STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465115	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT MT OGDEN	400 EAST 5350 SOUTH OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584	**The Terrace at Mt. Ogden** **Plan of Correction – 2567 12/15/2022**	POC Completion date: 2/20/2023

PoC Date: 2/20/2023
PoC Accepted by H. Flint on 1/30/2023

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

POC DISCLAIMER: The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).

*F584 Safe/Clean/Comfortable/Homelike Environment

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	1/20/23

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

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F 584	Continued From page 1 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined, for 5 of 27 sampled residents, that the facility did not provide a safe, clean comfortable and homelike environment. Specifically, resident wheelchairs were dirty and a lift was dirty. Resident identifiers: 13, 17, 33, 34, and 52. Findings include: 1. On 12/13/22 at 1:45 PM, resident 33 was observed in her wheelchair. Resident 33 wheelchair was observed to have a soiled wheelchair cushion, the sides and wheels of her wheelchair were soiled. On 12/15/22 at 12:46 PM, an observation was made of resident 33's wheelchair. Resident 33's wheelchair was observed to have a soiled cushion. In addition, the sides and wheels of her wheelchair were soiled. 2. On 12/15/22 at 12:26 PM, an observation was made of resident 52's wheelchair. Resident 52's wheelchair was observed to have a green pad on it. There was food and debris on the pad. There was a strong urine odor. There was debris on the sides of the cushion and the wheels were soiled. 3. On 12/15/22 at 12:55 PM, an observation was made of resident 34. Resident 34's wheelchair was observed to be soiled on the cushion and on the sides and the back where the motor was. 4. On 12/15/22 at 12:47 PM, an observation was	F 584	**Corrective action for residents found to have been affected by the deficiency:** Resident 13, 17, 33, 34, and 52 have had their wheelchairs cleaned. All lifts have been cleaned **Identification of others at risk:** All residents using a wheelchair and/or a lift have the potential to be affected. **Measures that will be put into place to ensure that this deficiency does not recur:** Staff educated in process that Night shift CNAs receive assignment sheet that includes which wheelchairs are to be cleaned. Nurse will verify that wheelchairs have been cleaned per assignment sheet. Staff educated that Wheelchairs are also to be cleaned as needed in addition to the scheduled cleaning. Staff educated that lifts are to be wiped down between each resident use but will also be deep cleaned every Sunday Night. Nurse will verify that lift has been deep cleaned per schedule. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this**	

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F 584	Continued From page 2	F 584	**deficiency has been corrected and will not recur:**	

made of resident 17's electric wheelchair. Resident 17's wheelchair was observed to be soiled on the arm rests, and there was crumbs and debris under the joystick. Resident 17's cushion had debris and a white substance dried on it.

5. On 12/13/22 at 1:35 PM, an observation was made or resident 13's room. Resident 13's dresser had 3 of the 6 handles broken. Resident 13 stated the handles will just break again anyway. Resident 13's wheelchair was observed to be dirty. Resident 13 stated the Certified Nursing Assistants (CNA) cleaned wheelchairs at night.

6. On 12/15/22 at 12:45 PM, an observation was made of a sit to stand lift outside room 136 and 134. The lift was observed to be soiled on the foot rests.

On 12/15/22 at 12:15 PM, an interview was conducted with CNA 4. CNA 4 stated the night shift CNAs should be cleaning the wheelchairs.

On 12/15/22 at 12:28 PM, an interview was conducted with CNA 3. CNA 3 stated there was a nightly list for CNAs to be cleaning wheelchairs on night shift. CNA 3 stated there was a list in the CNA binder at the nurses station. CNA 3 was unable to find a list of wheelchairs cleaned. CNA 3 stated there was nothing specifically signed off when the wheelchair was cleaned.

On 12/15/22 at 12:57 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was an assignment book with which wheelchairs were cleaned on which days. The DON stated there was no log or

DON/Designee will complete visual inspection of at least 3 wheelchairs and 2 lifts three times a week x 4 weeks to ensure appropriate process is in place. The results of the audit will be assessed and concerns will be reported to the QA committee for review. QA committee will determine the need for continuation and frequency of audit. The QA process will be overseen by the administrator or designee.

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F 584 Continued From page 3

anything because it had not been a problem having the wheelchairs cleaned. The DON stated if staff noticed a dirty wheelchair, they cleaned it. The DON stated CNAs were to wipe the lifts down between each resident.

F 676 SS=D Activities Daily Living (ADLs)/Mntn Abilities
CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)

§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:

§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...

§483.24(b) Activities of daily living.
The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and

F 584

*F676 Activities Daily Living (ASLs)/Mntn Abilities

F 676 **Corrective action for residents found to have been affected by the deficiency:**

Resident 33 saw dental hygienist on 1/10/23 and had teeth cleaned.

