

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 46A071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Lomond Peak Nursing and Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 524 East 800 North Ogden, UT 84404	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200</p> <p>Based on observation and interview it was determined, for 4 of 29 sampled residents, the facility did not provide a safe, clean, comfortable and homelike environment, which included housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, resident rooms were observed to have fly strips that were covered in flies that had been hung for an unknown amount of time. Resident identifiers: 8, 24, 34 and 47.</p> <p>Findings Include:</p> <p>On 4/22/24 at 11:23 AM, an observation was made in the 100 and 200 hall. Fly strips with dead flies were found in room [ROOM NUMBER] and room [ROOM NUMBER].</p> <p>On 4/22/24 at 12:27 PM, an observation was made of room [ROOM NUMBER] with a fly strip present. Multiple dead flies were observed stuck to the paper.</p> <p>On 4/22/24 at 2:56 PM, an observation was made of room [ROOM NUMBER] with a fly strip hanging from the ceiling. The fly strip was visible from the resident hallway and had multiple dead flies.</p> <p>On 4/22/24 at 12:54 PM, an interview was conducted with Housekeeper (HK) 1. HK 1 stated they were responsible for cleaning resident rooms. HK 1 stated they never touched the fly strips. HK 1 stated the fly strips drove them crazy. HK 1 stated they wondered how the flies were getting in the building and believed it was because of the open doors. HK 1 stated they knew the flies were inside since they were stuck on the fly strips. HK 1 stated they had accidentally touched one of the fly strips with their head recently and was immediately grossed out. HK 1 stated they did not have extra fly strips in their supply area and they were unaware of where to find more.</p> <p>On 4/23/24 at 8:46 AM, an interview was conducted with resident 8. Resident 8 stated that she does not know how long the fly strip had been in her room. Resident 8 stated that she was told that the fly strip needed to be up in her room to help with gnats.</p> <p>On 4/23/24 at 11:12 AM, an interview was conducted with resident 34. Resident 34 stated she was unsure how long the fly strip had been up in the corner of her room. Resident 34 stated that it had been there long enough to have dead flies attached to it. Resident 34 stated that no one had come to check on the fly strip or to remove it.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/23/24 at 11:19 AM, an interview was conducted with resident 47. Resident 47 stated that the fly strip was placed in his room last summer. Resident 47 stated that he did not remember asking for the fly strip to be placed in his room. Resident 47 stated that there were a lot of flies in the summer inside the facility.</p> <p>On 4/24/24 at 10:04 AM, an interview was conducted with resident 24. Resident 24 stated that she asked for the fly strip about one year ago and it has never been changed or removed.</p> <p>On 4/24/24 at 9:30 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated that fly strips went up in spring or late fall. The Maintenance Director stated that some residents had a hard time keeping the food from getting flies. The Maintenance Director stated that residents had to ask for the fly strips. The Maintenance Director stated that there were some fly strips in common areas and ultraviolet (UV) plug in lights to help combat the flies in the facility. The Maintenance Director stated that fly strips were changed monthly or more often if a lot of flies started to accumulate. The Maintenance Director stated that residents asked to have the fly strips taken down.</p> <p>On 4/25/24 at 10:27 AM, an interview was conducted with the Administrator (ADM). The ADM stated that a pest company sprayed the facility monthly. The ADM stated that UV lights had been added to areas in the facility to help cut down on insects. The ADM stated that fly strips were hung up in resident rooms if residents complain about flies. The ADM stated that the Maintenance Director kept a log of what rooms had the fly strips in them. The ADM stated that he knew that the strips were hung up in the spring and fall and that was when the flies were the worst in the building.</p> <p>On 4/25/24 at 11:35 AM, the log of the fly strips was reviewed. Rooms 101 (Resident 24) and room [ROOM NUMBER] (Resident 8) were not included on the log as having fly strips in their rooms.</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563</p> <p>Based on observation, interview and record review it was determined the facility did not provide sufficient support personnel to safely and effectively carry out the function of the food and nutrition services. Specifically, meals were served later than the posted meal time, there were contradicting meal times provided to surveyors verses posted in the dining room and residents complained of late meals. Resident identifiers: 17, 30, and 68.