STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A071	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lomond Peak Nursing and Rehabilitation, LLC	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)
F 0689 Level of Harm - 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** Based on observation, interview, and record review it was determined, for 2 out of 26 sampled residents, that the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, two high fall-risk residents did not have interventions put in place after falls and interventions were repeated. One of these examples was cited as harm. Resident identifiers: 39 and 43.Findings included: HARM 1. Resident 43 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, mild cognitive impairment, and ataxia. On 10/6/25 at 2:59 PM, an interview was conducted with resident 43. Resident 43 stated that he had fallen a few times at the facility and had gotten hurt. Resident 43 stated that he had gone to the hospital a few times for lacerations. Resident 43's medical record was reviewed 10/6/25 through 10/9/25. An admission Minimum Data Set (MDS) dated [DATE] documented resident 43 as supervision or touching assistance with transfers, toileting, and bed mobility. A care plan dated 1/21/25 and revised on 7/23/25 revealed, [resident 43] is at risk for falls r/t [related to] impaired gait and balance, Parkinson disease, moderate impaired cognition, ataxia, chronic pain, osteoarthritis, degenerative disk [sic] disease, neurogenic claudication, use of medications that increase risk for falls, impaired vision, impaired hearing, and reoccurring falls.Resident 43's progress notes were reviewed and revealed the following: a. On 1/24/25 at 6:12 PM, resident had unwitnessed fall in his bathroom. resident states he was trying to walk out of the bathroom and his feet wouldn't move. resident fell forward hitting his right eyebrow on a shelf. resident noted with a deep cut to the area. MD [medical doctor] notified. neuros [neurological] initiated. LN [licensed nurse] cleansed w/ [with] NS [normal saline] and applied steri strips. Care plan intervention for this fall: Educated resident to ask for staff assistance in the bathroom when he finishes toileting. b. On 2/3/25 at 11:09 PM, Residents roommate came to the nurses station stating that resident was on the floor. Resident found lying on floor next to bathroom door. He couldn't describe how he had fallen. No injuries sustained. Assisted to wc [wheelchair]. Neuro checks and vs [vital signs] started. MD and management notified. Reminded resident to use call light for assistance and encouraged to drink water. Call light within reach. Checked on often by staff. Care plan interventions for this fall: The resident has been educated to use his wheelchair for nocturnal restroom visits. c. On 3/3/25 at 10:44 PM, Resident observed on the floor sitting by the bathroom door. Resident states ?he fell when walking to the bathroom'. No injuries noted.Care plan intervention for this fall: Moved resident closer to nurses station to be able to do more frequent rounds. d. On 3/17/25 at 10:53 AM, was called down to resident room by house keeping who stated that resident had fallen upon arrival resident was up walking with his walker to the restroom he was asked to stop so a head to toe assessment could be done small skin tear above his right eye was noted and some bruising to his forehead neuros were started at that time and resident was allowed to cont [continue] to the restroom when asked resident stated that he tripped when housekeeping was asked she stated that he tripped over his shoes (that were in thewalk [sic] way) and fell face first on the floor she asked him to stay put but he got up and cont to the restroom (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	administration and Md. notified attempted to call his sister [name redacted] but both numbers were out of service. Care plan intervention for this fall: The resident has been educated to ensure that shoes are kept out of the walkway. e. On 3/26/25 at 1:50 AM, Resident is on alert charting for an unwitnessed fall that happened at 1905 [7:05 PM] on 03/25/2025. Resident was in the shower room when he tripped and fell forward. Resident stated he did not hit is [sic] head. Residents vitals were WNL [within normal limits]. Neuro checks were started and physician was notified.Care plan intervention for this fall: Resident was educated to ask for staff assistance when undressing in the shower room. f. On 4/2/25 at 4:55 AM, During routine rounds, (CNAs) [certified nurse assistant] discovered the resident seated on the floor with his feet extended. Upon inquiry, the resident expressed that he was attempting to get out of bed to reach the bathroom but lacked adequate support, resulting in his fall from the edge of the bed. Care plan intervention for this fall: Resident will work with physical therapy on balance and strengthening, g. On 4/2/25 at 5:35 AM, On 4/2, at approximately 0520 [5:20 AM] the nursing staff was conducting routine neuro checks following a previous fall involving the resident. During this procedure, the nurse discovered the resident on the floor. The resident reported that he attempted to rise from his walker when he began to experience increased weakness in his right leg and knee, which caused him to fall backward and strike his head against the dresser.Care plan intervention for this fall: The facility will provide the resident with floor to ceiling positioning bar to assist with transferring in and out of bed. h. On 4/8/25 at 1:05 AM, Resident had an unwitnessed fall at around 0025 [12:25 AM] while trying to go to the bathroom. Resident tripped over his shoes and fell on his bum. Resident stated he did not hit is head and was not in any pain.Care plan intervention for this fall: The resident has been educated to keep his shoes under the bed when he is not wearing them. i. On 5/8/25 at 3:41 AM, Staff was sitting at nurses station when there was a loud crash. Resident was found lying prone with walker in front of him. Denies hitting head. No injuries found with assessment. Assisted to sitting position on bed. Neuro checks and vital signs started with no changes from baseline assessment. Reminded resident to use call light for assistance if feeling unsteady. Fluids encouraged. Call light within reach.Care plan intervention for this fall: Resident has been educated to ask for staff assistance to the bathroom when he is feeling drowsy in the middle of the night. It should be noted that this intervention was used on 1/24/25. j. On 5/16/25 at 5:54 PM, Resident was found by staff sitting on the floor of his room. He stated he fell trying to go to the bathroom.Care plan interventions for this fall: Reeducate resident to ask for staff assistance. It should be noted that this intervention was used on 1/24/25 and 5/8/25. k. On 5/22/25 at 10:53 PM, CNA came to nurses station stating that resident had fallen in the shower. Resident found sitting on floor in shower room. No injuries noted. Denied hitting head. Helped to get dressed. Resident alert and oriented. Able to use wheelchair and came out to the nurses station where Neuro checks and vital signs were started. Resident stated that he was trying to put underwear on and slipped on the wet floor. MD and management notified.Care plan intervention for this fall: The resident was educated to allow staff to help him get dressed in the shower