Staff educated that CNAs to notify nurse if resident refuses to allow them to provide oral care and nurse to attempt. If resident still refuses nurse to document refusal in resident's chart.

Identification of others at risk:

All residents who require assistance with oral care have the potential to be affected.

All residents reviewed to determine who needs assistance with oral care and care plan updated as appropriate.

Measures that will be put into place to ensure that this deficiency does not recur:

Residents identified to require assistance with oral care to have care plan updated to reflect this. This is to be included on the Kardex so that CNAs can see this. Staff educated that

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F 676	Continued From page 4 snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined, for 1 of 27 sampled residents, that based on the comprehensive assessment residents were not provided the necessary care and services to ensure that a resident's abilities in activities of daily living did not diminish. Specifically, a resident was not provided oral care and was observed with build up on her teeth. Resident identifier: 33. Findings include: Resident 33 was admitted to the facility on 4/23/20 with diagnoses which included unspecified dementia, anxiety, mood disorder, major depressive disorder, contractures to right shoulder, left hip and right hip, left hand contracture, left shoulder, left elbow, left wrist, right knee, left ankle, and right hand. On 12/13/22 at 1:45 PM, an observation of resident 33 was made. Resident 33 was observed to have white and yellow build up substance on her teeth around the gum line. Resident 33's medical record was reviewed on 12/15/22. A quarterly Minimum Data Set (MDS) dated 10/21/22 revealed resident 33 no dental issues. The MDS further revealed that resident 33	F 676	CNAs are to notify nurse if resident refuses to allow them to provide oral care and nurse to attempt. If resident still refuses nurse to document refusal in resident's chart. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** DON/Designee to complete review of at least 3 residents 3 times a week x 4 weeks to ensure appropriate process in place. The results of the review will be assessed and concerns will be reported to the QA committee for review. QA committee will determine the need for continuation and frequency of Review. The QA process will be overseen by the administrator or designee.	

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required 1 person extensive assistance with personal hygiene.

A care plan dated 4/23/20 revealed "[resident 33] has ADL (activities of daily living) Self Care Performance Deficit r/t (related to) weakness, impaired cognition." The goals was "Will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and Personal Hygiene)with staff assistance as needed." Interventions included "Converse with resident while providing care"; "Explain all procedures/tasks before starting"; "Praise all efforts at self care"; "Encourage to discuss feelings about self-care deficit"; and "Encourage to participate to the fullest extent possible with each interaction."

The Certified Nursing Assistant (CNA) documentation in the tasks section of resident 33's medical record revealed "PERSONAL HYGIENE: SELF PERFORMANCE - How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)" was completed on 11/17/22, 12/1/22, 12/2/22, 12/4/22 and 12/10/22 in the last 30 days.

On 12/15/22 at 10:22 AM, an interview was conducted with CNA 1. CNA 1 stated he did not know about resident 33's teeth. CNA 1 stated that occasionally staff did oral care. CNA 1 stated he was not sure if there was a specific process for oral care. CNA 1 stated when staff got residents up in the morning, and would then brush residents' teeth. CNA 1 stated resident 33 did not refuse help with her activities of daily living with him but had refused for some female CNAs.

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On 12/15/22 at 10:25 AM, an interview was conducted with CNA 2. CNA 2 stated oral care depended on the type of assistance a resident needed. CNA 2 stated when she assisted resident 33 with oral care, she needed to tell her what to do and had to remind her by doing the oral care. CNA 2 stated resident 33 had her own teeth. CNA 2 stated she cared for her once and resident 33 did not refuse oral care.

On 12/15/22 at 12:29 PM, an interview was conducted with CNA 3. CNA 3 stated oral care should be done in the morning and at night. CNA 3 stated some residents were able to do their own oral care but she assisted residents who needed help. CNA 3 stated resident 33 needed help with oral care and staff had to complete full oral care. CNA 3 stated resident 33 did not have dentures. CNA 3 stated sometimes resident 33 refused oral care, so staff tried again at a later time. CNA 3 stated sometimes resident 33 bit down on the tooth brush and staff were unable to brush her teeth. CNA 3 stated she had not worked with resident 33 much so had not noticed build up on her teeth.

On 12/15/22 at 12:42 PM, an observation of resident 33's teeth was conducted with CNA 1. CNA 1 was observed to put gloves on and ask resident 33 if we could see her teeth. Resident 33's teeth had a white and yellow substance at the gum line and on the front right teeth there was a large bump. Resident 33 stated she did not know if staff cleaned her teeth.

