

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465109	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/24/2025
NAME OF PROVIDER OR SUPPLIER Holladay Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4782 South Holladay Boulevard Salt Lake City, UT 84117	

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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563</p> <p>Based on interview and record review the facility did not complete a comprehensive assessment every 12 months. Specifically, 1 of 37 sample residents, an annual Minimum Data Set (MDS) was completed over 13 months after the previous annual assessment. Resident identifier: 18.</p> <p>Findings include:</p> <p>Resident 18 was admitted to the facility on [DATE] with diagnoses which included biomechanical lesions of thoracic, heart failure, and chronic kidney disease.</p> <p>Resident 18's annual MDS was reviewed. The MDS had an assessment reference date (ARD) on 2/2/25. The assessment was completed on 3/18/25.</p> <p>On 3/24/25 at 11:02 AM, an interview was conducted with the MDS coordinator. The MDS coordinator stated the MDS's needed to be completed and submitted 14 days after the ARD date. The MDS coordinator stated resident 18's MDS was completed late. The MDS coordinator stated that sometimes when she got behind, she focused on the current MDS's that were due because the others were already late.</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
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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563</p> <p>Based on interview and record review, the facility did not assess a resident using the quarterly review instrument no less frequently than once every 3 months. Specifically, 4 of 37 sampled residents, quarterly Minimum Data Set (MDS) assessments were completed greater than 3 months apart. Resident identifiers: 9, 10, 39 and 63.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident 10 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, major depressive disorder, and hypertension. Resident 10's quarterly MDS had an assessment reference date (ARD) of 1/11/25 and was completed on 3/17/25. The previous quarterly MDS was completed on 10/24/25. 2. Resident 9 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, fibromyagia, and major depressive disorder. Resident 9's quarterly MDS had an ARD date of 1/13/25 and was completed on 3/17/25. The previous quarterly MDS had an ARD date of 10/13/24 was completed 12/27/24. The previous quarterly MDS had an ARD date of 7/13/24 and was completed on 9/7/24. The previous quarterly MDS had an ARD date of 4/12/24 and was completed on 5/11/24. 3. Resident 39 was admitted to the facility on [DATE] with diagnoses which included spinal stenosis, Alzheimer's disease, hypertension and heart failure. Resident 39's quarterly MDS had an ARD date of 1/22/25 and was completed on 3/18/25. The previous quarterly MDS had an ARD date of 10/24/25 and was completed on 11/8/24. 4. Resident 63 was admitted to the facility on [DATE] with diagnoses which included nontraumatic subdural hemorrhage, vascular dementia and type 2 diabetes mellitus. Resident 63's quarterly MDS had an ARD date of 1/5/25 and was completed on 3/17/25. The previous admission MDS had an ARD date of 10/8/24 and was completed on 10/11/24. <p>On 3/24/25 at 11:02 AM, an interview was conducted with the MDS coordinator. The MDS coordinator stated the MDS's needed to be completed and submitted 14 days after the ARD date. The MDS coordinator stated resident 9, 10, 39 and 63's MDS's was completed late. The MDS coordinator stated that sometimes when she got behind, she focused on the current ones because the others were already late.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431</p> <p>Based on interview and record review, it was found that the facility failed to ensure that a resident received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically, 1 of 37 sampled residents, did not have an intervention for podus boots implemented to prevent pressure ulcers. Resident identifier: 37.</p> <p>Findings include:</p> <p>Resident 37 was admitted to the facility on [DATE] with diagnoses which included dementia with anxiety, weakness, constipation, and urinary tract infection.</p> <p>Review of resident 37's records was completed on 3/17/25 through 3/24/25.</p> <p>A quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 37 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition was intact.</p> <p>A nursing note dated 2/1/25 at 3:09 PM revealed that certified nursing assistant (CNA) let this nurse know that redness was found on the left lateral malleolus. Nurse identified this was blanchable redness. Nurse practitioner (NP) notified and podus boots applied as preventative measure.