STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465111	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandy Health and Rehab	50 East 9000 South Sandy, UT 84070

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46232 Based on observation and interviews, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, black spots were observed in the resident showers. Findings Included: On 8/13/24 at 12:10 PM, an observation was made of the 200-hall resident shower room. Black spots were observed on the lower corner base board left of the shower entrance. On 8/13/24 at 11:50 AM, an interview was conducted with Housekeeping (HK). HK stated the certified nursing assistants (CNAs) were responsible for cleaning the resident shower rooms. HK stated the certified nursing assistants were given the supplies to clean the shower rooms. HK stated they only cleaned resident room and resident common areas. On 8/13/24 at 2:06 PM, an interview was conducted with CNA 1. CNA 1 stated housekeeping cleaned the showers once a week and the cna's were responsible for cleaning up after resident showers. CNA 1 stated they sanitized the shower chairs and housekeeping scrubbed the showers. On 8/13/24 at 2:31 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated housekeeping disinfected the shower floors and toilets. The ADON observed the black dots on the shower corner and stated the appearance was black and dotty and it was possibly scum. On 8/13/24 at 2:34 PM, an interview was conducted with the Administrator (ADM). The ADM stated the cna's wiped down the shower room and housekeeping cleaned it as needed. The ADM stated they assumed housekeeping came in and wiped down the corners and baseboards. The ADM stated the black spots looked like mold in their opinion. The ADM stated it also looked like typical moisture spots and it was something that needed a deep clean. The ADM stated the were going to find someone to clean the shower room tonight.

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49789 Based on interview and record review, it was determined that for 1 of 28 sampled residents, in response to allegations of abuse, neglect, exploitation or mistreatment, the facility did not have evidence that the violations were thoroughly investigated. Specifically, an allegation of neglect was not thoroughly investigated to determine if neglect had occurred. Resident identifier: 7. Findings include: 1. Resident 7 was admitted to the facility on [DATE] on hospice services with diagnoses of traumatic subdural hemorrhage without loss of consciousness, subsequent encounter- chronic obstructive pulmonary disease, unspecified- chronic hepatic failure without coma, personal history of transient ischemic attack, major depressive disorder, and generalized anxiety disorder. Exhibit 358 revealed that staff became aware of the incident on 1/26/24 at 2:30 am. The exhibit revealed that resident 7 had a fall and sustained a laceration above R[right] eye. Exhibit 359 revealed that, Staff found [resident 7] on the floor in her room in the early morning hours. They assisted her back into bed and started neuro checks. Nurse [nurse's name] stated that she was uncooperative with Neuros and sent her to the hospital. [Nurse's name] did not reach out to hospice first and sent her out and stated there was a brain bleed, which was on [resident 7] primary dx [diagnosis] when she came into [facility name] in the first place. Summary of interviews with the alleged victim stated, Resident [resident 7] is non verbal. Visual cues do not appear to have incurred psychosocial distress or harm. [Resident 7] was transferred to [facility name] from a different facility due to her decline and terminal agitation. [Resident 7] is at her baseline. [It should be noted that there was no interview with the Certified Nursing Assistant [CNA] who discovered the resident on the ground, according to the nurse's incident report documented on 1/26/24 at 1:59 am. There was no information regarding the resident's condition prior to the fall, whether the call light was within reach, what position the bed was in from which the resident fell , whether routine checks were being performed, how long since the CNA had checked on the resident, and whether the resident was presenting with agitation prior to the fall.] Resident 7's medical records were reviewed from 8/12/24 to 8/14/24. On 1/22/24, the facility put in place fall precautions in the resident's care plan for staff to Answer call lights promptly, continually educate the resident regarding safety issues, and instruct the resident about what to do should they experience a fall. Encourage the resident to not get up by him or herself, but rather to call for help. On 1/23/24, the hospice note stated the resident was admitted to hospice with a primary diagnosis of respiratory failure. The hospice nurse also stated the following .She is a high fall risk due to increased weakness and current bed bound status but because of her restless and pain patient appears uncomfortable, continues to move around in bed and trying to get out of bed, with her current disorientation and inability to recognize disabilities and weakness she is at high risk for another fall . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[It should be noted that the hospice nurse did not state the resident was on hospice services for a brain bleed and did not state the resident was experiencing terminal agitation.] On 1/25/24 at 3:22 pm, the nurse documented the following in the progress notes Primary Diagnosis: stroke, R[right] wrist fx[fracture], blind in L [left] eye Focused Assessment: med [medication] and pain mgmt [management] Adjustment to Admission: well and accepting Pain Management: prn [as needed] pain medication Mental Status/Behavior: a[alert]&o[oriented] x2 Improvement/Decline: n/a[not applicable] Notification(s):. [It should be noted that the facility did not list brain bleed or terminal agitation as a primary diagnosis.] On 1/26/24 at 1:59 am, the nurse documented in the incident report, CNA was doing her rounds and found her lying face down on the right side of her bed. She notified this nurse. PT[patient] assessed and found to have a 2 laceration over the R eye. ROM[range of motion] to the bilateral upper and lower extremities, she L shoulder pain. PT didn't remember how she got to floor. Immediate action taken stated: PT transferred back to bed. PT not compliant with Neuro[neurological] checks. Bleeding over the right eye stopped, laceration cleaned and steri-stripped. EMS[emergency medical services] notified. Patient transferred to the hospital for further evaluation and TX[treatment]. On 1/26/24 at 2:29 am, the nurse stated the following in a progress note PT transferred back to bed. PT not compliant with Neuro checks. Bleeding over the right eye stopped, laceration cleaned and steri-stripped. EMS notified patient transferred to the hospital for further evaluation and TX [treatment]. MD [medical doctor] notified, Ability hospice notified. Daughter [name] was called twice and message left . At 1/26/24 at 3:53 am, the facility nurse entered the following progress note ER [emergency room] nurse from [hospital name] hospital called to let us know that she has a brain bleed and is being transferred to [hospital name]. [It should be noted this was the first documentation of a brain bleed as one of the resident's primary diagnoses.] On 1/26/24, an IDT[interdisciplinary team] note stated Event: Unwitnessed fall in room, in the middle of the night w\ [with] a major injury. Resident status before event: Stable Risk factors: Anxiety, hx strokes, resp failure Preventive measures before event: assist with ADLs[activities of daily living], call light within reach, meds/treatments as ordered, anticipate needs, pain control. The interdisciplinary team note further stated that the resident was experiencing no weight [NAME] or dehydration, was experiencing 6/10 pain, and the resident's mobility was at baseline. On 1/26/24 a typed statement in the supporting documentation for Form 359 determination stated, Everything was normal and [resident 7] had gone to bed and was resting. We found [resident name] on the floor in her room in the early morning hours. We assisted her back into bed and started neuro checks. [Resident 7] was experiencing terminal agitation. At that time [resident 7] was not cooperative with Neuros and so we sent her to the hospital. I did not reach out to hospice first and sent her out for being non compliant with neuros. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[It should be noted that the descriptive term terminal agitation was used after the resident fell and struck resident's head causing bleeding over right eye and was not used by the physician, nursing or hospice to describe the resident's behavior leading up to the fall.] On 2/2/24, the submitted form 359 report stated that the resident was sent out to the hospital where it was discovered they had a brain bleed. The report stated the brain bleed was on [resident 7's] primary dx when she came in to [facility name] in the first place. On 8/13/24, the nurse stated in a phone interview that they would not have worded the incident statement on 1/26/24 the way it was written, using the words terminal agitation, and didn't believe it was their statement. The nurse also stated that they believed the CNAs had been conducting routine checks on the resident, the call light was in place, and that the bed was in the lowest position but was unsure whether these were done.