On 12/15/22 at 1:03 PM, an interview was conducted with the Director of Nursing (DON). The DON stated residents' oral care was

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F 676	Continued From page 7 completed when the CNAs got the residents up in the morning and when the residents went to bed at night. The DON stated resident 33 had severe dementia and pushed staff away and said "no, no, no." The DON stated with oral care resident 33 bit down on the tooth brush. It should be noted there were no notes or care plans regarding resident 33 refusing assistance with activities of daily living. F 690 Bowel/Bladder Incontinence, Catheter, UTI SS=D CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	F 676	*F690 Bowel/Bladder Incontinence, Catheter, UTI F 690 **Corrective action for residents found to have been affected by the deficiency:** Resident 24's plan of care has been reviewed and updated as appropriate. **Identification of others at risk:** All residents who are dependent with repositioning and toileting have the potential to be affected. All residents reviewed to determine who is dependent with repositioning and toileting and care plan updated as appropriate. **Measures that will be put into place to ensure that this deficiency does not recur:** Residents who are dependent with repositioning and toileting will have care plan in place with repositioning and toileting plan in place and on Kardex for CNAs to see. CNAs educated on where to find plan of care on Kardex and on the importance of ensuring	

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F 690	Continued From page 8 continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined, for 1 of 27 sample residents, that the facility did not ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, a resident did not receive brief changes, skin checks, and toileting services in coordination with good nursing care and outlined in the resident's care plan. Resident identifier: 24. Findings include: Resident 24 was admitted to the facility on 3/27/18 with diagnoses that included rheumatoid arthritis (RA), hemiplegia, cerebral infarction, left hand, shoulder and elbow contractures, osteoarthritis, depression, bilateral knee contractures, depression, and cognitive communication deficit. Resident 30's medical record review was completed on 12/15/22. On 12/13/22 at 12:30 PM, resident 24 was observed in the activity room. Resident 24 was able to answer in yes and no answers to a few	F 690	our residents are being toileted and repositioned at least every 2 to 3 hours even when they are up out of bed in their wheelchair. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** DON/Designee to complete review of at least 2 residents 3 times a week x 4 weeks to ensure appropriate process in place. The results of the review will be assessed and concerns will be reported to the QA committee for review. QA committee will determine the need for continuation and frequency of Review. The QA process will be overseen by the administrator or designee.	

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questions.

On 12/14/22 at 10:48 AM, a continuous watch was initiated. Resident 24 was observed to be in the activity room with 16 residents and one activity staff during an activity. Resident 24's wheelchair back appeared to be at approximately an 80 degree angle. At 10:50 AM, resident 24 was observed to be taken to the hallway and was provided a smoking apron. At 11:00 AM, resident 24 was taken outside with other residents to smoke. Resident 24 smoked approximately half her cigarette and was brought back inside at 11:14 AM and was pushed to the dining room. Resident 24 was observed sitting in the dining room until 11:49 AM when she was served lunch. Resident 24 was asked if she required her casserole to be cut, to which she shook her head "no." Resident 24 was observed feeding herself and drank coffee and orange juice. At 12:05 PM, resident 24 was observed to finish eating and was served a gelatin-salad appearing dessert at 12:07 PM. At 12:24 PM, resident 24 was pushed to the activity room where a total of five residents were watching a John Wayne western. At 1:01 PM, resident 24 was taken outside for a smoking break. At 1:10 PM, resident 24 was pushed back into the activity room where she was placed in front of Bonanza with three other residents. At 1:35 PM, resident 24 asked staff when she would be taken to BINGO. Resident 24 asked activity staff (AS) 1 for a root beer. At 1:41 PM, AS 1 retrieved a root beer for resident 24. At 2:00 PM, another western started, and resident 24 began calling out for staff. At 2:07 PM, the other residents left the activity room to go "prepare for BINGO." At 2:18 PM, resident 24 was taken to BINGO in the dining room, which began at 2:30 PM. Resident 24 continued to play BINGO when

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the continuous watch ended at 2:48 PM. An immediate interview was conducted with the Recreation Therapist (RT), who stated that BINGO would continue until 4:00 PM.

Resident 24's latest Minimum Data Set (MDS) evaluation was a quarterly assessment performed on 10/27/22. Resident 24's MDS revealed the following:

a. Resident 24 had a BIMS (Brief interview for Mental Stats) score of 5/15, which indicates severe cognitive impairment.

b. Resident 24 had no exhibited rejection of care.

c. Resident 24 required two person assistance for bed mobility, transferring, and toilet use.

d. Resident 24 was dependent for toileting and the helper performed all the physical effort.

e. Resident 24 required substantial/maximal assistance for rolling left and right, moving for sitting to lying or lying to sitting, and transferring, including toilet transferring.

f. Resident 24 did not have a toileting program.

g. Resident 24 was always incontinent of urine and bowel.

h. Resident 24 was at risk for developing pressure ulcers.