</p> <p>A physician's order dated 2/1/25 stated podus boots in place as preventive measure for pressure injury to left lateral ankle. The boots were to be applied every shift for preventative to pressure injury.</p> <p>Resident 37's face sheet revealed under Special Instructions: Skin breakdown prevention: Apply moisturizing lotion to BUE [bilateral upper extremities] qd [every day], Offer/encourage long sleeves or geri-sleeves to BUE as a preventative measure for skin breakdown One-person physical assistance with all transfers; podus boots</p> <p>Resident 37's had a care plan initiated on 8/2/24 that revealed resident 37 had a potential risk for pressure ulcer development related to non-ST-segment elevation myocardial infarction (NSTEMI), asthma, elevated troponin, arrhythmia, high blood pressure (HTN), impaired mobility, obesity, possible lung cancer (CA), weakness, preference to not have Low Air Loss (LAL) mattress in place following education on risks associated with preference. The goal was that resident 37 would have intact skin, free of redness, blisters or discoloration by/through review date of 5/18/25. The interventions developed were that resident 37 would notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care, created on 8/2/24 and podus boots as ordered, created on 2/3/25.</p> <p>An observation was made on 3/17/25 at 3:06 PM, that resident 37's left lateral ankle was red.</p> <p>Observations were made on 3/17/25 at 3:06 PM, 3/20/25 at 10:25 AM, and 3/20/25 at 1:59 PM, of resident 37 in bed and podus boot was not applied to left foot. Podus boot was located in the corner against the wall of resident 37's room.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Treatment Administration Record (TAR) revealed that resident 37 had podus boot in place on 3/17/25 and 3/20/25.</p> <p>On 3/17/25 at 3:06 PM, an interview with resident 37 was conducted. Resident 37 stated she had a boot that she needed to have on her left foot since she had a sore spot on her left ankle. Resident 37 stated that she felt like she was getting a wound and they were not doing anything about it.</p> <p>On 3/20/25 at 2:19 PM, an interview was conducted with the staff development (SD). The SD stated the way Certified Nursing Assistants (CNA) were made aware when residents were to have podus boots placed was that the nurses told CNAs during report or there was also an alert on the resident's chart under Special Instruction. The SD stated that the special instructions were located on the face sheet of the resident's electronic medical record.</p> <p>On 3/20/25 at 2:58 PM, an interview with Licensed Practical Nurse (LPN) 1 was conducted. LPN 1 stated that she informed the CNAs at the beginning of the shift on which residents had orders for podus boots or who needed their heels floated. LPN 1 stated the CNAs came and told her when the podus boots had been applied she went to the resident and verified that the resident had podus boots. LPN 1 stated she then marked off the task or order for the shift on the TAR.</p> <p>On 3/20/25 at 3:04 PM, an interview with Assistant Director of Nursing (ADON) 1 was conducted. ADON 1 stated that podus boots were ordered by the physician and were in the orders. ADON 1 stated that orders for podus boots were located on the care sheet or treatment record and also as an alert on the resident's face sheet. ADON 1 stated there were special instructions located on the residents' face sheet when the chart was opened, important treatments were placed there to alert staff. ADON 1 stated that he would expect the nurse to check and verify the boots were on the resident due to it being a physician's order, and it needed to be followed.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</p> <p>Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents and had an environment that was as free from accident hazards as was possible. Specifically, tools were left in the bathroom of a cognitively impaired resident. In addition, a staff member was observed to carry oxygen tanks down the hallway that were unsecured. Resident identifier: 47.</p> <p>Findings include:</p> <p>1. Resident 47 was admitted to the facility on [DATE] with diagnoses which included dementia with behavioral disturbance, anxiety disorder, major depressive disorder and cognitive communication deficit.</p> <p>Resident 47's medical record was reviewed 3/17/25 through 3/24/25.</p> <p>On 3/20/25 at 2:36 PM, a phone interview was conducted with resident 47's family member. The family member stated resident 47's bathroom was out of use for 4 days. The family member stated the bathroom had tools, feces and the toilet was not secured to the floor. The family member stated resident 47 had dementia and it was not safe to have tools and an unsecured toilet available to her.</p> <p>A quarterly Minimum Data Set (MDS) dated [DATE] documented resident 47 had a BIMS (Brief Interview of Mental Status) score of 7, a score between 0-7 indicated severe cognitive impairment. And that resident 47 required a one person physical assist with transfers and toilet use.