

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465111	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Sandy Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 50 East 9000 South Sandy, UT 84070	

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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>Based on interview and record review it was determined, for 2 of 41 sample residents, that the facility did not provide the residents with the right to manage his or her financial affairs. Specifically, residents who had authorized the facility to manage any personal funds did not have ready and reasonable access to those funds. Resident identifiers: 30 and 295.</p> <p>Findings include:</p> <p>On 4/13/25 at 11:12 AM, an interview was conducted with resident 30. Resident 30 stated she could not get her money unless it was a weekday because no one was available who had access to the money, on the weekends. Resident 30 stated she was told she would just have to wait until Monday to get her money.</p> <p>On 4/16/25 at 11:00 AM the facility grievance binder was reviewed. A grievance form from resident 295 dated 6/4/24 documented. No one to give money out on the weekend. Business office states there is no money to give out on weekends. The response to the grievance was documented as, We spoke about collecting money on Fridays if she needs it. The follow-up action was documented on the form as, [Resident 295] didn't write this, she doesn't collect money very often and she has no issues collecting funds. The form was signed by the resident and the administrator.</p> <p>On 4/16/25 at 8:34 AM, an interview was conducted with the Business Office Manager (BOM). The BOM stated they have a trust and bank account for resident 30. The BOM stated the residents do not have access to their funds on the weekends. The BOM stated he was the person who gave out the money to residents and that he only worked Monday through Friday.</p> <p>On 4/16/25 at 1:26 PM, an interview was conducted with the Administrator (ADM). The ADM stated the residents could request funds from the BOM manager or they could request it from the ADM. The ADM stated they were in the process of allocating that responsibility to the activities staff but that had not been put into the place yet. The ADM stated they had some gaps with how the residents received their funds and there were times on the weekend that no one was available to give the money to the residents. The ADM stated that another barrier they encountered was that there was no cash in the money box due to limited funds. The ADM stated it took a couple of days for the corporate team to get them the money after it was requested. The ADM stated there had been an incident in the past where a resident did not get their money because it was not available.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on interviews and observation, the facility failed to provide housekeeping and maintenance services necessary to maintain a safe, clean, comfortable, and homelike environment. Specifically, the shower rooms were in disrepair and one shower room was malodorous. Resident identifier: 37, 46 and 89.</p> <p>Findings include:</p> <p>On 4/13/25 at 2:41 PM, an interview was conducted with resident 46. Resident 46 stated that the 100-hall shower room constantly smelled like soiled diapers and that it was so bad she refused to use that shower.</p> <p>On 4/15/25 at 9:11 AM, an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated resident 46 refused to go in the 100-hall shower room because it had a smell. CNA 4 stated the 100-hall shower room smelled like smoke or sewer maybe.</p> <p>On 4/16/25 at 8:53 AM, an observation was made of the south 300 hallway shower room. The tile on the base of divider wall was observed to be missing and broken.</p> <p>On 4/16/25 at 2:52 PM, an interview was conducted in the 200-hall shower room with the Maintenance Director. The Maintenance Director stated the broken tiles along the bottom of the divider wall needed to be replaced and the open gap between the tiles from top to bottom of the divider wall needed to be fixed because the humidity could penetrate the wall behind the tile. The Maintenance Director pointed to dark spots around the sprinkler head and in the corner to the left of the window with a large water spot and stated that it was mold and needed to be fixed. The toilet was covered by a plastic sheet and the Maintenance Director stated the toilet did not work because the main pipe was broken.</p> <p>On 4/13/25 at 10:53 AM, an interview was conducted with resident 89. Resident 89 stated that the shower room in the 100-hallway smelled bad, so she requested to get showered in a different hall ' s shower room.</p> <p>On 4/13/25 at 11:29 AM, an observation of the shower room in the 100 hallway was made. The shower room appeared clean but had a smell similar to sewage.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/15/25 at 9:08 AM, an unidentified aid and unidentified resident were observed to exit the shower room in the 100 hallway. The resident stated that the shower room smelled bad. The unidentified aid stated that the large trash can needed to be emptied, and that the facility was not very good at emptying it. Upon entering the shower room in the 100 hallway it was observed to have a strong urine odor. Outside of the shower stall sat a fabric chair with brown substance on the seat and white staining on the back and seat of the chair. There were two large 32-gallon garbage cans with lids observed in the shower room of the 100 hallway. One of the large garbage cans was unlabeled and had a plastic liner with soiled linens. The second large garbage can was labeled Trash and had no plastic liner and was half full of briefs and other trash. There was a very strong urine odor when the lid was removed from the garbage can labeled Trash. Inside the shower stall were two shower chairs. Both of the shower chairs had a brown substance on the seat area. While inside the shower stall an unpleasant odor, similar to sewage, could be smelled.</p> <p>On 4/15/25 at approximately 10:45 AM, an interview was conducted with resident 37. Resident 37 stated that he will not use the shower room in the 100 hallway because it stinks.</p> <p>On 4/16/25 at approximately 1:00 PM, an interview was conducted with CNA 3 while inside the shower room in the 100 hallway. CNA 3 stated that some residents would not use this shower due to the unpleasant odor. CNA 3 stated that she noticed the unpleasant odor the previous week when a resident refused to be showered in the shower room of the 100 hallway. The CNA stated that it was housekeeping's responsibility to empty the garbage can with the soiled linens; and that it was the CNA's responsibility to empty the garbage can labeled Trash.