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Resident 24's care plan revealed the following:

a. "Has potential for pressure ulcer development and skin impairment r/t (related to) immobility, muscle weakness, cerebral infarction, hemiplegia, RA (rheumatoid arthritis), contractures, incontinence." Initiated: 2/3/20 with interventions that included "Needs monitoring/reminding/assistance to turn/reposition."

b. Resident 24 "Has Hemiplegia/Hemiparesis (paralysis) r/t Stroke" with interventions that included "Provide assistance with turning and repositioning to keep body in good alignment and to prevent skin breakdown."

On 11/28/22 at 2:05 PM, a Nurse Practitioner (NP)/ Physician Assistant (PA) note revealed that resident 24 "... is severely debilitated from history of a stroke with hemiplegia and multiple contractures. She is totally dependent for transferring [and] positioning. She has no ability to reposition... in wheelchair and has issues with past and current skin breakdown.... Ordered a Tilt-In-Space wheelchair with pressure relieving cushion to reduce risk of skin breakdown."

[Note: Resident 24 was in a tilt-in-space wheelchair during the observation listed above on 12/14/22, but was not observed to be tilted in any other angle than approximately 80 degrees.]

Nursing notes revealed the following:

a. On 8/19/22 at 6:00 PM, "...Turning/repositioning program is being used to

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maintain skin integrity. Other observations and interventions include Resident is turned and repositioned q 2 (every two) hours and PRN (as needed), resident is provided peri care q 2 hours and PRN..."

b. On 8/23/22 at 11:00 AM, "...Pressure Relief: Repositioning, offloading per facility protocol. Dietary Interventions: Facility protein supplement with meals twice daily until wound closure. IMPRESSION: Based on today's evaluation, wound healing potential is fair, and may be delayed. Current and future wounds may be unavoidable due to the following comorbidities impairing wound healing...."

c. On 8/24/22 at 11:00 PM, "...Turning/repositioning program is being used to maintain skin integrity.
Other observations and interventions include Resident is turned and repositioned q2 hours and PRN...."

d. On 10/23/22 at 10:00 AM, "...Turning/repositioning program is being used to maintain skin integrity..."

e. On 11/8/22 at 11:21 AM, a nursing note revealed "...Repositioning, offloading per facility protocol...."

The Certified Nursing Aide (CNA) task checklist for the previous 30 days revealed that CNAs documented toilet use for resident 24 on the following dates and times:

a. 11/14/22, did not occur

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b. 11/15/22 at 9:17 AM

c. 11/16/22, did not occur

d. 11/17/22 at 12:51 AM

e. 11/18/22, did not occur

f. 11/19/22 at 1:59 PM

g. 11/20/22 at 10:42 AM

h. 11/21/22 at 12:39 AM

i. 11/22/22, did not occur

j. 11/23/22 at 1:20 AM and 11:29 PM

k. 11/24/22, did not occur

l. 11/25/22 at 1:59 PM

m. 11/26/22, did not occur

n. 11/27/22 at 11:00 AM

o. 11/28/22, did not occur

p. 11/29/22, did not occur

q. 11/30/22 at 3:07 PM

r. 12/1/22, did not occur

s. 12/2/22, did not occur

t. 12/3/22 at 1:18 AM

u. 12/4/22, did not occur

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v. 12/5/22 at 12:03 PM

w. 12/6/22, did not occur

x. 12/7/22 at 9:22 AM

y. 12/8/22 at 12:27 AM

z. 12/9/22 at 3:23 AM and 7:25 PM

aa. 12/10/22, did not occur

bb. 12/11/22 at 4:27 AM

cc. 12/12/22 at 10:30 AM

On 12/15/22 at 9:42 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that CNAs were to chart for tasks by the end of their shift for all activities that were completed. CNA 2 stated that for residents who could not move, the CNAs were to rotate them every two hours. CNA 2 stated that the only residents that were rotated were those who were in bed and not those who were up in a wheelchair. CNA 2 stated that resident 24 was not on the reposition list. CNA 2 stated that resident 24 could not reposition herself in her wheelchair. CNA 2 stated that residents' briefs were checked when the resident got out of bed, after meals, after activities, and/or if there was any sign that they were soiled or wet. CNA 2 stated that resident 24 had told CNA 2 when her brief was wet in the past, but had not expressed wetness in the past month.