</p> <p>A nurses note dated 2/4/25 documented, Spoke with daughter to address concerns, on [resident 47's] noted decline including refusal of medications at times, refusal of food/fluids at times, aggression with cares/showers and cognitive decline.</p> <p>On 3/20/25 at 2:17 PM, an interview was conducted with the Maintenance Director (MD). The MD stated if something needed to be fixed it was put in the tells program which alerted him 24/7. The MD stated there have been several cases when the main sewer line was clogged. The MD stated resident 47's toilet was clogged and he tried to unclog it but had to call a plumber. The MD stated there were several briefs and wipes that had clogged the line. The MD stated he had removed towels, pull ups and wipes from resident 47's toilet. The MD stated resident 47 had to use another bathroom until it was cleared. The MD stated he possibly left tools in the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/20/25 at 2:48 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1 who stated resident 47 was a 1 person assist in terms of Activities of Daily Living (ADLs), she would walk for hours and hours and was not redirectable. ADON 1 stated she would wander all the time even with medical intervention and she would flush everything down the toilet. ADON 1 stated he doubted that there was feces on the bathroom floor but there may have been tools on the floor. ADON 1 stated he was called by the family about the issue. When he came in he blocked off the bathroom door with caution tape. ADON 1 stated the incident happened on either Friday night or Saturday morning and the residents were moved to another room on Sunday or Monday. ADON 1 stated the residents would use the shower room when they needed a toilet.</p> <p>On 3/20/25 at 3:27 PM, an interview was conducted with the Resident Advocate (RA) who stated resident 47 was really confused and wandered into rooms and she was placed on a one to one for the last few weeks she was in the facility.</p> <p>A follow up interview was conducted with the RA on 3/24/25 at 9:49 AM. The RA stated that she was not in the facility when it happened, the daughter called her. The RA stated there was a flood from resident 47's room and it drained into the Director of Nursing's (DON's) office. The RA stated maintenance was fixing the toilet and they left the hole where the toilet used to be open in the floor and tools were left on the floor of the bathroom. The RA stated that You can not do that with a dementia patient. The RA stated there was no way to lock the bathroom door and the residents should have been moved to another room. The RA stated that she did not know if resident 47 went in to the bathroom but she would be physically able to do that and it would not be safe. The RA stated the resident's daughter had sent her a picture that showed tools and the toilet on the floor. The RA stated she could not remember if there was any dirt or feces in the bathroom.</p> <p>On 3/24/25 at 10:13 AM, an interview was conducted with the DON and ADON 1. The DON stated resident 47 had gotten to a point where her behaviors were exacerbated. The DON stated that they put measures in place for her safety but she progressively got worse over time, she was very impulsive. The DON stated that resident 47's toilet was being repaired, the toilet was taken out over the weekend and replaced on Monday. The DON stated resident 47 stayed in the room over the weekend and the staff were taking her to the shower room to use the restroom. ADON 1 stated he believed there was not a toilet in the room and was unsure if there were any tools on the floor. ADON 1 stated he taped off the room when he came in over the weekend.</p> <p>On 3/24/25 at 10:23 AM, a follow up interview was conducted with a MD who stated that they did leave the toilet in the room and maybe the snake was left in there. The MD stated the resident would have been able to get into the bathroom while the toilet and tools were in there. The MD stated he had told the staff to put a bedside commode in bathroom if the resident needed to use it but to take her to the shower room if possible.</p> <p>On 3/24/25 at 11:03 AM, an interview was conducted with CNA 3 who stated that resident 47 wandered and was a full assist with cares. CNA 3 stated resident 47 was eventually put on a one on one supervision to keep her safe. CNA 3 stated she was not part of the toilet incident. CNA 3 stated residents 47 should be taken to the shower room if their bathroom was not working.