room. l. On 6/15/25 at 6:17 PM, Resident had a witnessed fall. Got out of wheelchair to move a walker, when he went to sit back into his wheelchair he misjudged where the chair was and fell. [NAME] [sic] pain. No visible injuries.There was no updated intervention added to the care plan. m. On 7/3/25 at 6:42 AM, The resident had a witnessed fall. The nurse was entering the room when the resident attempted to sit in their power wheelchair when they missed and fell on their buttocks. The resident did not hit their head or sustain any injuries related to the fall.There was no updated intervention added to the care plan. n. On 7/6/25 at 12:47 PM, was called down to resident room he was sitting in the middle of the restroom floor next to a small puddle of water and the sink a head to toe assessment was done and resident was asst [assisted] up x [times] 1 and asst with walking x 2 to his recliner neuros started when asked what happened he stated he went to the restroom to urinate when he was done and leaving he lost his balance and reached out and grabbed the sink taking the sink with him when he fell when asked if there were objects or water on the floor before he fell he said no when asked why (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	he did not take his walker or call for help he stated he did not think he needed help pt [patient] education done on the importance of using his walker any time he wants to ambulate and if he is feeling weak he needs to call for help resident states understanding Md. and management notified of fall.Care plan intervention for this fall: The resident was re-educated to ask for staff assistance. It should be noted this intervention was used on 1/24/25, 5/8/25, and 5/16/25. o. On 7/10/25 at 7:25 PM, I was administering medication to another resident when it was reported that the resident had a witnessed fall in the shower room. The CNA was able to help the resident back into the shower chair, and he was not injured, nor did he hit his head.Care plan intervention for this fall: Educate staff members to position the resident's wheelchair close to the grab bar in the shower for extra support when standing up. p. On 8/14/25 at 9:00 AM, Resident had an unwitnessed fall in his bathroom. Resident stated that he was trying to use the toilet and fell but he does not remember what happened to cause him to fall. There was a laceration located at the back of his head, due to concern of head trauma 911 was called. Care plan intervention for this fall: The facility installed an extra grab bar next to the toilet to provide the resident with enhanced support during restroom use. q. On 8/23/25 at 6:22 PM, At 1555 [3:55 PM] Nurse was notified by resident's room mate that the resident had fallen. Nurse found resident on the bathroom floor lying on his right side. Resident stated that he lost his balance and fell.Care plan intervention for this fall: The resident has been educated to leave the bathroom lights on when exiting to ensure adequate lighting for him to safely return to his chair. r. On 9/6/25 at 4:58 PM, The resident's roommate reported to the nursing station that the resident had experienced a fall in his room. The nurse promptly intervened and discovered the resident on the floor in a seated position. An assessment of the environment indicated no obstacles present, adequate lighting, and no moisture on the floor. Notably, the resident's walker was not in sight. The resident did not engage the call light prior to the incident and indicated that he was attempting to pull up his pants when he lost his balance and fell.Care plan intervention for this fall: Risk vs [versus] benefit discussion. s. On 9/6/25 at 8:01 PM, CNA called nurse to residents bathroom where resident was found on the floor sitting on his bottom with 4 wheeled walker next to him; CNA states she was in the room and heard the resident fall; no call light was used; no socks or shoes on; light was on inbathroom [sic] and there was no clutter or wet floors;States [sic] he stumbled backward while washing his hands; denies hitting head and states he landed on his bottom. Care plan intervention for this fall: Educated to use assistive device when going to the bathroom. It should be noted that on 2/3/25 resident 43 was educated to use his wheelchair for nocturnal restroom visits. t. On 9/27/25 at 11:31 PM, resident on alert charting for unwitnessed fall in his bathroom. resident did not request help to the restroom and fell as he was trying to sit on the toilet. resident landed between the toilet and the wall, denied pain at the time. neuros and vitals started, MD notified. attempted to call and notify sister, left voicemail as she did not answer. resident assessment normal at the time of the fall and resident denied pain at the time, later complained of pain to his left pinkie as he stated he tried to catch himself with that hand. treated with ibuprofen, resident stated it was effective. vitals and neuros WNL, will continue to monitor.Care plan intervention for this fall: IDT [interdisciplinary team] held a meeting with resident to identify barriers to why he does not ask for help while in the bathroom. On 10/8/25 at 10:00 AM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that resident 43 was unsteady, had balance issues, and was a fall risk. The CNA Coordinator stated that resident 43 had fallen in the shower. The CNA Coordinator stated that resident 43 had gotten injured when he fell down in his bathroom and had to get staples to the back of his head when he hit the toilet. On 10/8/25 at 10:23 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 43 had trouble transferring and did not have good balance. CNA 2 stated that resident 43 should always have assistance with transferring and needed help in and out of the bathroom. On 10/8/25 at 11:00 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that resident 43 was a fall risk. LPN 2 stated that resident 43 had been injured by his falls. LPN 2 stated that resident 43 had received staples in his head from a fall in August 2025. On 10/9/25 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	at 8:18 AM, an interview was conducted with the Administrator (ADM). The ADM stated that he had had a discussion with resident 43 about his falls. The ADM stated that resident 43 had gotten a laceration above his eye and on the back of his head that had required hospital visits. On 10/9/25 at 10:06 AM, an interview was conducted with the Director of Nursing (DON), the Director of Clinical Services (DCS), and the ADM. The DCS stated that for the falls that occurred on 6/15/25 and 7/3/25, nurses did not open a risk management plan and interventions were not implemented because the administration did not know about the falls. The DON stated that resident 43 fell a lot in the bathroom and they had a meeting with resident 43 about it. The ADM stated they were thinking about getting a sign to put in the bathroom to remind the resident to call for assistance. 