On 12/15/22 at 9:50 AM, CNA 1 was interviewed. CNA 1 stated that some of the residents needed

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to be repositioned every two hours, and reported that 4 residents who stayed in bed needed repositioning. CNA 4 stated that resident 24 was not on a repositioning checklist. CNA 1 stated that CNAs were to check briefs every two hours. CNA 1 stated that resident 24 was "a little tricky" because she liked to remain in her wheelchair all day. CNA 1 stated that resident 24 did not report when her brief was wet, and required two people to change her and the use of the Hoyer lift. CNA 1 stated that it was difficult to change resident 24's brief because the sling was required. CNA 1 stated that resident 24 did not want to go back to bed, so CNAs did not usually change her during the day unless she had a bowel movement. CNA 1 stated that often, resident 24 remained in her wheelchair "all day." CNA 1 stated that she did not know if there was a cushion in resident 24's wheelchair. CNA 1 stated that when the CNAs changed resident 24's brief, they looked for red marks that looked like pressure injuries, because resident 24 had pressure injuries in the past. CNA 1 stated that resident 24's skin was usually intact. CNA 1 stated that resident 24's brief could not be checked while resident 24 was in a common area, so the CNAs would have to take resident 24 to her room to check her brief. CNA 1 stated that resident 24 usually got out of bed just before breakfast, between 7:00 AM and 7:30 AM, and would not return to bed until after dinner.

On 12/15/22 at 10:03 AM, Registered Nurse (RN) 2 was interviewed. RN 2 stated that resident 24 could hold a cup of water and feed herself, but otherwise required staff assistance for all cares and tasks. RN 2 stated that resident 24 could not adjust herself in her wheelchair. RN 2 stated that resident 24 required two people and a Hoyer lift to transfer into bed for brief changes. RN 2 stated

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that resident 24 liked to "sit all day long." RN 2 stated that resident 24 should have been repositioned, but will sometimes yell and scream at staff. RN 2 stated that resident 24 did not like to have her brief changed, but when staff educated her about the importance of having regular brief changes, resident 24 would let staff assist her. RN 2 stated that resident 24's cares should be charted in the CNA tasks for repositioning and brief changes.

On 12/15/22 at approximately 3:00 PM, the Director of Nursing (DON) and Corporate Resource Nurse (CRN) were interviewed. The CRN stated that resident 24 should have been repositioned every two to three hours. The DON stated that resident 24's care plan stated that resident 24 required frequent repositioning. The DON stated that some staff did not know that residents in wheelchairs required repositioning.

F 700 Bedrails
SS=D CFR(s): 483.25(n)(1)-(4)

§483.25(n) Bed Rails.
The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

F 690

*F700 Bedrails

F 700 **Corrective action for residents found to have been affected by the deficiency:**

Resident 3 bed rail was replaced.

Resident 3 reassessed by therapy to ensure bed rail safety and appropriateness.

Identification of others at risk:

All residents who have bed rails have the potential to be affected.

Therapy to review all bed rails to ensure no safety issues.

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F 700	Continued From page 17 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined for 1 of 27 residents that the facility failed to reevaluate the risks versus benefits of the installed side rails for a resident. Specifically, one resident had a skin tear occur from the use of the current side rail. Resident identifier: 3. Findings Include: Resident 3 was admitted to the facility on 6/21/22 with diagnoses which included heart failure, type 2 diabetes mellitus, morbid obesity, and reduced mobility. On 12/13/22 at 12:01 PM, an interview was conducted with resident 3. Resident 3 stated she injured her left forearm on the inside of the side rail. Resident 3 stated that the inside of her side rail had something that stuck out for her to put her remote in. Resident 3 stated that her arm slid off the side of the rail and scraped the part for the remote-control holder. Resident 3 stated this happened on a day she wasn't coordinated and couldn't control her upper body. Resident 3's medical records were reviewed on 12/14/22 A Minimum Data Set (MDS) - section P restraints and alarms dated 10/25/22 documented that	F 700	**Measures that will be put into place to ensure that this deficiency does not recur:** Staff educated on potential safety issues that can occur with the use of bed rails and on the importance of reporting any suspected potential for safety issue. Therapy to assess residents to determine need for bed rail use and for any potential risk associated with bed rail use. Assessment to be completed prior to bed rails being put on, Quarterly, and as needed with any change in condition. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** DON/Designee to complete review of at least 3 residents with bed rails 2 times a week x 4 weeks to ensure appropriate process in place. The results of the review will be assessed and concerns will be reported to the QA committee for review. QA committee will determine the need for continuation and frequency of Review. The QA process will be overseen by the administrator or designee.	

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resident 3 did not use any bed rails.