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/24/25 at 11:06 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3 who stated resident 47 had extreme anxiety that they tried to manage with medications but that did not work. LPN 3 stated the staff took the residents to the shower room if their bathroom was not working. LPN 3 stated it would have been unsafe for tools to be left within reach of resident 47.</p> <p>On 3/24/25 at 11:10 AM, an interview was conducted with CNA 4 who stated near the end of resident 47's stay, her dementia worsened. CNA 4 stated prior to this resident 47 was confused but manageable with redirection. CNA 4 stated she was not aware of resident's toilet not working and stated it would have been dangerous for tools to be left in reach of resident 47 since she was so impulsive.</p> <p>On 3/24/25 at 11:13 AM, an interview was conducted with the CNA Team Lead (CNATL) who stated they would take resident 47 to the shower room while her bathroom was being fixed. CNATL stated, To be honest, yes. The toilet was lying on the floor, there was an open hole in the floor and there were random tools on the floor in the bathroom. The CNATL stated that resident 47 would not have been safe to go in there with tools and the toilet lying on the ground.</p> <p>2. On 3/17/25 at 12:16 PM, an observation was made of Registered Nurse (RN) 1. RN 1 was observed to carry an oxygen tank from room [ROOM NUMBER] through the hallway to a closet by the nurses station. RN 1 was observed to get an oxygen tank from the closet and walked back through the hallway to room [ROOM NUMBER].</p> <p>On 3/18/25 at 3:16 PM, an interview was conducted with Clinical Resource Nurse (CRN) 1 and ADON 1. CRN 1 and ADON 1 stated oxygen needed to be in a dolly and not carried in staffs arms. CRN 1 stated the concern would be dropping the oxygen tank when it was being carried.</p> <p>30563</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563</p> <p>Based on observation, interview and record review the facility did not ensure that each resident who needed respiratory care was provided such care consistent with professional standards of practice. Specifically, 1 of 37 sampled residents, did not have a physician's order for oxygen and no orders to change the tubing and humidifier. Resident identifier: 43.</p> <p>Findings include:</p> <p>Resident 43 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis, type 2 diabetes, foot ulcer and chronic obstructive pulmonary disease.</p> <p>On 3/17/25 at 1:29 PM, an interview and observation was conducted with resident 43. An oxygen concentrator was observed by resident 43's bed and there was no date on the tubing or the humidifier. Resident 43 stated he used oxygen and needed a personal oxygen tank when he went out of the facility but the oxygen tanks were too big to take with him.</p> <p>Resident 43's medical record was reviewed 3/17/25 through 3/24/25.</p> <p>A care plan dated 1/15/25 revealed resident had altered cardiovascular status. An intervention was to give oxygen as ordered by the physician.</p> <p>There were no active physician's orders for oxygen located in resident 43's medical record.</p> <p>There was a discontinued physician's order dated 1/9/25 which revealed resident 43 was going to discharge home on 1/8/25 with 2-3 liters of continuous oxygen via nasal cannula. The order further revealed resident 43's saturations on room air when walking were 80% and resting was 87%.</p> <p>On 3/18/25 at 2:42 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated she asked the nurse to find out if a resident required oxygen. NA 1 stated if a resident needed oxygen, then she would ask the nurse how many liters the resident needed. NA 1 stated some residents were able to tell her how much they needed. NA 1 stated she had not cared for resident 43 but thought he was alert enough to tell staff how many liters he needed. NA 1 stated she changed the humidifier water when it was dirty or when it was running out of water. NA 1 stated the tubing was changed when it was dirty or as needed.</p> <p>On 3/18/25 at 2:45 PM, an interview was conducted with NA 2. NA 2 stated the nurse let her know which residents required oxygen. NA 2 stated the water was changed when it was low. NA 2 stated the tubing was changed if it was found on the floor or it was dirty. NA 2 stated resident 43 used oxygen but did not know how much he needed. NA 2 stated she would check the resident's concentrator to find out how many liters of oxygen they needed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/18/25 at 2:49 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated if a resident needed oxygen, the amount depended on their vital signs, diagnosis and physician's orders. RN 2 stated residents needed a physician order for oxygen. RN 2 stated resident 43 was his own responsible party and he was alert and oriented to person, place, time and situation. RN 2 stated resident 43 was able to determine when he wanted to wear oxygen and when he did not want to. RN 2 was observed to review resident 43's medical record and stated there was no physician's order for oxygen or for changing the tubing and humidifier. RN 2 stated resident 43 was scheduled for discharge with oxygen and the order was not restarted. RN 2 stated staff offered portable oxygen tanks to resident 43 when he left the facility but they were cumbersome so resident 43 did not take oxygen with him. RN 2 stated the facility did not have small oxygen tanks to offer resident 43 and had not asked management about one.