2. Resident 39 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, unspecified dementia, insomnia, generalized muscle weakness, and repeated falls. Resident 39's medical record was reviewed 10/6/25 through 10/9/25. On 10/7/25 at 1:26 PM, resident 39 was observed to be laying in bed. The bed was pushed up against the wall and there was no fall mat observed in the room or next to the bed. A Quarterly MDS dated [DATE] documented resident 39 was a partial/moderate assist with transfers, toileting, and bed mobility. A Brief Interview for Mental Status (BIMS) dated 12/20/24 revealed that resident 39 had a score of 4. A score of 0-7 indicated severe cognitive impairment. A care plan dated 12/22/23 and revised on 7/6/25 revealed, The resident is at risk for falls r/t: dementia, terminal diagnosis of CHF [congestive heart failure], unsteady gait and balance, hx [history] of falls, use of medications that increase risk for falls, respiratory failure, chronic hypoxia, SOB [shortness of breath], use of oxygen, episodes of incontinence, reoccurring falls, and pain.Resident 39's progress notes revealed the following: a. On 1/8/25 at 10:32 AM, The CNA was checking on the resident after her bathroom door alarm went on. The nurse intervened and found the resident in a supine position. Care plan intervention for this fall: Staff provided the resident with longer oxygen tubing so she could safely reach the bathroom. b. On 1/11/25 at 11:30 AM, CNA alerted nurse that pt had fallen in restroom, pt ambulating without assistance, and fallen attempting to transfer to toilet, bed alarm, door alarm, in place at this time, pt has had frequency r/t current UTI [urinary tract infection], CNA was alerted by alarms and went in to assist to pt's needs and pt was sitting on floor next to pt's toilet, pt stated that they missed the toilet when trying to sit down and fell down on their buttock. Care plan intervention for this fall: Staff received re-education on the importance of offering routine toileting, especially considering the resident's increased frequency related to her UTI. c. On 1/28/25 at 10:04 AM, was called down to resident room resident was sitting on the toilet she was wearing fuzzy socks and no shoes the floor in the restroom had some water spots on the floor CNA was asked what happened she reported that she arrive resident was sitting on the floor getting herself up CNA tried to get her to stay were she was but she refused and cont to get up and sit on the toilet at that time a head to toe assessment was done no injuries noted neuros [neurological] started resident was educated on the importance of using hercall [sic] light or to verbally ask for help and to wait for the help Management, Md and [family member] have been notified of the fall.Care plan intervention for this fall: The staff was re-educated on the importance of ensuring that residents wear appropriate footwear, especially socks with grips. d. On 4/9/25 at 5:18 AM, Resident had an unwitnessed fall in her bathroom around 0312 [3:12 AM]. Resident was very confused and did not know if she had hit her head or how she had fallen. Resident was placed back into bed with pressure alarm functioning correctly. It should be noted that hospice initiated Depakote for increased agitation and this intervention was not placed on the care plan. e. On 4/11/25 at 12:45 PM, Resident was found on the floor in a side lying position. She states she went to get out of bed and tripped. There was a significant amount of oxygen tubing lying on her room floor that may have caused her to trip. The tubing was organized and put in an appropriate spot. Resident states she is not in any pain or feels she sustained an injury from the fall. Care plan intervention for this fall: Staff has received education on the proper management of the resident's oxygen tubing, ensuring it is wrapped and stored safely when she is in her room. It should (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	be noted that on 1/8/25 an intervention for longer oxygen tubing was implemented. f. On 4/23/25 at 5:40 PM, Resident had a witnessed fall. Resident's chair alarm went off and CNA checked on her. Found her on the floor in the TV [television] common area. Vitals were done. Neuro assessment was done. Resident stated she was trying to get into a chair. After reviewing camera footage it was determined that resident did not hit her head.Care plan intervention for this fall: Staff have been educated to offer the resident to sit in the recliner in the common area before dinner. g. On 5/6/25 at 3:42 PM, was called into the common area resident was sitting on the floor with her back to the chair head to toe assessment was done no injuries noted resident denies c/o [complaining of] pain or discomfort reviewed video of common area resident was attempting to transfer herselffrom [sic] w/c [wheelchair] to chair she sat down on the edge of the chair and slid into the floor she did not hit her head after assessment she was asst x one into her w/c.Care plan intervention for this fall: Staff has been educated to ask the resident to sit in the recliner after lunch if she does not want to lie in bed. h. On 5/25/25 at 7:58 PM, The resident sustained a fall while attempting to self-transfer. The CNA witnessed the incident, during which the resident slipped from her chair and landed on her buttocks. The CNA promptly alerted the nurse, who intervened immediately.Subsequently, the resident was assisted into a recliner to watch television, and monitoring will continue as part of her care plan.Care plan intervention for this fall: Staff have been instructed to offer the resident the option to sit in the recliner until she feels ready for bed to help mitigate future incidents. It should be noted that after the fall on 4/3/25 staff were educated to offer the resident to sit in the recliner in the common area before dinner. i. On 6/7/25 at 11:52 AM, resident was sitting in common area in front of the nurses station she attempted to stand and slid out of her chair onto the floor head to toe assessment done no injuries noted she denies c/o [complained of] increased or abnormal pain she did not hit her head Md and management notified.Care plan intervention for this fall: Staff members have been educated to offer the resident the option to sit in the recliner or lie down between meals to enhance her comfort. j. On 6/16/25 at 4:14 PM, called down to resident room resident was laying on the floor on the far side of her nightstand with her w/c on top of her a head to toe assessment was done no injures were noted she was asst up x 1 and toileted.Care plan interventions for this fall: To further enhance safety, the facility will provide a fall mat to be placed next to her bed. It should be noted, upon observation resident 39 did not have a fall mat at bedside. k. On 7/19/25 at 5:09 PM, resident alarm went off upon arrival to room resident was standing and turning to sit in her w/c she missed her w/c and slid down onto the floor she did not hit her head she landed on her buttocks. Care plan intervention for this fall: Re-educated staff on additional call light system and how to recognize and answer it promptly. l. On 9/1/25 at 7:36 PM, Nurse was called to lounge area to assess resident that had fallen; resident was found on floor next to chair, lying on back; witness states resident stood up and lost balance falling backward over arm of armchair; resident landed on buttock and then backof [sic] head hit the floor; resident stated she was getting up to get into her wheelchair and lost her balance.Care plan intervention for this fall: staff education was reinforced to ensure the call light/alarm system remains operational at full volume and not on vibrate. It should be noted on 7/19/25 staff were re-educated on the call light system. m. On 9/7/25 at 12:35 PM, At 1130 [11:30 AM] resident attempted to stand up from