</p> <p>Findings include:</p> <p>On 4/22/24 at 10:38 AM, an interview was conducted with Cook 1. Cook 1 stated the 200 hall cart was served, then 100 and 300 hallway, then the other 300 hallway cart, the independent residents in the main dining room and then residents who required assistance. Cook 1 stated she started serving at 11:45 AM.</p> <p>On 4/22/24 at 12:01 PM, the meal times were posted in the main dining room. The meal times for lunch were the hallways were 12:00 PM, the assisted dining was served at 12:15 PM and independent was served at 12:30 PM.</p> <p>The meal times provided by the Administrator (ADM) upon entrance to the facility revealed the first hall cart for the lunch meal was to be delivered at 12:00 PM and the last cart was delivered at 12:30 PM. The dining room was to be served at 12:30 PM.</p> <p>On 4/22/24 at 12:12 PM, an announcement through the facility was observed. The staff member announced the hall cart was ready. The hall meal cart was observed at the end of the 100 hallway outside the dining room.</p> <p>On 4/22/24 at 12:13 PM, the meal cart was observed to be taken to the 200 hallway at 12:13 PM. The first tray was delivered to room [ROOM NUMBER].</p> <p>On 4/22/24 at 12:32 PM, an observation was made of a meal cart in the 100 hallway. An observation was made of the meal cart transported to the 300 hallway. An observation was made of the hall trays to be delivered.</p> <p>On 4/22/24 at 12:35 PM, an observation was made of the facility dining room. 2 residents were observed in the dining room.</p> <p>On 4/22/24 at 12:43 PM, an observation was made of the 300 hallway meal cart being delivered.</p> <p>On 4/22/24 at 12:54 PM, an observation was made of the 400 hallway meal cart. The meals from the cart were done being serving at 12:59 PM.</p> <p>On 4/22/24 at 1:02 PM, an observation was made of the main dining room. Meals were observed to be served in the dining room.</p> <p>(continued on next page)</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/24/24 at 12:07 PM, an observation was made of lunch tray service in hall 200. The first tray was served.</p> <p>On 4/24/24 at 12:22 PM, an observation was made of lunch tray service in hall 100. The first tray was served.</p> <p>On 4/24/24 at 12:24 PM, the ADM stated to resident 68 that his lunch would be served to him within 5-10 minutes in hall 400.</p> <p>On 4/24/24 at 12:25 PM, an observation was made of lunch tray service in hall 300. The first tray was served.</p> <p>On 4/24/24 at 12:46 PM, an observation was made of lunch tray service in hall 400.</p> <p>On 4/24/24 at 12:22 PM, an observation was made of the 100 hallway meal cart delivered.</p> <p>On 4/24/24 at 12:26 PM, an observation was made of the 300 hallway meal cart delivered.</p> <p>On 4/24/24 at 12:44 PM, an observation was made of the 400 hallway cart out of the kitchen. At 12:46 PM, the first meal tray was delivered to the 400 hallway.</p> <p>On 4/24/24 at 12:35 PM, an observation of the main dining room was made. Residents were offered refreshments.</p> <p>On 4/24/24 at 12:49 PM, the first meal tray was served and at 12:58 the last meal was served.</p> <p>On 4/24/24 at 12:58 PM, the last 2 meals were plated for the dining room.</p> <p>On 4/24/24 at 8:00 AM, an interview was conducted with resident 17. Resident 17 stated the meals were always late and they had to wait a long time in the dining room to get served food. Resident 17 stated she would like to have a clock in the dining room to know what time she was served meals.</p> <p>On 4/22/24 at 2:37 PM, an interview was conducted with resident 30. Resident 30 stated that he doesn't know when meals are being served. Resident 30 stated that he has almost missed meals because they were constantly being served at different times.</p> <p>On 4/25/24 at 10:06 AM, an interview was conducted with the ADM. The ADM stated dietary staff delivered hall trays, then the main dining room and then the residents in the main dining room that required assistance.</p> <p>On 4/25/24 at 12:46 PM, an interview was conducted with the Dietary Manager (DM). The DM stated stated they recently changed the meal times and the one posted in the dining room was incorrect and usually meals were delivered on time. The DM stated the hallways were to be served about 12:00 PM and the main dining room at 12:30 PM.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30563</p> <p>Based on observation, interview and record review it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the dish machine washing temperature did not reach the required temperature, cups were observed to have a white substance inside of them and a staff member was observed to touch dirty surfaces with gloves and then touched clean dishes. Resident identifier: 84.