</p> <p>On 3/18/25 at 3:05 PM, an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated she checked resident saturations to know if they required oxygen. CNA 5 stated she looked at the resident concentrator to determine how many liters the resident needed. CNA 5 stated oxygen tubing was changed every Sunday night and the date was written on the tubing. CNA 5 stated she was not sure when resident 43's tubing was changed last.</p> <p>On 3/18/25 at 3:16 PM, an interview was conducted with Clinical Resource Nurse (CRN) 1. CRN 1 stated a physician's order was required for oxygen use. CRN 1 stated the tubing and humidifier were changed weekly and as needed. CRN 1 stated she was not sure why resident 43 did not have oxygen orders or orders to change tubing and humidifier. CRN 1 stated changing the tubing and humidifier was in the Treatment Administration Record.</p> <p>On 3/18/25 at 3:23 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated the facility had some smaller portable oxygen cylinders for resident who were ambulatory. ADON 1 stated he did not know that resident 43 requested a smaller portable oxygen tank. ADON 1 stated the tubing and humidifier were changed every Sunday by the Lead CNA. ADON 1 stated the normal portable oxygen tanks needed to be in a portable oxygen cart because they were so big.</p>		

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<p>F 0728</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.</p> <p>30563</p> <p>Based on interview and record review, the facility did not ensure that any individual working in the facility as a nurse aide for more that 4 months, on a full-time basis, was competent to provide nursing and nursing related services; and completed a training and competency program, or a competency evaluation program approved by the State. Specifically, a Nurse Aide (NA) was employed at the facility on a full-time basis, for approximately 8 months with out completion of training and competency evaluation program.</p> <p>Findings include:</p> <p>On 3/20/25, staff member (SM) 1's employee record was reviewed.</p> <p>SM 1 was hired on 2/9/24 as a NA.</p> <p>The Nursing Assistant registry revealed a NA certification was issues on 10/8/24.</p> <p>On 3/24/25 at 11:55 AM, an interview was conducted with Regional Nurse Consultant (RNC) 1. RNC 1 stated that she did not know why SM 1 was employed longer than 4 months without certification. RNC 1 stated there may have been some confusion with the staffing waiver.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52146</p> <p>Based on interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was defined as any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences. Specifically, for 1 out of 37 sampled residents, a resident's metoprolol was administered outside of the physician's ordered parameters. Resident identifier: 50.</p> <p>Findings included:</p> <p>Resident 50 was admitted to the facility on [DATE] with diagnoses which included, acute idiopathic pericarditis, supraventricular tachycardia, single subsegmental thrombotic pulmonary embolism, chronic kidney disease, and thyrotoxicosis.</p> <p>Resident 50's medical record was reviewed on 3/17/25 through 3/24/25.</p> <p>On 2/24/225, metoprolol tartrate oral tablet was ordered for hypertension, with the following parameters: hold for a Systolic Blood Pressure (SBP) < [less than] 100 or a pulse < [less than] 50.</p> <p>On 3/5/25 at 7:00 AM, it was documented that metoprolol was administered despite resident 50's SBP being documented as 94.</p> <p>On 3/6/25 at 7:00 AM, it was documented that metoprolol was administered despite resident 50's SBP being documented as 94.</p> <p>On 3/7/25 at 7:00 AM, it was documented that metoprolol was administered despite resident 50's SBP being documented as 95.</p> <p>On 3/13/25 at 7:00 AM, it was documented that metoprolol was administered despite resident 50's SBP being documented as 96.</p> <p>On 3/14/25 at 7:00 AM, it was documented that metoprolol was administered despite resident 50's SBP being documented as 98.</p> <p>On 3/15/25 at 7:00 AM, it was documented that Metoprolol was administered despite resident 50's SBP being documented as 92.</p> <p>On 3/20/25, an interview was conducted with Assistant Director of Nursing (ADON) 1. ADON 1 stated that nursing staff were expected to follow the parameters given in the medication order when determining whether to administer or hold a medication.