wheelchair in the hallway near the nurses station. The wheelchair moved form [sic] behind the resident and the resident lost her balance and fell onto the ground, landing on her right side and hitting the right side of her face on the ground. Resident was promptly assessed and moved from ground to wheelchair .Care plan intervention for this fall: Staff members have been instructed to encourage the resident to utilize the recliner before meals to minimize the risk of falling, as the recliner provides a more stable surface upon rising from a seated position. It should be noted this intervention was used on 4/23/25, 5/6/25, 5/25/25, and 6/7/25. n. On 9/12/25 at 11:13 PM, Resident has an unwittnessed [sic] fall around 1745 [5:45 PM] in her room. Resident was unable to express if she had hit her head or not. Neuro checks started.Care plan intervention for this fall: All new staff members received education regarding the proper recognition of the resident's additional call light system. Furthermore, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	our competency checklist for new hires will be updated to reflect this change.It should be noted that placing resident 39 in the recliner was used as an intervention on 4/23/25, 5/6/25, 5/2/25, 6/7/25, and 9/7/25. Staff education on the call light system was used as an intervention on 7/19/25, 9/1/25, and 9/12/25.On 10/8/25 at 9:54 AM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that resident 39 was a fall risk and required a lot of transfer assistance. The CNA Coordinator stated that resident 39 had a pressure sensor alarm that would buzz at the nurse's station whenever resident 39 got up out of bed or a chair. The CNA Coordinator stated that current fall interventions for residents were written on a white board in the administration office. The CNA Coordinator stated that the sensor alarm was the only intervention that she knew of for resident 39. On 10/8/25 at 10:36 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 39 liked to stand up and if her alarm went off staff needed to respond quickly. CNA 1 stated that resident 39 was a fall risk and was kept in the common area as often as possible. CNA 1 stated that resident 39 was confused with dementia.On 10/8/25 at 10:54 AM, an interview was conducted with LPN 2. LPN 2 stated that resident 39 was a fall risk and was on a pressure alarm. LPN 2 stated the alarm was portable and could be kept in her pocket or on the medication cart in order for a nurse to hear it. LPN 2 stated that interventions for falls were found in the care plan and management kept those updated. LPN 2 stated that resident 39 cognitively could not use a call light to call for assistance.On 10/9/25 at 8:02 AM, an interview was conducted with the DON and the DCS. The DCS stated that resident 39 was forgetful and staff were trained to routinely check on residents to prevent falls, remove clutter, and to encourage residents to wear proper footwear. The DCS stated that resident 39 was a fall risk and should have a fall mat in her room. On 10/9/25 at 8:04 AM, an interview was conducted with the ADM. The ADM stated that resident 39 was a fall risk. The ADM stated that there was an alarm system in place to help alert staff. The ADM stated that newer staff had to be re-educated regarding care for resident 39 as staff would get her up and leave her in a wheelchair and that was why the recliner was used as an intervention multiple times. The ADM stated he was unsure why the fall mat was removed or if it was causing falls for resident 39.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility did not provide or obtain laboratory services to meet the needs of its residents. If the facility provided its own laboratory services; the services must meet the applicable requirement for laboratories. Specifically, the facility glucometers were not being calibrated according to the manufacturer requirements and the control solution available was expired. Findings included:On [DATE] at approximately 3:00 PM, the 200 hall medication cart and medication storage room were observed. There were bottles of glucometer control solution in both the 200 hall medication cart and the medication storage room with an expiration date of [DATE]. There were no bottles available that were not expired.On [DATE] at 3:03 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated she did not know what the process for testing the glucometers was because the night shift tested the glucometers. On [DATE] at 11:00 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated each resident had their own glucometer and the night shift nurses tested the glucometers weekly. The ADON stated staff were trained according to the manufacturer requirements. The facility Administrator (ADM) provided the glucometer manual which revealed .Always check the expiration date-DO NOT use control solutions if they're expired.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility did not provide food that was palatable, attractive, and at a safe and appetizing temperature. Specifically, for 7 out of 26 sampled residents, residents complained of the quality and taste of the food and a test tray was not palatable. Resident identifiers: 3, 4, 6, 10, 11, 56, and 77.Findings Included: On 10/6/25 at 10:22 AM, an interview was conducted with resident 56. Resident 56 stated the food was bland and did not taste good. On 10/6/25 at 11:50 AM, an interview was conducted with resident 4. Resident 4 stated that the food did not taste good and most of the time she bought her own food to eat.On 10/6/25 at 2:34 PM, an interview was conducted with resident 10. Resident 10 stated that the food was dry and not tasty.On 10/6/25 at 3:07 PM, an interview was conducted with resident 6. Resident 6 stated the food was not edible.On 10/6/25 at 3:48 PM, an interview was conducted with resident 11. Resident 11 stated the food was lukewarm and not good and he had to buy his own snacks.On 10/7/25 at 9:32 AM, an interview was conducted with resident 3. Resident 3 stated the food was only good when they got it right. Resident 3 stated the kitchen had trouble getting the orders correct.On 10/7/25 at 10:00 AM, an interview was conducted with resident 77. Resident 77 stated the food was absolutely terrible.On 10/8/25 at 1:20 PM, a test tray was sampled. The menu was garlic roasted chicken, penne alfredo, parsley carrots, and bananas foster cake. The pasta was mushy, overcooked, and had no flavor. The chicken was dry and grisly and hard to chew. The carrots were diced and did not contain parsley. The cake had a strong artificial banana flavor and was dry in texture.On 10/9/25 at 8:48 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that he had received food complaints from residents and there was a food committee. The DM stated that he had complaints from residents about undercooked chicken and so now he was making sure that the chicken was overly cooked. The DM stated that he had been told his food was too spicy so he had stopped using seasonings in the food.