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19354 Based on observation, interview, and record review, it was determined for 2 of 28 sample residents, that the facility did not ensure that all residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Specifically, a resident did not receive treatment to a right foot full thickness laceration and another resident's wounds had no documented measurements. Resident Identifiers: 15 and 26. Findings include: 1. Resident 15 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, difficulty walking, difficulty swallowing, enlarged prostate, and a lack of coordination. Resident 15's medical record was reviewed from 8/14/24 through 8/15/24. On 3/26/24 at 4:28 PM, a facility report incident (FRI) was submitted to the State Survey Agency (SSA). It documented that on 3/26/24 at 1:00 PM, resident 15's right fifth toe had been run over while he was being propelled down the hall in his wheelchair. The wound nurse assessed the right fifth toe as having a laceration. The wound Nurse Practitioner (NP) was notified, and an order was obtained to send resident 15 to the emergency department (ED) for possible stitches. The ED physician documented resident 15 had redness and bruising to the right fifth toe with a small laceration to the adjoining web space. An x-ray was obtained and a diagnosis, of a lateral dislocation of the proximal interphalangeal (PIP) joint and a non-displaced fracture of the middle right fifth toe was made. The hospital discharge instructions were reviewed. The facility was to keep the 4th and 5th toes on the right foot buddy taped until an order to discontinue the buddy tape was received. The facility was to put a cotton ball or a piece of gauze between the taped toes to prevent friction or pressure. The March 2024 Treatment Administration Record (TAR) was reviewed. There was no documentation that the ordered dressing changes were completed to the right food open areas or that the area was monitored for signs of infection. On 4/2/24 at 4:10 PM, the wound NP documented an initial evaluation. It was documented that resident 15 had two broken toes and an opening, but sutures were not placed. The right fifth toe was assessed as being red and detached. On 4/2/24, Registered Nurse (RN) documented there was a full thickness laceration that measured 1 centimeter (cm) by 1 cm with small amount of serosanguinous (a wound drainage that is thin and watery with a light red or pink color) fluid, and 100% slough (dead skin tissue that may have a yellow or white appearance) in the wound bed. The RN documented that Medihoney was to be applied to the wound bed covered with a bordered gauze. The dressing was to be changed three times a week and as needed if the dressing was soiled or became dislodged. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April 2024 TAR was reviewed. There was no documentation that the treatment of the Medihoney was implemented until 4/6/24. Note: there was a four-day delay in the implementation of the medihoney treatment. On 4/9/24, a RN documented the wound treatment was to remain unchanged to promote autolytic debridement. The RN documented that resident 15 was to be seen by a podiatrist related to the discoloration of the right 5th toe and that the toe did not appear to be attached to the foot. On 4/15/24, the RN documented that the full thickness laceration measured 0.5 cm by 0.5 cm and had a scant amount of serosanguineous drainage with 100% slough. It was also documented that resident 15 had a podiatrist appointment scheduled for 4/18/24. In an email sent to the DON on 8/20/24 at 12:40 PM, the DON stated that she was not sure why the order for Medihoney was not implement until 4/6/2024. Note: The order was transcribed into the April TAR on 4/6/24. 46232 2.Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of left side hemiplegia, epilepsy, bipolar type schizoaffective disorder, cognitive communication deficit, burn of second degree of lower back, burn of second degree of buttock, burn of third degree of lower back, and personal history of traumatic brain injury. Resident 26's medical records were reviewed from 8/12/24 to 8/15/24. On 7/19/24, a hospital wound care progress note documented, resident 26 was seen by inpatient wound care to evaluate and treat their back and buttocks burns which resident 26 obtained from being on hot pavement for 30 minutes. The documented wound measurements for the resident 26's back was 20.9 x 19.0 x 0.1 centimeters (cm), with a total surface area of 210.5 square (sq) centimeters (cm). The documented wound measurements for the buttocks wound was 17.1 x 12.2 x 0.1 cm, with a total surface area of 125.4 sq cm. On 7/22/24, a wound care progress note documented, [Resident 26] was a [AGE] year old female seen for wound care evaluation in [name of facility]. She sustained burns after she used methamphetamine and fell outside on the pavement and was unable to get up until the fire department responded. She has 2nd and 3rd degree burns on her back in [sic] buttocks. The documented measurement was, Total surface area 27% [percent] posterior torso thoracic region thru buttocks. [Note: no individual wound measurements were obtained for resident's back and buttocks wounds.] On 7/29/24, a weekly wound observation assessment for wounds 1 and 2 documented it was the first time the NP had observed