</p> <p>On 3/24/25, an interview was conducted with Clinical Resource Nurse (CRN) 1. CRN 1 stated that the expectation was for nursing staff to follow orders, including parameters, in regards to administering or holding medications.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431</p> <p>Based on observation and interview, the facility did not ensure that drugs and biologicals used in the facility were labeled in accordance with accepted professional principles, and included the expiration date when applicable. Specifically, for 1 out of 37 sampled residents, an opened insulin injector pen was labeled with an open date past the 28 days and was in the medication cart available for use. Resident identifiers: 26.</p> <p>Findings included:</p> <p>Resident 26 was admitted to the facility on [DATE] with diagnoses which included acute diastolic congestive heart failure, paroxysmal atrial fibrillation, and type 2 diabetes mellitus.</p> <p>On 3/19/25 at 8:20 AM, an observation of the first floor medication cart. Resident 26's Lantus insulin pen was observed to be marked with an opened date of 2/13/25. Lantus insulin pen was opened for 34 days making it 6 days past professional standards of 28 days.</p> <p>On 3/19/25 at 8:20 AM, an interview with Licensed Practical Nurse (LPN) 2 was conducted. LPN 2 stated that insulin should be discarded 28 days after medication had been opened. LPN 2 stated that she was reordering the insulin, and it should have been discarded.</p> <p>On 3/20/25 at 2:58 PM, an interview was conducted with LPN 1. LPN 1 stated that insulin should be labeled with date when it is opened and can be stored in the medication cart for 28 days. LPN 1 stated once medication has reached 28 days the insulin needed to be disposed of.</p> <p>On 3/20/25 at 3:04 PM, an interview with Assistant Director of Nursing (ADON) 1 was conducted. ADON 1 stated that insulin stored in the medication cart should have an opened date, the date was done with a marker. ADON 1 stated that once the insulin was open 28 days, it should be reordered and the old one disposed of.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>30563</p> <p>Based on observation, interview, and record review, the facility did not provide food that was palatable, attractive, and served at a safe and appetizing temperature. Specifically, for 8 out of 37 sampled resident, residents complained of food quality, a test tray not attractive or palatable and resident council minutes revealed complaints of food quality. Resident identifiers: 23, 33, 37, 50, 60, 124, 126 and 286.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 3/20/25 at 2:06 PM, an interview was conducted with resident 23. Resident 23 stated that the food was not good. Resident 23 stated that she completed the meal request forms, but the food delivered was often not what she ordered. Resident 23 stated that she was attempting to eat less carbohydrates, but had been served lots of pasta and rice. Resident 23 stated that the food tasted okay, but the food was usually cold. On 3/17/25 at 9:50 AM, an interview was conducted with resident 33 who was sitting on her bed eating her breakfast. Resident 33 stated the food was always cold, it did not matter what meal was being served the food was cold. On 3/17/25 at 3:06 PM, an interview was conducted with resident 37. Resident 37 stated that the food was not that great and it always comes cold. On 3/20/25 at 2:06 PM, an interview was conducted with resident 50. Resident 50 stated the food was not good and served cold. Resident 50 stated they filled out menus, but it was not what they ordered. Resident 50 stated there was lots of pasta and rice served which she tried to avoid. Resident 50 stated she did not eat cause it did not taste good. On 3/17/25 at 11:27 AM, an interview was conducted with resident 60. Resident 60 stated that the food was terrible and it came cold especially the eggs. Resident 60 stated that, cold eggs are horrible, you can't eat cold eggs. Resident 60 stated that it was a lottery draw, since the food that came did not match the menu. On 3/17/25 at 10:31 AM, an interview was conducted with resident 124. Resident 124 stated food was bland and cold. Resident 124 stated she was not sure if real eggs or real butter were able to be served. Resident 124 stated she did not eat margarine or artificial sweeteners. Resident 124 stated she preferred plain yogurt without sugar in it. Resident 124 stated she was provided vanilla yogurt with sugar in it which she was unable to eat. On 3/17/25 at 10:44 AM, an interview was conducted with resident 126. Resident 126 stated the food had been terrible and it just wasn't good. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8. On 3/17/25 at 1:11 PM, an interview was conducted with resident 286. Resident 286 stated the food was disgusting and they would not eat it. Resident 286 stated their family brought food. Resident 286 stated the food orders were never delivered correctly. Resident 286 stated the foods were served at the wrong temperatures. Resident 286 stated they had informed the nurses of the food and their response was They'll look at it.</p> <p>On 3/20/25 at 12:25 PM, an observation was made of the hall trays exiting the kitchen. A test tray was requested. At 12:35 PM, the following foods temperatures were obtained [Note: All temperatures were in degrees Fahrenheit]:</p> <ul style="list-style-type: none"> a. meat was 138 b. rice was 113 - bland to the taste c. peas were 118 - no seasoning d. dessert was 56.3 - e. milk was 44.0 <p>The meat was tough to chew and bland to taste. The rice was bland to taste. The peas were bland to the taste and not seasoned. The dessert was palatable.</p> <p>A review of the resident council minute revealed the following complaints related to food:</p> <ul style="list-style-type: none"> a. September 2024, suggestions for dietary were to read the menu better and the presentation was not good. b. November 2024, dietary was still not reading dislikes and likes. The water for the hot chocolate was luke warm, coffee is very watery, fruit was being put on hot plates. The eggs were very cold. c. December 2024, dietary was not reading the menu and residents were not getting what they ordered. The food was not served hot. d. January 2025, dinner food was not served at appropriate temperatures. <p>On 3/20/25 at 1:46 PM, an interview was conducted with the Dietary Manager (DM). The DM stated there were not a lot of complaints about cold food. The DM stated about 2 months ago they changed how the trays were plated and served in the hallway. The DM stated he heard the temperatures were better from that change.</p> <p>On 3/20/25 at 2:04 PM, an interview was conducted with the Administrator. The Administrator stated food complaints during resident council were on and off. The Administrator stated there was a change in the organization of how the food was plated and served to the hallway in November or December. The Administrator stated the DM was involved on the floor and engaged with the residents. The Administrator stated the facility bought a new enclosed cart and was working on getting a pellet warmer to keep food warmer. The Administrator stated kitchen staff were obtaining food temperatures as the food left the kitchen.</p> <p>(continued on next page)</p>		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44640 52146

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>30563</p> <p>Based on observation, interview and record review the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the dish machine temperatures were not meeting the required temperature for sanitation.</p> <p>Findings include:</p> <p>On 3/17/25 at 9:34 AM, the dish machine temperature log was reviewed. The washing temperature and the sanitizer were documented for each meal for March 2025. On 3/17/25 for the breakfast meal had a temperature of 120 degrees Fahrenheit and the sanitizer was 200 parts per million (PPM). Dietary Aide (DA) 1 was observed to be changing the sanitizer solution. DA 1 was observed to check the sanitizer and it was 0 PPM. An interview was immediately conducted with the Dietary Manager (DM). The DM stated the sanitizer was not working and staff stopping the use of the dish machine to wash dishes.</p> <p>On 3/20/25 at 1:20 PM, a follow-up observation was made of the dish machine. The following cycles were observed: [Note: All temperatures were in degrees Fahrenheit.]</p> <ol style="list-style-type: none"> 1. The washing temperature was 100 and the rinse temperature was 105. DA 1 was observed to put away 1 large pan for the steam table, a knife, an ice cream scoop and a Tupperware with the clean dishes. 2. The washing temperature was 100 and the rinse temperature was 115 to 118. DA 1 was observed to put away 2 trays, a pan, a lid and a ladle. 3. The washing temperature was 110 and the rinse temperature was 110. DA 1 was observed to put away a pitcher, 4 water carafes and a blue bin. 4. The washing temperature was 110 and rinse was 120. 5. The washing temperature was 100 and the rinse was 110. DA 1 was observed to put away cups, plates and pitcher with the clean dishes. <p>At 1:34 PM, an interview with DA 1 was conducted. DA 1 stated the temperature needed to be above 120 for the wash and 120 for the rinse.</p> <p>A review of the forms titled Dish Machine Log for January, February and March 2025 revealed 200 PPM for all days and 120 to 145 for the temperature. There was no specification of what temperature. The bottom of the form revealed Minimum water temperature need to be 120 degrees and If both the PPM and temperature are not met dishes must be done in the 3-compartment sink. On 3/17/25 for breakfast meal it was documented 200 PPM for sanitizer and 120 for the temperature. On 3/20/25 for the lunch meal it was documented 200 PPM and 120 temperature.