Bed rail/ transfer bar safety assessment dated 6/24/22 documented that physical therapy (PT) recommended bed rails to allow resident 3 to pull herself up in bed into a sitting position.

Bed rail/ transfer bar safety initial assessment dated 8/16/22 and 8/17/22 revealed that resident 3 did have difficulty with balance/poor trunk control.

A nursing progress note on 11/10/22 at 10:00 PM stated, "Resident has a new skin tear to L (left) forearm. CNA's (certified nursing assistants) were doing cares and when resident was turned onto her right side, her left arm got caught up in the bed rail and left a skin tear. Site was cleansed and covered. Hospice was notified. Will have AM (morning) shift f/u (follow up) with family in the morning regarding the incident."

Per November and December 2022 progress notes, resident 3 required wound care to her left forearm skin tear from 11/11/22 through 12/9/22.

Resident 3's care plan was reviewed and revealed a care area for actual impairment to skin integrity. The goal identified was skin tear to left forearm will be healed. Interventions were identified and included as follows: 1. Education done with staff on safe bed positioning and turning to prevent possible injury. 2. Encourage good nutrition and hydration in order to promote healthier skin. This care plan was initiated on 11/11/22. Another care area identified was the use of ¼ bed side rail for positioning and ease in mobility. The goal identified was that resident 3 would remain free of complication related to side

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rail use through the review date. Intervention identified included: 1. Discuss with resident, family/caregivers, the risk and benefits of side rail use, when side rails should be used, and any concerns or issues regarding side rail use. 2. Evaluate/record continuing risks/benefits of side rail use, alternatives, need for ongoing use, reason for use. 3. Monitor/document/report to Medical doctor as needed changes regarding effectiveness of side rail use, if appropriate; any negative or adverse effects noted from side rail use. This care plan was initiated on 12/14/22.

On 12/15/22 at 11:43 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 3's skin was really frail. RN 1 stated that at the beginning of November 2022, resident 3's left arm got stuck in between the mattress and the side rail resulting in a skin tear. RN 1 stated the first time she saw the skin tear, she recalled it being a good size and having steri strips on it. RN 1 stated that the skin tear took a long time to heal and it looked like that resident had a scar as a result of that skin tear.

On 12/15/22 at 12:26 PM, an interview was conducted with CNA 5. CNA 5 stated that it took two people to clean resident 3 since she was unable to turn herself at all. CNA 5 stated that resident 3 crossed her arms during brief changes and when turned to either side, resident 3 sometimes got pinched in between the bed rails.

On 12/15/22 at 12:39 PM, an interview was conducted with CNA 6. CNA 6 stated that resident 3 was able to hold onto the bedrail during brief changes. CNA 6 stated that resident 3 had a hard time breathing when turned onto her right side and that was why they mostly turned her to her

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left side. CNA 6 stated that resident 3 liked to lean towards her left side so they usually wedged a pillow or a blanket in between resident 3 and the siderails to prevent skin breakdown.

On 12/15/22 at 2:20 PM, an interview was conducted with the Director of nursing (DON) and the corporate resource nurse (CRN). The DON and CRN stated that resident 3 used the siderail to pull herself up. The DON and CRN stated that physical therapy did an evaluation on resident 3 on the use of side rails and recommended that resident 3 use them for bed mobility. The DON and CRN stated resident 3 signed a consent form for use of the bed rails. The CN stated there was one instance where resident 3 was turned in bed and bumped her arm against the bed rails. That was the only issue she was aware of resident 3 had with the bed rail. The DON and CRN stated they did staff education on bed rail safety and repositioning. The DON and CRN stated they were unaware the resident 3 had been pinched between the bed rail multiple times. The DON and CRN stated they would have therapy look into it.

F 804 SS=E Nutritive Value/Appear, Palatable/Prefer Temp
CFR(s): 483.60(d)(1)(2)

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced

F 700

F 804

*F804 Nutritive Value/Appear, Palatable/Prefer Temp

Corrective action for residents found to have been affected by the deficiency:

New plate warmer was purchased.

Staff educated on the importance of timely passing trays to prevent resident's food from getting cold.

Identification of others at risk:

All residents have the potential to be affected.

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F 804	Continued From page 21	F 804	**Measures that will be put into place to ensure that this deficiency does not recur:**	

by:
Based on observation, interview, and record review it was determined, for 12 of 27 sampled residents, that the facility did not serve food that was prepared by methods that conserved nutritive value, flavor, and appearance or serve food and drink that was palatable, attractive, and at a safe and appetizing temperature. Specifically, residents complained of cold and unappetizing food. In addition, green beans and peas were overcooked and resident council minutes revealed residents' complaints of food quality. Resident identifiers: 1, 7, 13, 20, 34, 37, 41, 45, 49, 55, 59, and 61.