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	46A071	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, it was determined that the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, there were undated food items stored in the refrigerator and freezer, hairnets were not worn correctly; resident refrigerators' temperatures were not monitored and food was unlabeled and undated; a dietary aide touched fish, chicken, and pasta with gloved hands after touching multiple surfaces; and chicken and fish were chopped with the same knife during lunch service causing cross-contamination of foods. Findings included: On 10/6/25 at 8:11 AM, an initial tour of the kitchen was conducted. The following observations were made: a. Dietary Aide (DA) 1 was wearing a hairnet with her bangs uncovered by the hair net. b. There was undated pudding in cups in the refrigerator. c. There was covered juice in cups that were undated. d. There was an opened and undated carton of thickened orange juice. e. There was an opened and undated container of lettuce. f. There was an opened and undated bag of tater tots in the freezer.On 10/7/25 at 9:16 AM, an observation was made of the resident refrigerators. The following observations were made: a. In the 200/300 refrigerator there was no thermometer to monitor the temperature. b. There was a container with pasta that was undated. c. There was an undated bag of fruit that was mushy and leaking on the shelves. d. There was an opened and undated container of pudding. e. The shelves in the door of the 200/300 refrigerator were covered in a brown sticky substance. f. There were burritos uncovered, undated, and opened to air in the 200/300 freezer. g. There was an ice cream shake that was unlabeled and undated in the 100/400 freezer. h. There was a frozen chimichanga in the freezer with a use by date of 10/4/23. i. There was an unlabeled and undated Subway sandwich in the refrigerator that was hard to the touch. j. There was an undated and unlabeled chicken sandwich in the refrigerator that was hard to the touch.On 10/8/25 at 12:19 PM, a follow-up tour was conducted in the kitchen. The lunch tray line was observed and the following observations were made: a. At 12:20 PM, DA 1 was wearing a hairnet with her bangs uncovered. b. At 12:37 PM, DA 2 put on gloves, opened the oven door, picked up a plate and touched the middle of the plate with his gloved hand. DA 2 then touched the chicken and slid it to the side of the plate with his gloved hand. c. At 12:40 PM, DA 2 with the same gloved hands, picked up two pieces of fish and placed them on a plate. d. At 12:41 PM, DA 2 with the same gloves, picked up a plate and placed his gloved fingers in the center of the plate. DA 2 then picked up a piece of fish with the same gloved hand and placed the fish on the counter and began to cut up the fish. e. At 12:42 PM, DA 2 touched chicken as it was placed on top of pasta on the plate. DA 2 was still wearing the same gloves. f. At 12:44 PM, DA 2 slid pasta to the side of the plate with the same gloved hands and then touched the chicken as it was placed on top of the pasta. g. At 12:48 PM, DA 2 removed his gloves and donned new gloves. h. At 12:50 PM, DA 2 rested both gloved hands with the palms down on a dirty countertop. i. At 12:51 PM, DA 2 touched pasta and chicken with his gloved hands. j. At 12:52 PM, DA 2 picked up chicken and then chopped it in the same area that he had cut up fish with the same gloved hands and knife. k. At 12:54 PM, DA 2 picked up fish with his gloved hands and placed the fish on a plate. On 10/8/25 at 1:39 PM, an interview was conducted with DA 2. DA 2 stated that allergies and preferences of residents were on meal tickets. DA 2 stated that to prevent food allergies in residents he would keep a close eye on the foods, made sure he changed gloves, and used different kitchen utensils. DA 2 stated that there were two residents in the facility who have fish allergies. On 10/9/25 at 8:48 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that hairnets needed to be worn by the kitchen staff that covered the entire head. The DM stated that kitchen staff should wash their hands often. The DM stated that kitchen staff should change gloves every time they moved out of their station or if they touched things. The DM stated that he preferred if staff did not touch food with gloved hands. The DM stated that items should be dated and labeled if they were in the refrigerator or freezer. The DM stated that he was not sure of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who was responsible for the resident refrigerators and that the kitchen staff was not doing it. The DM stated that he knew of two residents in the facility that had fish allergies. The DM stated there were no issues with cross contamination because the chicken and fish were cooked. On 10/9/25 at 9:11 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the night shift nurses were responsible for maintaining the resident refrigerators. The DON stated that items in the refrigerator should be dated and labeled. The DON stated that she was not aware of any residents who had fish allergies.A review of the outside food policy revealed: Policy:It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident.Policy Explanation and Compliance Guidelines:1. Family members or other visitors may bring the resident food of their choosing.2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated.a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator.b. The prepared food must be consumed by the resident within 3 days.c. If not consumed within 3 days, food will be thrown away by facility staff.d. The facility will not be responsible for maintaining any reusable items.3. All food items brought in that are manufactured and does not require refrigeration, may be kept in the resident room inside a lock tight container that is provided by the resident.4. Foods may be reheated in a microwave and should be stirred during the reheating process and reheated to at least 165 F.5. Ensure that reheated foods are cooled enough to a palatable temperature prior to consuming to prevent burns.6. It is the responsibility of the resident and/or resident representative to maintain said container and items in the container.7. All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative.8. If any part of this policy is not followed, the facility reserves the right to protect others by not allowing food items to be brought into the facility for a resident.9. The facility staff will assist residents in accessing and consuming food that is brought in by resident and family or visitors if the resident is not able to do so on their own.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 5 out of 26 residents, Enhanced Barrier Precautions (EBP) were not implemented for residents, staff were observed not performing hand hygiene during medication administration, and glucose monitors were not disinfected according to manufacturer instructions. Resident identifiers: 5, 8, 39, 67, and 73.Findings included: Enhanced Barrier Precautions On 10/6/25 at 8:37 AM, an initial tour of the resident hallways was conducted. No signage indicating transmission based precautions were observed outside residents' doorways. Pink and green dots were observed on some of the resident name placards. On 10/6/25 at 8:50 AM, an interview was conducted with the Office Manager Assistant, who stated that the pink and green dots indicated residents' code status. 