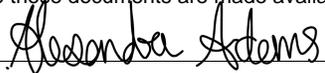


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|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465115 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER THE TERRACE AT MT OGDEN | | | STREET ADDRESS, CITY, STATE, ZIP CODE 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 000 | INITIAL COMMENTS A complaint investigation was started on 10/07/2024 and ended on 10/08/2024. The facility was inspected according to the Long Term Care federal regulations. The allegation was able to be substantiated and deficiencies were cited. | F 000 | 000 Preparation and execution of the Plan of Correction does not constitute admission or agreement by The Terrance at Mt. Ogden of the truth of the facts alleged or the conclusions set forth in this statement of deficiencies. This Plan of Correction is prepared and executed solely because the provisions of Federal and State law require it. The Terrance at Mt. Ogden maintains that the alleged deficiencies do not, individually, or collectively, jeopardize the health or safety of our residents nor are they of such character as to limit our capacity to render adequate resident care. Furthermore, The Terrance at Mt. Ogden asserts that it is in substantial compliance with regulations governing the operation and licensure of this long-term care facility, and this plan of correction, in its entirety, constitutes this provider's allegation of compliance. | 11/27/24 | |
| F 684 SS=D | Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined there was a delay in care for a resident complaining of leg numbness and weakness for 1 of 4 sampled residents. Resident identifier: 1. Findings Include: Resident 1 was admitted to the facility on 5/17/2024 and discharged on 6/30/2024 with diagnoses of wedge compression fracture of the thoracic (t) vertebra of t7-t8 , multiple rib fractures, muscle weakness, cognitive communication deficit, and schizophrenia. On 6/26/2024 at 12:38 PM, a provider documented a cranial nerve exam and | F 684 | <u>F684: Quality of Care</u> <u>Corrective Action:</u> Resident 1 discharged from the facility on 6/30/2024 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
 **Executive Director** **11/22/24**

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.

 11/27/2024

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| F 684 | <p>Continued From page 1</p> <p>neurological exam was conducted on resident 1 due to complaints of being unable to move or feel their legs for the last day. The provider documented no abnormalities were noted. Resident 1 had been able to feel and move their lower extremities at the time of the exam.</p> <p>On 6/29/2024 at 4:48 AM and 11:54 AM, licensed practical nurses documented resident 1 had complained of lower extremity paralysis. There was no provider documentation or communication located to indicate the provider had been made aware of resident 1's change of condition.</p> <p>On 6/30/2024, a registered nurse documented resident 1 had been seen by the provider and sent to the emergency room due to hypoxia, nausea, and new onset paralysis to lower extremities. At 1:30 PM, the provider documented resident 1 had been sent to the emergency room due to a new diagnosis of peripheral neuropathy and no movement to their lower extremities post vertebral compression fracture.</p> <p>It should be noted resident 1 had a 5 day hospital admission with diagnoses including but not limited to Cauda equina compression, epidural abscess, and osteomyelitis of the thoracic vertebra.</p> <p>On 10/7/2024 at 2:19 PM, an interview was conducted with the Administrator (ADM). The ADM stated they were recently made aware that resident 1 had made claims of a fall at the facility and staff had not been taking care of them. The ADM stated there was no documented incident of a fall and there had been no report of a fall.</p> | F 684 | <p><u>Identify others at risk:</u></p> <p>Current residents of The Terrace at Mt. Ogden with change in adls status are at risk.</p> <p><u>Systemic changes:</u></p> <p>1.DON/Designee re-educated clinical staff on facility process of notification to medical providers of change in condition/quality of care. The education for current staff was current staff was completed by 10/23/24.</p> <p><u>Monitor:</u></p> <p>1. A audit tool was initiated to monitor compliance with the quality of care/change in condition process by the clinical nurse resource on 10/8/2024</p> <p>2.DON/designee will observe 3 random residents with abnormal vital signs to assure proper notification to medical provider was completed.</p> <p>3. DON/designee will observe 3 random residents with changes in adl status to assure proper notification to medical provider was completed.</p> | | |

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| F 684 | Continued From page 2 On 10/7/2024 at 2:42 PM, an interview was conducted with the Nurse Practitioner (NP). The NP stated the last encounter they had with resident 1 was when resident 1 voiced they were unable to move or feel their legs and the NP observed a lack of movement in resident 1's lower extremities. The NP stated they sent resident 1 to the hospital but they were unsure if resident 1 was faking or exaggerating their symptoms. The NP stated they remembered they rounded on resident 1 on a Sunday and immediately sent them out that day due to their symptoms and their past medical history. The NP stated resident 1's lumbar back all of a sudden got worse and they were unable to move their legs and with their history, they knew this was going to happen eventually. On 10/8/2024 at 9:48 AM, a follow up interview was conducted with the ADM. The ADM stated they were unable to provided further documentation to show the provider had been notified of resident 1's condition on 6/29/2024. | F 684 | 4. DON/designee will observe 3 random residents with significant weight change to assure proper notification to medical provider was completed. 5. DON/designee will observe 3 random residents with fall to assure proper notification to medical provider and responsible party was completed. 6. DON/designee will observe 3 random residents with orders for antibiotics to assure treatment was started timely. 7. Audits to be conducted bi-weekly x 4 weeks then weekly x 4 then monthly x 1 or until QAPI has deemed substantial compliance has been achieved. Results of audits to be reviewed in QAPI. | | |