Findings Included:

1. On 12/13/22 at 2:56 PM, resident 1 was interviewed. Resident 1 stated that the eggs were usually cold and not good.

2. On 12/13/22 at 3:01 PM, resident 7 was interviewed. Resident 7 stated that the food was always cold by the time they received it.

3. On 12/13/22 at 1:35 PM, resident 13 was interviewed. Resident 13 stated that the food was cold.

4. On 12/13/22 at 1:08 PM, resident 20 was interviewed. Resident 20 stated that the food was the worst part of the facility. The food was always pancakes and eggs, and that the food was always cold. The resident stated that the tortilla they received for lunch was cold and they did not like the menu.

5. On 12/13/22 at 1:35 PM, resident 34 was interviewed. Resident 34 stated that the food

New plate warmer was purchased.

Staff educated on the importance of timely passing trays to prevent resident's food from getting cold.

Food council is held once a month. Dietary manager to go over menus and get input from residents on preferences and complaints.

Activities to hand out weekly menu with alternatives to the residents so that if they do not like the meal they can choose an alternative.

Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:

Dietician/Designee to complete test tray weekly x 4 weeks to ensure appropriate process in place. The results of the review will be assessed and concerns will be reported to the QA committee for review. QA committee will determine the need for continuation and frequency of Review. The QA process will be overseen by the administrator or designee.

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needed improvement; they were served potatoes or pancakes every day.

6. On 12/13/22 at 2:20 PM, resident 37 was interviewed. Resident 37 stated that they were served too many beans; the food tasted like Miralax and it had the same effect as Miralax.

7. On 12/13/22 at 1:25 PM, resident 41 was interviewed. Resident 41 stated that the food was cold all the time, though it usually tasted good, and that the coffee was always hot.

8. On 12/13/22 at 1:43 PM, resident 45 was interviewed. Resident 45 stated that the foods served were repetitive and frequently served with gravy.

9. On 12/14/22 at 8:40 AM, resident 49 was interviewed. Resident 49 stated that the food had no flavor; the resident did not receive coffee or orange juice this morning.

10. On 12/13/22 at 1:29 PM, resident 55 was interviewed. Resident 55 stated that the food was not great and was usually cold.

11. On 12/13/2022 at 2:21 PM, resident 59 was interviewed. Resident 59 stated that the meat tasted freezer burnt, and the resident does not eat it.

12. On 12/13/2022 at 1:12 PM, resident 61 was interviewed. Resident 61 stated that all of the food served was cold, the tortillas were cold at lunch, and that the food served was not good.

On 12/14/2022 at 11:32 AM, a test lunch tray was requested after observing the trayline. At 11:39

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AM the test tray was placed onto the 200 hallway delivery cart. At 11:47 AM, the meal trays were served to the 200 hallway. An observation was made of the meal trays. There were no hot pellets observed between the base and the meal plate prior to serving. The following temperatures were obtained: [Note: All temperatures were in degrees Fahrenheit.]

a. Chicken King Casserole was 162

b. Peas were 121

c. Green Beans were 115

d. Salad was 52

e. Gelatin Dessert was 59.

Resident council minutes revealed the following complaints of food:

a. 8/9/2022 "...mentioned they do not like Sausage Patties, or French toast sticks ..."

b. 9/13/2022 "Residents would like more protein options for breakfast besides sausage"

c. 10/11/2022 "Residents would appreciate grilled cheeses to not be pre-cooked"

d. 11/08/2022 "...Food has been cold but staff is being replaced so hopefully food quality will improve ..."

On 12/15/22 at 1:40 PM, an interview was conducted with the Dietary Manager (DM). The DM stated the facility recently purchased a new plate warmer. The DM stated that the plate

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	465115	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT MT OGDEN	400 EAST 5350 SOUTH OGDEN, UT 84405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 804 Continued From page 24

warmer was broken for about 4 weeks and residents complained of cold food. The DM stated kitchen staff warmed plates in the oven and steamer during that time. The DM stated she had never seen pellet warmers between the plate and the base.

F 812 SS=E Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, uncooked meats were stored above ready to eat foods, there were soiled areas in the kitchen, cracked paint, missing grout and broken tiles.

F 804

*F812 Food Procurement, Store/ Prepare/Serve- Sanitary

F 812

Corrective action for residents found to have been affected by the deficiency:

Kitchen staff educated on appropriate storage of meat, appropriate labeling and dating food items, and appropriate use of hair nets. Identified areas cleaned in the kitchen. Weekly cleaning schedule has been reviewed by registered dietician and updated to include identified items. Maintenance to work on repair of identified items in the kitchen.