the wounds and had no prior reference to them. In the measurement sections for both wounds, the NP documented, Unable to get an accurate measurement - burns are throughout back with epithelial bridges in between. The weekly wound observation assessment for wound 1 documented resident 26 had 3rd degree burns to bilateral buttocks. The wound tissue was described to be moist with granulation tissue and 60 % of slough tissue present. Wound 2 documented resident 26 had 3rd degree burns to their back. The wound tissue was described to be moist with granulation tissue and 80 % of slough tissue present. No foul odors were noted for either wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/24, a weekly wound observation assessment for wound 1 documented the wound had worsened and the wound was described as moist with 100 % slough tissue present and a foul odor. Wound 2 was documented to remain unchanged and the slough tissue had decreased by 10%. There were no documented measures for the wounds and the NP documented, Unable to get an accurate measurement - burns are throughout back with epithelial bridges in between. On 8/15/24 at 8:42 AM, an interview was conducted with the Director of Nursing (DON). The DON stated they had wound nurse and wound NP that rounded every Monday to assess all the wounds. The DON stated the nurses were required to do the wound changes when the wound nurse was not there. The DON stated wound measurements were obtained every Monday. The DON stated wound measurements were used to see if the wound was healing, used to compare how it has progressed and if they needed to make changes to the wound care. The DON stated the purpose of wound measurements was to make sure they were providing the care they needed for the wound. The DON stated there should be wound measurements for resident 26's wounds.

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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** 46232 Based on interview and record review, the facility did not 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, for 2 out of 28 sampled residents, one resident eloped from the facility and sustained 2nd and 3rd degree burns. Additionally, another resident was found outside the facility doors while wearing a wander guard. Resident Identifiers: 10 and 26. Findings Included: 1. Resident 26 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of left side hemiplegia, epilepsy, bipolar type schizoaffective disorder, cognitive communication deficit, burn of second degree of lower back, burn of second degree of buttock, burn of third degree of lower back, and personal history of traumatic brain injury. On 8/13/24 at 2:40 pm, an interview was conducted with resident 26. Resident 26 stated they had snuck out of the facility and had not informed staff of their location. Resident 26 stated they fell on the pavement and sustained burns down to their crack. Resident 26 stated the burns were uncomfortable. Resident 26's medical records were reviewed from 8/12/24 to 8/15/24. On 6/25/24, an Admission Minimum Data Set (MDS) documented Resident 26 had a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment. On 6/19/24, an admission wandering risk scale documented, resident 26 had a history of wandering and the previous facility stated resident 26 was a frequent wanderer. Resident 26's wander score indicated they were a wander risk. Resident 26's physician orders were reviewed and documented the following wander guard orders: a. An order with a start date of 6/19/24 and end date of 7/8/24 documented, May have wander guard to right ankle: Check for Placement and Function Q [every] shift. every shift for Safety b. An order with a start date of 7/8/24 and end date of 7/10/24 documented, May have wander guard to wheelchair: Check for Placement and Function Q shift. every shift for Safety. c. An order with a start date of 7/25/24 documented, Wander Wander Guard on wheelchair every shift for safety. It should be noted resident 26 went 6 days without a wander guard order before they left the facility without informing staff of their where abouts. The Leave of Absence binder was reviewed and there was no indication resident 26 had signed out. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 26's progress notes were reviewed and documented the following: a. On 7/5/24 at 5:27 AM, a nurse note documented, PT [patient] used her lighter to burn off her wander guard strap. Placed the wander guard onto the back of her w/c [wheelchair] and she took it off. Administrator made aware. b. On 7/16/24 at 6:45 PM, a late entry nurse note documented, Police called and notified nurse that they had a female that stated she was a resident at [name of facility]. Police gave her name and stated she was heading south in her wheelchair down state street. Police asked if we wanted to come [NAME] her back. Police stated she said she would come back later after visiting her friends. Nurse responded resident is