</p> <p>Findings include:</p> <p>1. On 4/22/24 at 10:38 AM, an initial tour of the kitchen was conducted. The following observations were made:</p> <p>a. On 4/22/24 at 10:41 AM, an observation was made of Dietary Aide (DA) 2. DA 2 was observed to touch dirty dishes and loaded them into a dish machine basket. DA 2 was observed to push the basket into the dish machine with gloved hands. DA 2 was observed to grab the handle on the dish machine with soiled gloves and pull it down. DA 1 was observed to have gloves on and touched the handle that DA 2 had touched with soiled gloves. DA 1 was observed to touch clean dishes and put them away without changing gloves or performing hand hygiene. At 10:43 AM, DA 2 was observed to touch the dish machine handle after touching dirty dishes. DA 1 was observed to touch the same handle with a gloved hand and then was observed to touch the inside of the plate domes and plate bases when putting them away. DA 1 was observed to remove gloves and perform hand hygiene at 10:44 AM.</p> <p>b. At 10:46 AM, an observation of the facility dish machine was made. [Note: All temperatures were in degrees Fahrenheit.]:</p> <p>i. The washing temperature was 110 for wash and the rinse temperature.</p> <p>ii. The washing temperature was 115 and rinse temperature was 122.</p> <p>iii. DA 2 was observed to check the sanitizer solution and stated it was at 100 parts per million of chlorine. DA 2 was interviewed and stated the dish machine temperatures were to be 120 to 160 for the washing cycle and the rinse cycle. DA 2 stated the temperatures were checked before starting dishes after each meal.</p> <p>2. On 4/22/24 at 12:54 PM, an observation was made of a meal cart in the 400 hallway. The vents on the back of the meal cart were observed to have a dried white substance dripping out of them and down the back of the meal cart.</p> <p>3. On 4/24/24 at 3:04 PM, a follow-up kitchen tour was conducted. The following was observed:</p> <p>a. There was a white substance on the back of a meal cart after it had been cleaned by DA 2.</p> <p>b. There was a white substance inside cups that were stored in the clean area.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>c. The dish machine temperatures were the following: [All temperatures were in degrees Fahrenheit.]</p> <p>i. At 3:19 PM, an observation was made of DA 2 touching the handle of the dish machine. DA 1 was observed to touch the same handle with a gloved hand and then touch clean dishes and replace them with clean dishes.</p> <p>ii. At 3:20 PM, the washing cycle was 110 and the rinsing cycle was 120.</p> <p>iii. At 3:21 PM, an observation was made of DA 1 documenting temperatures from the dish machine. The temperatures documented were 139 for the washing cycle and 137 for the rinsing cycle.</p> <p>iv. At 3:23 PM, the washing cycle was 110 and rinsing cycle was 120. DA 1 was observed to place mugs and bowls from the dish machine to the shelves with clean dishes.</p> <p>v. At 3:26 PM, the washing cycle was 111 and the rinsing cycle was 125.</p> <p>An interview was immediately conducted with the Dietary Manger (DM). The DM stated the dish machine needed to run a few times for the temperatures to be above 120 for the washing cycle and the rinsing cycle. The DM stated he was unable to see the thermometer because it was too low, so he drew a line above the thermometer so staff could see the temperatures. The DM stated there was a water booster that was set to 150 so the temperatures were not able to be below 120.</p> <p>vi. At 3:30 PM, an observation was made of DA 2 touching the dish machine handle after DA 1 had touched the same handle with soiled gloves. DA 2 was observed to touch the inside of the domes and replace the domes with clean dishes without removing gloves or performing hand hygiene.</p> <p>vii. At 3:31 PM, the washing cycle was 116 and the rinsing cycle was over 125.</p> <p>An interview was conducted with DA 2. DA 2 stated if the dish machine sat unused for a few minutes, then it had to be run a few times to get the temperature above 120 for the washing and rinsing cycles.</p> <p>On 4/22/24 at 11:05 AM, an interview was conducted with resident 84. Resident 84 stated that the cups are dirty with a white film. Resident 84 stated that he asked the staff what the white stuff was and was told that it was hard water buildup. Resident 84 stated that he was able to wipe the white residue out of the cup with his finger. Resident 84 stated that he doesn't think the cups are being washed at a high enough temperature. Resident 84 stated that he refuses to use the cups and requested only to use Styrofoam cups.</p> <p>On 4/25/24 at 12:46 PM, an interview was conducted with the DM. The DM stated the white substance in the glasses was from hard water. The DM stated that the facility was looking into a water softener. The DM stated that until the facility installs a water softener, the glasses were soaked in lime-away weekly and then re-washed. The DM stated that he was aware of the white substance and tried to buy new glasses but it continues to build up quickly. The DM stated that he was not aware that DA 1 was putting clean dishes away after touching the same handle as DA 2 had touched with soiled gloves.</p>		