Identification of others at risk:

All residents have the potential to be affected.

Measures that will be put into place to ensure that this deficiency does not recur:

Kitchen staff educated on appropriate storage of meat, appropriate labeling and dating food items, and appropriate use of hair nets. Weekly cleaning schedule has been reviewed by registered dietician and updated to include identified items. Dietary manager educated on appropriate process for entering work orders

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	465115	A. BUILDING _____ B. WING _____	12/15/2022

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THE TERRACE AT MT OGDEN	400 EAST 5350 SOUTH OGDEN, UT 84405

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F 812	Continued From page 25	F 812	to maintenance when areas in the kitchen need repair.	

Findings Include:

1. On 12/13/2022 at 9:46 AM, an initial tour of the kitchen was conducted. The following was observed:

a. In the walk-in refrigerator, a box of raw hamburger patties was found stored above breadsticks.

b. Inside the walk-in freezer there were large chunks of ice on the floor and ice circles hanging from the ceiling.

c. The door handle from the kitchen to the dining room was observed to have crumbs and debris in it.

d. There was cracked paint and drywall under the vents above the stove.

e. Underneath the prep sink a tile was missing.

f. There was missing grout on the tile in front of the oven.

g. Crumbs and debris were found around the edges of the flooring.

2. On 12/15/2022 at 1:37 PM, a follow up tour of the kitchen was conducted. The following was observed:

a. There was raw bacon and sausage stored above oatmeal, mixed vegetables, and rolls in walk-in refrigerator.

Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:

Dietician/Designee to complete review of kitchen weekly x 4 weeks to ensure appropriate process in place. The results of the review will be assessed and concerns will be reported to the QA committee for review. QA committee will determine the need for continuation and frequency of Review. The QA process will be overseen by the administrator or designee.

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	465115	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT MT OGDEN	400 EAST 5350 SOUTH OGDEN, UT 84405

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F 812	Continued From page 26	F 812		

b. There was a container labeled egg salad with no date in the walk-in refrigerator.

c. Inside the walk-in freezer there were large chunks of ice on the floor and ice circles hanging from the ceiling.

d. A three drawer plastic compartment with serving utensils was observed to be soiled with food on both the inside and outside of the drawers.

e. The shelf above trayline basins was observed to be soiled under the shelf.

f. Dietary Aide (DA) 1 was observed to be standing by the trayline rolling silverware in napkins. DA 1 was observed to not have her hair restrained. DA 1 was observed to put on a beanie right after the surveyors entered.

g. There was cracked paint and drywall observed under the vents above the stove.

h. Underneath the prep sink a tile was missing.

i. There was missing grout on the tile in front of the oven.

j. Crumbs and debris were observed around the edges of the flooring.

k. The door handle on the door from the kitchen to the dining room was observed to have crumbs and debris on its surface.

On 12/15/22 at 1:37 PM, Cook 1 was interviewed. Cook 1 stated the inside and outside of the 3

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	465115	A. BUILDING _____ B. WING _____	12/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT MT OGDEN	400 EAST 5350 SOUTH OGDEN, UT 84405

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F 812	Continued From page 27	F 812		

drawers with the utensils in it was cleaned weekly with soap.

On 12/15/22 at 1:40 PM, the Dietary Manager (DM) was interviewed. The DM stated the 3 drawers with the utensils were to be cleaned on a weekly basis. The DM stated the drawers were not on the cleaning schedule so she did not know what day they were cleaned. The DM stated uncooked meats were supposed to be stored on the bottom right shelf of the walk-in refrigerator to prevent meat juices from dripping and contaminating ready-to-eat foods. The DM stated the kitchen was supposed to be swept every night. The DM stated that the ice in the freezer was from the defrost cycle. The DM stated she had not noticed the missing grout and cracked tile. The DM stated the door handles were scheduled to be cleaned nightly. The DM stated the tray line was cleaned nightly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465115	A. BUILDING **01** B. WING _____	**12/14/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT MT OGDEN	**400 EAST 5350 SOUTH** **OGDEN, UT 84405**

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E 000	Initial Comments Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 12/14/2022 in the presence of the administrator and the plant manager are found in 42 Code of Federal Regulations, Section 483.73 The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. No deficiencies cited.	E 000		
K 000	INITIAL COMMENTS Statutory and regulatory authority for this Life Safety Code survey that was conducted on 12/14/2022 in the presence of the plant manager are found in 42 Code of Federal Regulations, Section 483.70, (a) and the 2012 Edition, NFPA 101 Life Safety Code including NFPA publications referenced therein. The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid. No deficiencies cited	K 000		

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

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