alert and able to leave facility at her own will. Following call from police, nurse noted resident had not signed out in LOA [leave of absence] book. Notified DON [Director of Nursing] of resident being out of building and phone call from police. Resident has spent time at friends house in the past and has returned in the time she stated she would return. c. On 7/17/24 at 7 PM, an elopement event note documented, Resident went LOA from the building on 7/16 @ [at] 6:45 pm, she did not state she would be out all night from the facility. On 7/17 resident still hadn't returned to the facility, reached out to the Case Worker for her but no answer. Reached out to a friend that resident had spent the night a couple of days before but she had not see the resident. Notified Administrator and reported the elopement to state and police. Reached out to hospitals in the area and noted that the resident was in the ER [emergency room] at the [name of local] hospital. No further information at this time. On 7/17/24, the Hospital history and physical documented resident 26 had fallen out of their wheelchair and was unable to get themselves off the hot pavement. It documented resident 26 was sunburnt and obtained burns to their back and buttocks. The facility abuse investigation, form 358 was submitted to the State Survey Agency (SSA) on 7/17/24 at 1:39 PM. An allegation of suspected elopement was reported. It documented resident 26 stated they were going downtown to visit a friend when she left the facility. The form documented staff became aware of the incident at 10 AM and the DON was made aware at 12 pm. A detailed account of the incident documented, Resident left facility at 7 pm on 7/16/24 telling staff she was doing [sic] downtown to visit a friend and did not return for morning medications as she normally does. Shift nurse notified nurse manager when resident was not present for med pass. Nurse manager notified administrator and elopement was reported to state agency. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility final investigation, form 359 was submitted to the SSA on 7/24/24. The documented outcomes stated, [Resident 26] went out of the facility and was found by the police. Patient stated she is a resident at [name of facility]. Police was notified she was going downtown to meet a friend. When the patient did not return that evening, we called at approximately 1:20 pm to her case worker and found her at the [local] hospital. An interview was conducted with resident 26 and stated, Per interview with resident she stated she left the facility without informing staff and took her manual wheelchair to state street. She stated she was with family and friends. Resident stated she fell out of her wheelchair and couldn't verbalize how or why or any additional clarifying details. The ambulance showed up and she was treated and the hospital let us know she was doing drugs and returned back to [name of facility]. The form documented there were no staff members that witnessed the resident leave the facility. A summary of staff interviews documented the cops located resident 26 on [a local street] but resident 26 did not want to return to the facility. The provided summary documented, Patient was placed on a wander guard on 6/19 on admission following the completion of the wander risk assessment per facility policy for safety. On 7/5 patient burned her wander guard off her wheelchair. A new wander guard was placed however, resident was not compliant with the safety plan. The Investigation verified the allegation had occurred. On 8/14/24 at 11:27 AM, an interview was conducted with the DON. The DON stated an elopement either when a resident left the building and was unable to return to the facility due to confusion or when a resident left the building without signing out the LOA book or telling staff they were leaving. The DON stated residents needed to inform staff of LOA so staff was aware of how long the resident was going to be gone for. The DON stated resident 26 was reported to be a wander risk from their previous facility and based off of their admission assessment, resident 26 was considered a high elopement/wander risk. The DON stated resident 26 had a stroke which might have contributed to cognitive issues. The DON stated resident 26 had found ways to remove their wander guard. The DON stated the previous administrator had done an assessment and made the decision to remove resident 26's wander guard. The DON stated normally a wander guard removal was a team decision to ensure the proper assessment had completed and the resident was no longer at risk to elope/wander. The DON stated staff were unaware resident 26 had left the building. The DON stated around 6 or 7 pm that night, the police had called the facility to inform them of a possible missing resident which was resident 26. The DON stated they attempted to reach resident 26 when they had not returned back to the facility in the morning. The