removed] If you are the Nurse, please call or text me as soon as you have an understanding of the event. Time is of the essence for our facility to abide by all abuse regulations. If the resident is injured, I only have 2 hours to call the State, the Police and the Ombudsman. If uninjured, I have 24 hours. If there is anything questionable, I need to be notified immediately. Even if you just want to talk through a situation, call or text anytime. (continued on next page)

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	46A070	A. Building B. Wing	07/11/2024

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I am the abuse coordinator, I take my job very seriously. [DON] and [SSW] also help with this but I am the one to immediately notify. [phone number removed]. Thanks for your help with this. I appreciate all you do to help keep our residents safe, healthy and happy. [signed by the Administrator and phone number removed]. The facility Abuse Investigating and Reporting Policy and Procedures revised July 2017 were reviewed and revealed the following: Policy Statement All reports of residents, abuse, neglect, exploitation, misappropriate of resident property, mistreatment and/or injuries of unknown source ('abuse') shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported. Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; . 2. An alleged violation of abuse, neglect, exploitation or mistreatment .will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. (Cross refer to F600)

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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** 33215 Based on observation, interview, and record review, the facility did not keep the resident environment as free of accident hazards as was possible; and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 1 out of 15 sampled residents, a resident that choked on their food and required the Heimlich maneuver did not have interventions implemented to prevent future choking. Resident identifier: 31. Findings included: Resident 31 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, systolic congestive heart failure, left bundle branch block, cardiac arrhythmia, basal cell carcinoma of skin, schizophrenia, adult failure to thrive, and insomnia due to medical condition. On 7/9/24 at 1:55 PM, an interview was conducted with resident 31. Resident 31 stated that breakfast that morning was really good. Resident 31 stated that she coughed all the time on her food because she had problems with her lungs. Resident 31 stated that she was able to eat lunch today and the staff served spaghetti. Resident 31's medical record was reviewed on 7/9/24. A care plan Focus dated 1/2/24, documented I have adult failure to thrive, r/t [related to] nausea, Na+ [Sodium] Diet restrictions, and Fluid restriction of 1800ml [milliliters] Hyperlipidemia. The interventions included, but were not limited to, RD [Registered Dietician] to evaluate and make diet change recommendations PRN [as needed]. An additional care plan Focus dated 1/2/24, documented I have an ADL [activities of daily living] self-care performance deficit r/t Disease Process CHF [congestive heart failure], Fatigue. The interventions included, but were not limited to, EATING: The resident is able to: eat independently with set up. On 1/3/24, the Nutrition/Dietary Assessment documented that the ordered diet was low sodium/fluid restriction. It was marked on the assessment that resident 31 required Continual Assistance: Requires constant assistance and/or supervision throughout meal. On 1/9/24, a physician's order documented low salt diet, regular texture. On 3/25/24 at 9:23 AM, a Nursing Note documented Note Text : During breakfast [resident 31] felt that she could not breath. Her vitals were BP [blood pressure] 115/80, HR [heart rate] 111, Resp [respirations] 20, o2 [oxygen] 95 RA [room air], temp [temperature] 97.0. [Resident 31] states that she was eating her cereal and swallowed wrong causing her to be short of breath. I had her cough, take deep breaths and rest in the chair for a moment. After about 5 minutes [resident 31] said she was feeling and breathing better. [Resident 31] sounded as though she has some phlem [sic] in her throat. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly (state optional) Minimum Data Set (MDS) assessment dated [DATE], documented that resident 31 required supervision of one person with eating. The MDS further documented that resident 31 had a Brief Interview for Mental Status (BIMS) score of 15. A BIMS score of 13 to 15 indicated cognitive cognition intact. On 6/1/24 at 6:42 PM, a COMMUNICATION - with Physician documented Situation: The Heimlich maneuver was performed. Background: [resident 31] choked at dinnertime (1700) [5:00 PM]. Assessment (RN) [Registered Nurse] /Appearance (LPN) [Licensed Practical Nurse]: [resident 31] walked into the dining area and when observed, she had her mouth wide open, gasping for air. She raised her hand up to her throat and when asked if she could breathe, stated 'no' by shaking her head. Her lips turned purple/blue. A piece of meat