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 3/20/25 at 1:35 PM, an observation and interview was conducted with the DM. The DM was asked to check the dish machine's sanitizer. The DM was observed to look at the thermometer. The DM stated the temperature should be above 120 for the wash cycle. The DM stated the thermometer the staff used was the one under the machine. The DM stated the water temperatures were higher when the laundry was not being done. The DM confirmed the wash and rinse cycles were 118. The DM instructed the kitchen staff to stop doing dishes and the dishes would have to be rewashed when the water was hotter. The DM stated he would call maintenance to turn up the hot water heater.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640</p> <p>Based on observation, interview, and record review, the facility did not establish an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Specifically, hand hygiene was not performed between residents who were being assisted with eating or performed when delivering lunch trays between multiple resident rooms. Resident identifiers: 25, 34, 35 and 43.</p> <p>Findings include:</p> <p>On 3/17/25 at 12:16 PM, lunch service was observed in the 2nd floor dining room.</p> <p>Certified Nursing Assistants (CNA) 1 and 2 were observed to sit at a table with residents 25, 34, 35 and 43, no hand hygiene (HH) was used prior to sitting down. CNA 1 was observed to put clothing protectors on each resident. CNA 1 was then observed to touch the utensils and plate of resident 34 then turn to resident 25 touch her utensils and gave her a bite of food. CNA 2 was observed to touch the wheelchair handle of resident 43, adjust his clothing protector, move the stool she sat closer to the table, then touched resident 43's utensils while giving him a bite of food. CNA 2 was then observed to pick up the utensils of resident 35 and give her a bite to eat. CNA 2 touched the arm of resident 35 then reached over and wiped the mouth of resident 43, no HH was used in between the interactions. CNA 1 was observed to give resident 34 a drink, wipe her mouth then reach over to resident 25 and wipe her mouth. CNA 2 was observed to hold resident 35's spoon with food on it over the clothing protector. The spoon was observed to touch the clothing protector, resident 35 was then given the bite of food and the spoon was then placed on resident 35's plate. CNA 2 then turned to resident 43 and gave him drink, CNA 2 was observed to hold the straw against resident 43's lips. CNA 2 then turned back to resident 35 and gave her a bite of food from the spoon that was on her plate. CNA 1 and 2 were observed to feed residents 25, 34, 35 and 43 during the entire lunch service without using HH in between interactions.</p> <p>On 3/17/25 at 12:33 PM through 12:52 PM, lunch service was observed during the 2nd floor room to room lunch service. An observation of CNA 1 serving room [ROOM NUMBER] the food tray, touched the draw curtain, grabbed another tray for room [ROOM NUMBER] delivered it and set up the tray in the room, exited room [ROOM NUMBER] and no HH was completed. CNA 1 retrieved a food tray for room [ROOM NUMBER] and then 208 without performing hand hygiene between serving trays. CNA 2 was observed to deliver food tray to room [ROOM NUMBER], set up the meal including uncovering the drink, touching the bedside table then proceeded to pick up another food tray and delivered the tray to the other resident in room [ROOM NUMBER]. CNA 3 was observed to go into room [ROOM NUMBER] came out with a meal tray and placed it on top of the meal cart, no HH was performed. CNA 3 began touching trays inside the meal cart touching the meal tickets, grabbed a meal tray and delivered it to room [ROOM NUMBER]. The Staff Development (SD) started moving trays around inside the meal cart, no HH was observed. The SD and CNA 1 grabbed a meal tray and delivered the trays to room [ROOM NUMBER] no hand hygiene was observed. The SD took a tray out of the meal cart and delivered it to room [ROOM NUMBER], no HH was observed before or after handling the meal trays.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/20/25 at 2:44 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1 who stated, the staff were expected to sanitize their hands in between feeding the residents and in between passing hall trays. The ADON stated he expected the staff to feed one resident then use hand sanitizer before feeding the other resident.</p> <p>On 3/24/25 at 11:28 AM, an interview was conducted with the Director of Nursing (DON) who stated, hand hygiene should be done in between hall trays being passed and in between feeding more than one resident.</p>		