

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465090	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Cascades at Orchard Park		STREET ADDRESS, CITY, STATE, ZIP CODE 740 North 300 East Orem, UT 84057	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on facility policy review, facility document review, and interview, the facility failed to develop written procedures for investigating allegations of abuse, misappropriation, and exploitation. The policy failed to include the procedures of a thorough investigations to include identification of staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation; investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment had occurred; or providing complete and thorough documentation of the investigation. This affected 1 (Resident #190) of 1 abuse investigations reviewed.</p> <p>Findings include:</p> <p>A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 10/2024, revealed, Residents have the right to be from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The policy indicated, 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements.</p> <p>The policy review revealed it did not include the procedures of a thorough investigation to include identification of staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation; investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment had occurred; or providing complete and thorough documentation of the investigation.</p> <p>Facility document review on 03/05/2025 at 12:45 PM revealed a two-hour state reportable notification, Form 358, was electronically filed with the state survey agency on 10/31/2024 regarding a report of sexual abuse on 10/29/2024. The report indicated Resident #190 reported that a male staff member touched the resident with his hand in an appropriate manner.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465090	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Cascades at Orchard Park		STREET ADDRESS, CITY, STATE, ZIP CODE 740 North 300 East Orem, UT 84057	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review revealed a five-day follow-up report, Form 359, was electronically submitted to the state survey agency on 11/06/2024 that indicated the facility completed its report with sufficient information for the results of the investigation. The facility concluded the allegation could not be verified. A review of the facility's abuse allegation documents indicated the facility did not have documented evidence of a thorough investigation, including the interviews that were conducted during the investigation.</p> <p>During an interview 03/05/2025 at 4:11 PM, the Administrator stated regarding the allegation made by Resident #190 that he interviewed the staff and wrote it down; and interviewed the one male staff member who worked that day. The Administrator stated he summarized the interviews by the resident, doctor, and the male staff member on duty on Form 359 (the five-day follow-up electronic submission investigation form to the state survey agency). When asked for a copy of the interviews, the Administrator then stated he did not write down any interviews for the resident, the doctor, or the staff member interviewed, and the Director of Nursing (DON) filled out some of the information on the form.</p> <p>During an interview regarding the allegation made by Resident #190 on 03/06/2025 at 11:26 AM, the Director of Nursing (DON) stated there were no other discussions with any other persons other than the nurse, the aide, and the resident. The DON stated he did not ask any residents if there were any issues with their care and the social worker during that time would have talked with the residents. The DON stated he just looked at the schedule and tried to figure who the male person was, but identified the persons who would have cared for the resident during that time.</p> <p>During a follow up interview on 03/06/2025 at 12:16 PM, the Administrator stated he discussed the allegation made by Resident #190 with the doctor who reported it, the DON, the aide, the resident, and another person; but could not remember who. The Administrator stated he did remember interviewing a resident but could not remember if there was anyone else. The Administrator stated the facility had a form containing general questions to the residents and they would document that, but this was not done at the time of the incident. The Administrator stated the only documentation he had was what was on Form 359 (five-day follow-up investigation). The Administrator stated he looked at the resident's past and the circumstances, then he interviewed the one male who was on staff during that time.</p> <p>On 03/06/2025 at 10:20 AM, the Administrator stated the facility did not have a policy for abuse investigations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465090	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Cascades at Orchard Park		STREET ADDRESS, CITY, STATE, ZIP CODE 740 North 300 East Orem, UT 84057	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document review, and facility policy review, the facility failed to have evidence that all allegations of abuse were thoroughly investigated for 1 (Resident #190) of 1 resident reviewed for abuse allegations.</p> <p>Findings included:</p> <p>A facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 10/2024, indicated, 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements.</p> <p>On 03/06/2025 at 10:20 AM, the Administrator stated the facility did not have a policy for abuse investigations.