DON stated later that day, resident 26 was located at one of the ER's with burns and positive meth use. 2. Resident 10 was admitted to the facility on [DATE] and discharged from the facility on 6/13/24 with diagnosis of wernicke's encephalopathy, alcohol abuse with intoxication delirium, alcoholic hepatitis without ascities, and altered mental status. Resident 10's medical records were reviewed on 8/12/24. A physician order with a start date of 5/3/24 and discontinue date of 6/14/24, documented as followed: check wanderguard placement: R [right] ankle. every shift. It should be noted that no wander risk assessment's were located in the resident's medical record. Resident 10's progress notes were reviewed and documented the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. On 5/4/24 at 10:28 AM, an admission 72 hour charting note documented, .very confused, seems to be her baseline. Wanders around looking for her room, her mom, etc .A [alert] &O [oriented] x [times]1-2, pleasantly confused, compliant with meds. b. On 5/8/24 at 9:38 PM, an elopement event note documented resident 10 had an elopement on 5/8/24 at 6:30 PM. The note stated resident 10 was found coming back inside from the side door. Resident 10 was noted to have a wanderguard placed on their left ankle and it was documented resident 10 wandered due to confusion but did not have any exit seeking behaviors. c. On 5/9/24 at 9:36 AM, an orders-administration note documented, .resident keep [sic] looking for exits but resident gets redirect easily. d. On 5/9/24 at 9:51 AM, an Intradisciplinary Team (IDT) Event Review stated the intervention for resident 10 elopement was, educate staff on importance of not allowing resident to exit outside independently. e. On 5/12/24 at 10:46 PM, an elopement note documented resident 10 had an elopement on 5/12/24 at 7 pm. The note stated resident 10 was found on the backside of the building sitting down on the grass and it was unknown how the resident got there. It was documented that resident 10 had a wander guard on their right ankle. f. On 5/13/24 at 3:39 PM, an IDT-Event note documented resident 10 was placed on hourly visual checks due an elopement. Additional interventions in response to resident 10's elopement included, doors were checked for locking/ alarm sounds and wanderguard was checked. g. On 5/14/24 at 2:50 AM, an alert note documented, Patient wandered all night long, kept opening doors and going into patient's rooms and waking them up. Many complaints from other patients. h. On 5/15/24 at 3:19 PM, a plan of care note documented, .She requires a wander guard bracelet for safety due to impulsiveness and frequent wandering. The facility Investigation was reviewed for the May 8th elopement and documented as followed: a. The facility abuse investigation, form 358 was submitted to the State Survey Agency (SSA) on 5/9/24 at 5:24 PM. An allegation of elopement was reported. Staff became aware of the incident on 5/9/24 at 6:30. The form documented, the Resident Advocate (RA) [name removed] was on their way home for the day, when they noticed resident 10 was outside the side [sic] facility. It was documented resident 10 was found on the north-west side of [facility]. The documented steps taken to protect resident 10 included bringing resident 10 back to the facility and checking all the doors to ensure they were locked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465111	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandy Health and Rehab	50 East 9000 South Sandy, UT 84070

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F 0689 Level of Harm - Actual harm Residents Affected - Few	b. The facility final investigation, form 359 was submitted to the SSA on 5/16/24 at 6 PM. The form documented there were no witness to the elopement and resident 10 had no recollection of the elopement. An interview with staff documented, .Resident was found coming back from outside of the facility door. Indicating that she was outside. In the additional summary section, the form documented resident 10 had another elopement during this investigation. The investigation verified the allegation had occurred. The form listed additional interventions which included, updating and putting signs on all the doors that better and clearly state and help residents understand the use for such door; daily egress Door check system, to ensue that Doors are being properly closed. The facility Investigation was reviewed for the May 12th elopement and documented as followed: a. The facility abuse investigation form 358 was submitted to the SSA on 5/13/24 at 2:18 PM. The form documented an allegation of elopement. The form documented resident 10 had eloped from the facility on 5/12/24 at 6:45 pm. The form documented a staff member had found resident 10 outside of the emergency exit door in the back yard of the facility. b. The facility final investigation, form 359 documented resident 10 was found outside by the