surfaced with the attempt of the Heimlich maneuver. She was continuously reminded/encouraged to cough. O2 saturations were monitored and remained stable. Once returned to her room, [resident 31's] O2 saturations were 96% RA and HR 80bpm [beats per minute]. She had no further complaints of shortness of breath. Reccomendations [sic]: Monitor for signs/symptoms of aspiration pneumonia and respiratory distress. On 6/1/24 at 6:51 PM, an Alert Note documented Note Text: [resident 31] was seen walking into the dining area at dinner time, when [name redacted], CNA [Certified Nursing Assistant] stated 'She's choking.' When I turned to observe the situation, [resident 31] had her mouth open gasping for air and raised her hand up to her neck. When asked if she could breathe, she shook her head 'no.' Her lips started turning purple/blue, so I immediately took action and attempted the Heimlich maneuver. I encouraged her to cough, to which she coughed up a piece of ground meat. She continued to complain that she couldn't breathe, gasping for air once more, so another attempt was made. She was, again encouraged to cough. I encouraged her to sit down and checked her O2 saturations, which were 95% RA and her heart rate was 102 bpm. She started saying 'I'm okay, it's getting better.' She returned to her chair in the common living area to finish her dinner. She had no further difficulty or complaints of shortness of breath. On 6/1/24 at 9:29 PM, a Behavior Note documented Note Text: [resident 31] was calm and accepting of care. She experienced a choking episode during dinner. She was heard talking to herself after dinner in her room while watching television. On 6/2/24 at 2:51 PM, a Behavior Note documented Note Text: Pleasant and cooperative with staff and peers. n [sic] choking episodes this shift. On 6/2/24 at 8:54 PM, an Alert Note documented Note Text: No adverse effects noted from increase to Coumadin dose. [Resident 31] has had no coughing or wheezing this shift. O2 sat [saturation] at baseline. On 6/3/24 at 5:44 PM, an Alert Note documented Note Text: Resident remains at baseline, no respiratory symptoms noted, appetite good. (continued on next page)

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	46A070	A. Building B. Wing	07/11/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24, an Office Visit note documented by the provider revealed . [resident 31] did choke on a piece of meat a few days ago while eating her dinner. She did require Heimlich maneuver to be performed by nurse. [Resident 31] does have a tendency to eat very quickly. She also mentions that she coughs when she drinks water. Instead she chews on ice which she has no trouble swallowing. Assessment & Plan (2) Esophageal dysmotility: Problem Comment: mild esophageal dysmotility noted on esophagram October 2023. This study was ordered by pulmonologist, who she saw during her hospitalization at [name redacted]. The study was done in [name redacted]. This did show mild esophageal dysmotility and transient stasis of a barium tablet at the hypopharynx, but eventual passage. This probably does explain her frequent coughing when drinking water. She instead will chew ice which she has no trouble swallowing. On 6/6/24 at 4:19 PM, a Nursing Note documented Note Text: [resident 31] had her recertification appointment with [name redacted] today. [Resident 31] and the doctor talked about the benefits of being at the care center, specifically the drastic improvement in her CHF. The doctor was informed of the choking episode on Saturday. [Resident 31] told the doctor that she has a difficult time swallowing especially fluids. She told [name redacted] the reason she chews ice chips rather than drinks water is because the water goes down the wrong tube. [Name redacted] ordered an esophagram to be done next week. On 6/6/24 at 8:20 PM, a Behavior Note documented Note Text: [resident 31] was calm and cooperative with care today. She denies any lingering issues from her choking episode a couple days ago. She had a Dr's [doctors] appointment today, a swallow study was ordered. On 6/7/24 at 11:53 AM, a Nursing Note documented Note Text: [name redacted] messaged me this morning and said she has decided not to order the swallow study for [resident 31] because she had one completed in October. On 6/9/24 at 1:52 PM, a Behavior Note documented Note Text : [resident 31] chooses to self isolate away from others during meals. She usually eats in the Livining [sic] room. She eats her meal in less than 5 minutes and is back to her room. She has an occasional deep cough, O2 93% on RA. On 6/15/24 at 12:39 PM, a Nutrition/Dietary Note documented Note Text: [resident 31's] weight is 127.8 pounds, this has been stable for he past 3 months, and has increased since admission. She is getting a low sodium diet, with regular consistency. She has had some choking with fluids, and has talked with her MD [Medical Doctor] regarding this. Currently, she is continuing with regular consistency of foods and fluids. Continue to encourage PO [by mouth] intake. I will continue to follow her care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 