</p> <p>An admission Record indicated the facility admitted Resident #190 on 09/13/2024. According to the admission Record, the resident had a medical history that included diagnoses of post-traumatic stress disorder (PTSD), personal history of adult physical and sexual abuse, and diffuse traumatic brain injury with loss of consciousness of unspecified duration. Further review of the admission Record indicated Resident #190 was discharged home on [DATE].</p> <p>An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/20/2024, revealed Resident #190 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had no behavioral concerns and required substantial/maximal assistance with toileting hygiene.</p> <p>Resident #190's Care Plan included a problem statement initiated 10/25/2024, revised 10/25/2024, that indicated the resident was at risk for PTSD related to sexual assault. Interventions directed staff to monitor for trauma-related triggers which impacted the resident and adjust care so triggers were avoided to the extent possible in order to prevent re-traumatization (initiated 10/25/2024), provide care consistent with attempting to limit the impact of past trauma (initiated 10/25/2024), and the resident should be able to give permission prior to anyone touching the resident and should always be told the steps of any care that was happening so the resident was not triggered from a previous assault (initiated 10/25/2024).</p> <p>Facility document review on 03/05/2025 at 12:45 PM revealed a two-hour state reportable notification, Form 358, was electronically filed with the state survey agency on 10/31/2024 regarding a report of sexual abuse on 10/29/2024. The report indicated Resident #190 reported that a male staff member touched the resident with his hand in an appropriate manner.</p> <p>Further review revealed a five-day follow-up report, Form 359, was electronically submitted to the state survey agency on 11/06/2024 that indicated the facility completed its report with sufficient information for the results of the investigation. The facility concluded the allegation could not be verified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465090	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Cascades at Orchard Park		STREET ADDRESS, CITY, STATE, ZIP CODE 740 North 300 East Orem, UT 84057	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/05/2025 at 3:35 PM, the Medical Director stated Resident #190 voiced to him that someone had grabbed them, and he notified the Administrator of the statement. Resident #190 stated that the resident needed to talk to the Administrator about a particular person who had touched them.</p> <p>During an interview 03/05/2025 at 4:11 PM, the Administrator stated he interviewed the staff and wrote it down; and interviewed the one male staff member who worked that day. The Administrator stated he summarized the interviews by the resident, doctor, and the male staff member on duty on Form 359 (the five-day follow-up electronic submission investigation form to the state survey agency). When asked for a copy of the interviews, the Administrator then stated he did not write down any interviews for the resident, the doctor, or the staff member interviewed, and the Director of Nursing (DON) filled out some of the information on the form.</p> <p>During an interview on 03/05/2025 at 4:39 PM, the DON stated the documentation submitted on Form 359 was by him because the Administrator was out of the country. The DON further stated the information submitted was based on information the Administrator and the DON both found out and their conclusion to their investigations. The DON stated they spoke with the resident and got their statement, and he spoke with other people who were on staff and looked through the staffing schedule to try to figure out who it could have potentially been. The DON stated he did not write down the interviews with the nurse or the male staff member who would have been working with the resident. The DON stated documentation could have been done better in the electronic medical record, at least what he had done.</p> <p>A review of Form 359, submitted to the state survey agency on 11/06/2024, indicated the facility conducted interviews with the resident and staff and included a short summary of the interviews on Form 359. The facility was unable to determine whom the resident indicated was the perpetrator. The form further indicated no reported signs of abuse was witnessed by staff.</p> <p>During a follow up interview regarding the allegation made by Resident #190 on 03/06/2025 at 11:26 AM, the DON stated there were no other discussions with any other persons other than the nurse, the aide, and the resident. The DON stated he did not ask any residents if there were any issues with their care and the social worker during that time would have talked with the residents. The DON stated he just looked at the schedule and tried to figure who the male person was, but identified the persons who would have cared for the resident during that time.</p> <p>During a follow up interview on 03/06/2025 at 12:16 PM, the Administrator stated he discussed the incident with the doctor who reported it, the DON, the aide, the resident, and another person; but could not remember who. The Administrator stated he did remember interviewing a resident, but could not remember if there was anyone else. The Administrator stated the facility had a form containing general questions to the residents and they would document that, but this was not done at the time of the incident. The Administrator stated the only documentation he had was what was on Form 359 (five-day follow-up investigation). The Administrator stated he looked at the resident's past and the circumstances, then he interviewed the one male who was on staff during that time.</p>		