1. Resident 5 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease, type 2 diabetes mellitus, and hemiplegia and hemiparesis following cerebral infarction. Resident 5's medical record was reviewed on 10/6/25 through 10/9/25. On 9/19/25, EBP were ordered related to wounds for resident 5. On 10/6/25 at 10:10 AM, no signage for EBP was observed outside resident 5's room. On 10/7/25 at 1:13 PM, EBP signage was observed outside resident 5's room. 2. Resident 8 was admitted to the facility on [DATE], with diagnoses that included paraplegia, neuromuscular dysfunction of bladder, and neurogenic bowel. Resident 8's medical record was reviewed on 10/6/25 through 10/9/25. On 6/5/25, EBP were ordered related to an indwelling catheter for resident 8. On 10/6/25 at 3:52 PM, no signage for EBP was observed outside resident 8's room. On 10/7/25 at 1:13 PM, EBP signage was observed outside resident 8's room. 3. Resident 73 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included congestive heart failure, type 2 diabetes mellitus, Parkinson's disease, and chronic kidney disease. Resident 73's medical record was reviewed on 10/6/25 through 10/9/25. On 10/7/25 at 9:35 AM, it was observed that the banner located in resident 73's electronic medical records stated Special Instructions: EBP (Enhanced barrier Precautions). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No physician order for EBP could be located in resident 73's medical record. On 10/8/25 at 9:01 AM, an interview was conducted with Nurse Aide (NA) 2. NA 2 stated that nursing management would communicate changes to EBP through a staff messaging app. NA 2 stated that EBP signage posted outside resident rooms was a new system. On 10/8/25 at 9:13 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that EBP signage should have been posted outside resident rooms, but frequent room changes made it difficult to update the signage. On 10/9/2025 at 12:46 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff were made aware of EBP in multiple ways, such as an EBP order in the resident's chart, EBP updates communicated through a staff messaging app, and EBP signage posted outside resident rooms. When asked why no EBP signage was observed in the hallways on 10/6/25, the DON stated that they previously used colored dots to indicate any transmission based precautions. The DON stated that they transitioned to posting EBP signage outside resident rooms because the colored dots were not as noticeable. The DON stated that previously EBP orders were posted on the banner located in a resident's electronic medical records. The DON stated that resident 73 was previously on EBP, and the electronic medical records banner had not been updated after resident 73 was no longer on EBP. Glucometer On 10/8/25 at approximately 9:00 AM, LPN 1 was observed performing medication administration for the 200 hall. LPN 1 obtained Resident 67's blood glucose using the residents personal glucometer. After LPN 1 obtained Resident 67s blood glucose, LPN 1 was observed to use an alcohol prep-pad to disinfect Resident 67's glucometer before securing it in a resealable plastic bag and placing it back into the bin next to the other residents glucometers. On 10/9/25 at 11:00 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the process for cleaning the glucometers were following the manufacturers requirements. The ADON stated the glucometer was wiped down daily with microclean wipes which had purple tops and then a 1-minute dry time. The ADON stated the glucometers were cleaned after every use. The manufacturer recommendations from the manual revealed, Cleaning and disinfecting the meter and lancing device is very important in the prevention of infectious disease. Cleaning is the removal of dust and dirt from the meter and lancing device surface so no dust or dirt gets inside. Cleaning also allows for subsequent disinfection to ensure germs and disease causing agents are destroyed on the meter and lancing device surface. The EvenCare G2 Meter is validated to withstand a cleaning and disinfection cycle of ten times per day for an average period of three years. The manual provided a list of disinfecting wipes that were approved for use to clean the glucometer. Hand Hygiene On 10/8/25 at approximately 9:30 AM, LPN 2 was observed performing a medication administration for the 400 hall. LPN 2 entered resident 39's room with their meds in a small cup. LPN 2 passed Resident 39 their medications and a cup of water. LPN 2 proceeded to exit the residents room to get more water for the resident and failed to sanitize their hands prior to touching both the cups and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water pitcher on the 400 hall medication cart that was used for all of the residents in that hall. On 10/8/25 at approximately 3:15 PM, an interview was conducted with LPN 2. LPN 2 stated during med pass hand hygiene should have been performed after passing medications to Resident 39 and prior to touching the cups and water pitcher on the medication cart.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 of 26 sampled residents, the facility did not provide residents the right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed. Specifically, a resident was not provided written notice when she had roommate changes. Resident identifier: 77. Findings included: Resident 77 was admitted to the facility on [DATE] with diagnoses which included dementia, generalized anxiety disorder, cognitive communication deficit, hypothyroidism, fibromyalgia, major depressive disorder and post traumatic stress disorder.On 10/17/25 at 10:00 AM, an interview was conducted with resident 77. Resident 77 stated she had different roommates and her current roommate had returned from the hospital recently. Resident 77 stated her roommate was not the same since returning from the hospital. Resident 77's medical record was reviewed. There were no notifications that resident 77 had roommate changes. There were no nursing progress notes located regarding roommate changes for resident 77. On 10/9/25 at 8:41 AM, an interview was conducted with the Resident Advocate (RA). The RA stated she usually gave a 24 hours notice before the room change to the resident who was moving. The RA stated that resident 77 complained of her roommate and she was moved out and another resident moved in. The RA stated then resident 77 was having problems with the new roommate so she requested her old roommate back, so they moved the original roommate back into resident 77's room. The RA stated she did not have documentation of room moves or notification to the residents. On 10/9/25 at 10:34 AM, an interview was conducted with the Director of Clinical Services (DCS) and the Director of Nursing (DON). The DON stated resident 77's roommate was moved and then resident 77 stated she missed her roommate so they moved her back. The DON stated usually when conducting a room change, the staff looked to see if the residents were compatible, then provided a 24 hour notice of the room change, unless there was a safety concern. The DCS stated the RA should be providing both residents with a form to notify them of the room change. The DCS stated the form was signed by the resident and scanned into their medical record.