vending machines. Resident 10 was brought inside, and they were still on the facility grounds and no alarm had gone off. Elopement charting was started on resident 10. Additional documentation included the doors and door locks were assessed on May 20, 2024. Daily Egress Door checks were completed, and the doors checked included the therapy exit, 100 hall, laundry hall, 200 hall, 300 hall, and Maintenance door. On 8/15/24 at 11:27 AM, an interview was conducted with the DON. The DON stated a wander assessment was done on admission and then quarterly. The DON stated if a resident scored high on the assessment and exhibited exit seeking behaviors, a wander guard was ordered by the physician. The DON stated a wander guard was used to keep the residents safe and notify staff if they were trying to exit the building. The DON stated central supply checked the wander guard door weekly to make sure it was working. The DON stated the front door was the only door that alarmed and locked with the wander guard system. The DON stated they did not have a wander guard system for the entire building. The DON stated all other entry doors remained locked. The DON stated the doors alarmed if they here held for 15 seconds. The DON stated there was a key to unlock the doors and it disabled the door alarm if the door was unlocked. The DON stated resident 10 was able to get out with a wander guard either because the door had not been locked or the alarm was not answered by staff. The DON stated after resident 10's elopement, signs were put on the doors to remind residents they could not go out those doors.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19354 Based on interview and record review, it was determined that for 2 of 28 sampled residents the facility did not ensure that the residents were free from significant medication errors. Specifically, a resident was not administered antibiotics as ordered that resulted in a treatment of an autolytic debridement and prophylactic medications were not administered to a resident who had 3rd degree burns to her buttocks and back. Resident identifiers: 15 and 26. Findings include: 1. Resident 15 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, difficulty walking, difficulty swallowing. enlarged prostate, and a lack of coordination. Resident 15's medical record was reviewed from 8/14/2024 through 8/15/2024. On 3/26/24 at 4:28 PM, a facility report incident (FRI) was submitted to the State Survey Agency (SSA). It was documented that on 3/26/24 at 1:00 PM, resident 15's right fifth toe had been run over while he was being propelled down the hall in his wheelchair. The wound nurse assessed the right fifth toe as having a laceration. The wound Nurse Practitioner (NP) was notified and an order was obtained to send resident 15 to the emergency department (ED) for possible stitches. The ED notes documented, resident 15 had redness and bruising to the right fifth toe with a small laceration to the adjoining web space. An x-ray was obtained and a diagnosis of a lateral dislocation of the proximal interphalangeal (PIP) joint and a non-displaced fracture of the middle right fifth toe. The ED physician documented that resident 15 was to be started on Cephalexin 500 milligrams (mg) twice a day. In a progress note, dated 3/27/24 at 5:23 AM, a Registered Nurse (RN) documented that resident 15 had returned from the ED and that there was an order for liquid Keflex that was sent with instructions to administer the Keflex for 5 days. The March 2024 and April 2024 medication administration records (MARs) were reviewed. There was no documentation that the Cephalexin order was transcribed onto the MARs or that the Cephalexin was ordered from the pharmacy. On 8/14/24 at 12:15 PM, the Director of Nursing (DON) reported that patient 15 did not receive the Keflex as ordered. 2. Resident 26 was readmitted to the facility on [DATE] with diagnoses which included a second degree burn to the lower back and buttock; a third degree burn of the lower back; Schizoaffective disorder, bipolar type; hemiplegia, left non-dominant side; a history of a traumatic brain injury; and stimulant abuse. Resident 26's medical record was reviewed from 8/12/24 through 8/15/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/4/24, the facility received an order to administer Keflex 500 mg four times a day for seven days. There was an interdisciplinary review on 8/6/24 where it was identified that the Keflex had not been transcribed into the electronic medical record. On 8/15/24 at 8:42 AM, an interview was conducted with the DON related to the antibiotics that were either not initiated or not administered in a timely fashion. The DON stated that the nurse who received that order was to documented the implementation of the order in a progress note, call the pharmacy to let them know, fax the order to the pharmacy for delivery. The DON stated that there was to be a 24 hour chart check after a new order was received.