1:27 PM, an interview was conducted with RN 2. RN 2 stated that choking would be defined as a food obstruction or blockage of air flow. RN 2 stated that using the Heimlich maneuver would be choking. RN 2 stated coughing was phlem or a sickness. RN 2 stated that choking was not normal. RN 2 stated the facility did not have a Speech Therapist (ST) on site but if an ST was needed she would have the doctor order a ST evaluation or she would send the resident out. RN 2 stated the residents worked with their individual providers and the providers would come to the facility and do the resident recertification visits. RN 2 stated the staff were able to send a 24 notice to the provider through the computer if anything was needed. RN 2 stated that management made appointments for the residents. RN 2 stated she had worked the shift after resident 31 had choked. RN 2 stated that she had received in report that resident 31 was eating in a recliner in the TV area and resident 31 started to choke and walked to the nurses station. RN 2 stated the nurse that was on shift turned resident 31 away from the dining room area facing the wall and performed the Heimlich maneuver. On 7/10/24 at 6:28 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated she was standing by the nurses station and the CNA was there and everyone was getting their dinner trays. LPN 1 stated she was talking to the CNA and turned around to go to the nurses station when the CNA stated that resident 31 was chocking. LPN 1 stated that resident 31 could not breath and was gasping. LPN 1 stated that she asked resident 31 if she could breath and resident 31 shook her head no. LPN 1 stated that she took resident 31 to the nurses station and did the Heimlich maneuver and a piece of meat came up. LPN 1 stated that she told resident 31 to keep coughing and had resident 31 sit down. LPN 1 stated she got resident 31's oxygen saturation and everything seemed okay. LPN 1 stated that resident 31's lips were blue. LPN 1 stated that she was not sure of a protocol after doing the Heimlich maneuver on a resident. LPN 1 stated she reported to the Director of Nursing (DON), the doctor, and made a note about the event to monitor resident 31 for aspiration pneumonia. LPN 1 stated that resident 31 was monitored for lung sounds but not vital signs. LPN 1 stated that resident 31 did get her blood pressure monitored every shift. LPN 1 stated that she did mention to someone but she was not sure who about changing resident 31's diet to a ground meat. LPN 1 stated the RD was responsible for the hospital side. LPN 1 stated she was not sure if there was anyone that did swallow evaluations anymore. LPN 1 stated she had worked at the facility for eight years and had not seen anyone do a swallow evaluation in a long time. On 7/11/24 at 8:55 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 31 was pretty independent but resident 31 did require help with her bath. CNA 1 stated that the staff cut up resident 31's food because resident 31 choked a lot. CNA 1 stated that resident 31 needed assistance with cutting up meats. CNA 1 stated if a resident required supervision with eating that would require then to que the resident. CNA 1 stated that resident 31 mainly ate in the living room. CNA 1 stated that resident 31 did pretty good eating if her food was cut up super small. CNA 1 stated the CNA staff had an alert charting in the front of the CNA book that documented that resident 31 needed her food cut up. An observation of the CNA book was conducted with CNA 1. CNA 1 stated if the documentation was highlighted yellow the CNAs did not need to worry about it because it was completed. The front of the CNA book documented Attention: Please Read alert charting daily! CNA 1 stated the documentation would indicate what was current or what happened on the prior shift. The second page of the alert charting documented 6/1/24 203 [resident 31] choked @ dinner on 6/1/2024 cut up her food for her to reduce choking hazard. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 12:12 PM, an interview was conducted with the Administrator. The Administrator stated if a resident required the Heimlich maneuver it should go into alert charting to monitor the resident. The Administrator stated the staff should monitor oxygen saturations and pass along to monitor for complications. The Administrator stated that a speech evaluation would be done if the doctor said to order those assessments. The Administrator stated there was not a ST anywhere in the town. The Administrator stated that she thought Occupational Therapy had a speech endorsement. The Administrator stated anything the doctor ordered they could do at the facility. The Administrator stated that staff could recommend a diet change. The Administrator stated resident 31 did what she wanted and was high functioning. The Administrator stated that resident 31 would check herself out of the facility and would go to the corner market. The Administrator stated that she was not sure if anyone had spoken to resident 31 regarding a diet change or ways to prevent choking in the future.