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review, it was determined that the facility did not ensure that any individual working in the facility as a nurse aide for more than 4 months was competent to provide nursing and nursing related services; and completed a training and competency program, or a competency evaluation program approved by the State. Specifically, a Nurse Aide (NA) was employed at the facility and worked as a NA for over 4 months without completion of a training or a competency evaluation program approved by the State.Findings included: On 10/8/25 NA 1's employee file was reviewed. NA 1 was hired on 5/7/25. NA 1 was still employed as a NA and the last shift worked was 10/3/25.On 10/8/29 at 2:08 PM, an interview was conducted with the Business Office Manager (BOM). The BOM stated that NA 1 was still employed by the facility as a NA. The BOM stated that NA 1 had not taken her test nor completed the NA program. The BOM stated that NA 1 had last worked on 10/3/25 and was now removed from the schedule. The BOM stated the Certified Nurse Assistant (CNA) Coordinator was in charge of scheduling NA's. On 10/8/25 at 2:16 PM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that NA 1 had been in the certification program, but had not completed the program. The CNA Coordinator stated that she found out at the beginning of September 2025 that NA 1 had not completed the program. The CNA Coordinator stated that NA's should not work after 120 days until they become certified.On 10/8/25 at 2:20 PM, an interview was conducted with the Administrator (ADM). The ADM stated that NA 1 had been hired and assigned to the CNA course. The ADM stated that NA 1 was having some personal problems and did not complete the course. The ADM stated he was not sure when NA 1 last worked, but knew it was after 120 days. The ADM stated that NA 1 is off the schedule and not working until she completed the course.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 1 of 26 sampled residents, the facility did not ensure each resident received necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Specifically, a resident with mental health diagnoses was not offered counseling services. Resident identifier: 77. Findings included: Resident 77 was admitted to the facility on [DATE] with diagnoses which included dementia, generalized anxiety disorder, cognitive communication deficit, hypothyroidism, fibromyalgia, major depressive disorder and post traumatic stress disorder. On 10/7/25 at 10:00 AM, an interview was conducted with resident 77. Resident 77 stated she was concerned because child molesters were moving into the facility and it made her feel really uncomfortable. Resident 77 stated her ex-husband molested her daughter so knowing there were residents like that in the facility brought back all her feelings. Resident 77 stated her roommate had Schizophrenia like her ex-husband and the roommate came back from the hospital about a week ago and was not the same. Resident 77 stated she goes to sleep fearing her roommate. Resident 77 stated she talked to the Resident Advocate (RA) yesterday about moving away from her roommate. Resident 77 stated her roommate moved out and another one in and that was worse so she asked for her roommate back. Resident 77 stated she did not have a therapist or talked to one but she really, really needs to. Resident 77 was observed to be on the verge of tears during the interview. Resident 77's medical record was reviewed 10/7/25 through 10/9/25.A Preadmission Screening Resident Review (PASRR) Level II dated 1/4/24 revealed resident 77 history included major depressive disorder with anxiety since her 20's. Resident 77 was abused and neglected as a child. Resident 77 had an abusive husband who sexually abused her little girl with her son as a witness. Resident 77 received mental health help for three years, which included one year at a sexual abuse treatment center. The PASRR further revealed Diagnostic Formulation: [Resident 77] has had a long history of trauma, and some history of subsequent treatment. She continues to experience depression and reactions to trauma despite the years since trauma has occurred. (However, it is also possible that she has had more recent traumatic experiences given her history of homelessness.) She has been insufficiently employed or unemployed, a reported past drug user, and is disconnected from family. She's had suicide attempts in the past and she has regular suicidal ideations for the past two years. She endorses high levels of anxiety and cannot pinpoint the origin of the anxiety. However, she does admit to having anxiety when planning for her future. She is seriously mentally ill.The PASRR continued with Recommendation for Specialized Services for mental illness treatment: Referral for mental health therapy and medication management as needed. Ongoing monitoring and assessing of her suicidal ideations due to current suicidal ideation and suicide attempts in the past. Continue to encourage [resident 77] to socialize with the other residents and engage in activities provided at the SNF [skilled nursing facility]. [Resident 77] scored a 13 on her BIMS [brief interview of mental status], but there have been concerns about her memory and prior records indicate a diagnose [sic] of dementia. Further testing for dementia would be beneficial.A care plan dated 12/27/23 and revised with no new interventions on 3/28/24 resident 77 had a Level II PASRR and is considered significantly mentally ill due to her diagnoses of Generalized anxiety disorder, depression recurrent/moderate, PTSD chronic, and dementia. The goal was Psychosocial, mental and physical needs will be met through the next review date. The interventions were Administer medications as ordered and monitor for adverse effects and notify physician as needed; Follow PASRR II plan of care:.Referal for mental health therapy and medication management as needed; Psychology consult as needed/recommended; Staff will utilize facility resources to meet the needs of the resident; and Updates will be made to PASRR and appropriate agencies notified as necessary. Another care plan regarding Trauma informed care initiated on 12/27/23 and revised on (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/24/24 revealed triggers were shouting, yelling, loud voices or anything that had the potential to move into violence. Interventions included arranging to receive services from a licensed mental health provider as indicated. There was no documentation located in the medical record regarding resident 77 was ever offered therapy or counseling services. On 10/9/25 at 8:52 AM, an interview was conducted with the RA. The RA stated she did not think that resident 77 would want counseling services. The RA stated there was a contracted Licensed Clinical Social Worker (LCSW) who reviewed the PASRR's, and the social history and psychological assessments completed by her upon admission and annually. The RA stated the LCSW then created the care plans based on that information. On 10/9/25 at 10:50 AM, an interview was conducted with the Director of Nursing (DON).The DON stated there was a therapist who came to the facility weekly to provide therapy but did not treat resident 77. The DON stated she thought therapy services were offered and resident 77 refused. The DON stated she did not document when therapy services were offered. On 10/9/25 at 1:40 PM, an interview was conducted with the Administrator and Director of Clinical Services. The Administrator stated resident 77 had never mentioned that she wanted mental health services or therapy. The Administrator stated resident 77 was very closed off when talking with new people. The Director of Clinical Services stated shortly after resident 77 was admitted , she offered therapy services but she refused. The Administrator stated he submitted the PASRR's and reviewed the recommendations. The Administrator stated resident 77 was admitted over 2 years ago and was not sure what the recommendations were but felt like every person was referred for mental health services. The Administrator stated offering mental health services should be documented in the residents medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, it was determined that the facility did not ensure that all drugs and biologicals were stored and labeled in accordance with accepted professional principles, under proper temperature controls and cautionary instructions, and the expiration date when applicable. Specifically, there were expired medications stored in the facility's medication storage room available for patient use. Findings included: On 10/8/25 at 2:05 PM, an observation was made of the facility's medication storage room. The following medications were observed and available for resident use:One bottle of Naproxen tablets expired 9/25 Two bottles of Vitamin C tablets expired on 8/25 One bottle of Calcium tablets expired 7/24Multi-Symptom Day Cold/Flu medicine expired 9/24 on the box, the medication inside of it showed an expiration date of 9/22 Anti-Anxiety Relief one bottle expired 10/2/23, one bottle 6/2/24, and another bottle expired 7/24/24Fiber Therapy bottle expired 12/22/24One bottle of Fiber Powder expired 3/25Two boxes of Fiber Lax caplets expired 9/25A box containing twenty-three bottles of protein shake supplements expired on 3/1/25Ammonium Lactate expired 7/25Arginine powder, Arginaid expired 8/6/25Two bottles of Magnesium Citrate oral solution had expired on 9/13/25Inside of the medication fridges, there were three boxes of the influenza vaccines that expired on 6/29/25Inside the medication fridge there were Covid vaccines that expired on 3/29/25 On 10/9/2025 at 10:57 AM, an interview was conducted with the Director of Clinical Services (DCS) and Director of Nursing (DON). The DCS stated that the night shift nurses were supposed to go through expired medications and return them to the pharmacy. The DCS and DON stated the pharmacy came to the facility daily except Sunday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A071	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lomond Peak Nursing and Rehabilitation, LLC	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)
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 of 26 sampled residents, the facility did not provide or obtain radiology services to meet the needs of the residents. Specifically, a resident did not have a Magnetic Resonance Imaging (MRI) scheduled. Resident identifier: 3. Findings included: Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis, neurologic neglect, dysphagia, major depressive disorder, insomnia, and mild-protein calorie malnutrition.On 10/7/25 at 9:32 AM, an interview was conducted with resident 3. Resident 3 stated she had a subluxation to her left shoulder. Resident 3 stated she went to a doctor's appointment 3 weeks ago and needed an MRI. Resident 3 stated the MRI had not been scheduled yet.Resident 3's medical record was reviewed 10/7/25 through 10/9/25. A nursing progress note dated 9/26/25 at 1:22 PM revealed, Resident had an appointment with an orthopedic provider today regarding her left shoulder. It appears the resident has atrophy of the left shoulder but rotator cuff tendons are intact. Ortho [orthopedic] provider recommends resident obtain an MRI of the left shoulder. Orthopedist also suggests the resident get more intensive post stroke care in a neuro rehab facility. MD [Medical Director] notified.On 10/9/25 at 8:20 AM, an interview was conducted with Nursing Aide (NA) 2. NA 2 stated resident 3 told her that her shoulder was a stage 4 dislocation and she complained of shoulder pain. On 10/9/25 at 9:13 AM, an interview was conducted with the Administrator who stated the Director of Nursing (DON) had a spreadsheet for appointments to be made by the Transport Director. The DON was observed to look at the spreadsheet and unable to find the appointment on the spreadsheet. The Administrator stated there was a folder of appointments to be made in the Transport Directors desk. The Administrator was observed to look in the folder and there were no documents for resident 3's MRI. On 10/9/25 at 11:23 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated she received the referral for MRI on 9/26/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A071	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lomond Peak Nursing and Rehabilitation, LLC	524 East 800 North Ogden, UT 84404

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that, for 1 of 26 sampled residents, the facility failed to provide food that accommodated resident allergies, intolerances, and preferences. Specifically, a resident was provided food that was listed as an allergy. Resident identifier: 50.Findings included: Resident 50 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, irritable bowel syndrome, and lactose intolerance.Resident 50's medical record was reviewed on 10/6/25 through 10/9/25.On 10/06/25 at 10:16 AM, an interview was conducted with resident 50. Resident 50 stated that even though he required a lactose intolerant diet, dairy products would frequently be on his meal trays. Resident 50 stated that he and the Certified Nursing Assistants (CNA) had repeatedly spoken to the kitchen staff about his lactose intolerance, but he continued to receive dairy on his meal trays. Resident 50 stated that he was constantly on the lookout for dairy products because he would develop diarrhea if he consumed any dairy products. Resident 50 stated that he was often served ranch with his salad, and when he asked for a substitute he was told ranch was the only dressing available. On 10/6/25 at 12:20 PM, an observation and additional interview were conducted with resident 50. Resident 50 stated that he was given ranch dressing on his lunch tray, and that he gave the ranch to his roommate. Resident 50's lunch tray was observed and the side salad was covered with plastic wrap. Resident 50 stated that he planned on eating the side salad dry because no substitute was available. An observation was made of resident 50's meal ticket. Resident 50's meal ticket stated: LACTOSE INTOLERANT, NO MILK OR PRODUCTS AT ALL.On 10/6/25 at 12:30 PM, an additional interview was conducted with resident 50, who stated that when he uncovered his salad to eat it he discovered there were cheese shavings mixed in with the salad. Resident 50 stated that he had notified the staff, and CNA's would bring him a new salad from the kitchen. On 10/8/25 at 9:13 AM, an interview was conducted with CNA 2. CNA 2 stated that food allergies were listed on a resident's meal ticket. CNA 2 stated that while substitute meals were available, the substitute for ranch dressing was not always in stock. On 10/9/25 at 8:48 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that resident 50 was lactose intolerant and could not have any milk products. Additionally, the DM stated that he would not serve ranch dressing or cheese to a resident that was lactose intolerant. On 10/9/25 at 12:46 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that a resident's food allergies and preferences were located in their chart and on their meal tickets. Additionally, the DON stated that staff were expected to check a resident's meal tray before they delivered it to the resident, and that substitutes were expected to be available in the kitchen.