</p> <p>On 4/16/25 at 2:02 PM, an interview with the Maintenance Director was conducted. The Maintenance Director stated that he had not gotten any maintenance requests for the shower room in the 100 hallway, until 4/15/25 when a resident had reported an odor. The Maintenance Director stated that he poured chemicals down the drain in response.</p> <p>On 4/16/25 at 2:07 PM, an interview was conducted with the Housekeeping Supervisor. The Maintenance Director acted as a translator. The Housekeeping Supervisor stated that shower rooms were cleaned every day, in the morning.</p> <p>On 4/16/25 at 2:09 PM, an interview was conducted with Housekeeping Staff. The Maintenance Director acted as a translator. Housekeeping Staff stated that the shower rooms are cleaned daily with three cleaners: disinfectant, odor control, and a floor cleaner.</p> <p>On 4/16/25 at 2:36 PM, an interview was conducted with the Administrator. The Administrator stated that he was aware of the odor in the shower room of the 100 hallway and that it had been an off and on issue. The Administrator stated that a plumber worked on the shower room of the 100 hallway in February 2024. The Administrator further stated that the Maintenance Director had been pouring chemicals down the drain.</p> <p>On 4/16/25 at 2:42 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she was unaware of any complaints concerning the odor in the shower room of the 100 hallway. The ADON stated that if a resident complained to a CNA, she expected the CNA to inform the floor nurse or the CNA coordinator. The ADON stated there was a program available to report maintenance needs, but she was unsure if it was utilized.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/25 at 2:56 PM, an interview was conducted with CNA 5. CNA 5 stated that a few months ago she entered a complaint into maintenance reporting system regarding the odor in the shower room on the 100 hallway. CNA 5 stated that the unpleasant odor did improve shortly after, but it had been slowly coming back. CNA 5 stated that she did not notice an odor in the shower room of the 100-hallway last week, but the unpleasant odor was noticeable this week.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined, for 1 out of 41 sample residents, that the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice. Specifically, a resident had a delay in getting sutures removed. Resident identifier: 55</p> <p>Findings included:</p> <p>Resident 55 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, generalized anxiety disorder, other lack of coordination, and major depressive disorder.</p> <p>On 4/13/25 at 10:06 AM, an observation and interview were made of resident 55. Resident 55's left leg was in a brace, there were sutures on the bridge of her nose that appeared to have scabs over them, and her left cheek had a greenish-purple discoloration. Resident 55 stated she had fallen down and broken her knee and hit her face.</p> <p>On 4/15/25 at 9:23 AM, an observation was made of resident 55 sitting in her wheelchair in her room, tugging at the sutures on the bridge of her nose.</p> <p>A review of resident 55's progress notes revealed:</p> <p>a. On 3/30/25 at 6:28 PM, a nurse's note documented, Note Text: Received a call from [name redacted] hospital at 18:15pm [6:15 PM]. They told that resident had broke her nose and had open fracture so, they suture it and also told that resident had fracture patella on her knee. so, they wrapped it and they told that we can take it offwhile [sic] shower but they want to immobilize resident leg. Nurse from [name redacted] told that they put resident on oral antibiotic and said resident received antibiotic for tonight dose and said needs to give from tomorrow [sic] morning. They told they put resident on Keflex for 5 days and they are sending resident back to facility.</p> <p>b. On 3/30/25 at 11:04 PM, a nurse's note documented, Note Text: Patient returned to facility at around 1900 [7:00 PM]. She was diagnosed with: Open displaced fracture of nasal bone, ground level fall, DNR [Do Not Resuscitate], laceration of face, patella fracture. She returned with an order for cephalexin 500 mg [milligrams] oral capsule BID [twice a day] for 5 days. Her first dose was given tonight. She has a brace to her left leg. She will need her sutures removed in 7 days. She will also need follow up care by house provider for her knee injury.</p> <p>A review of resident 55's hospital discharge paperwork documented, .Return to ED [Emergency Department] for suture removal in 7 days .</p> <p>On 4/15/25 at 7:45 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 55 had recently had a fall and fractured her nose and leg.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/15/25 at 2:53 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 55 fell and landed on her kneecap. LPN 1 stated resident 55 had a cut on the bridge of her nose and it required sutures and caused bruising around her face. LPN 1 stated that resident 55 still had the sutures in and believed they needed to remain for 14-21 days, though he was unsure.</p> <p>On 4/15/25 at 3:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 55 should have had the sutures removed on 4/8/25.</p>		

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<p>F 0775</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep complete, dated laboratory records in the resident's record.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined. for 1 out of 41 sample residents, that the facility did not file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, a resident's laboratory results were not located in the electronic medical records. Resident identifier: 6</p> <p>Findings included:</p> <p>Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included benign neoplasm of brain, chronic respiratory failure with hypoxia, heart failure, chronic obstructive pulmonary disease, and epilepsy.</p> <p>On 1/20/25 a pharmacy recommendation for resident 6 documented, This resident takes Phenytoin 300 TID [three times a day] and Phenobarbital 97.2 QD [every day], and a review of the chart could not find any serum levels in the last six months, and there are no routine orders in place for this lab to be drawn. The following intervention has been preapproved by the attending medical team through verbal communication and/or protocols:</p> <ol style="list-style-type: none"> 1. Draw serum Phenytoin 2. Draw serum phenobarbital <p>On 1/22/25 at 11:41 AM, progress note for resident 6 documented, Pharmacist completed monthly med [medication] review and recommended serum phenytoin and phenobarbital labs be drawn. MD [medical doctor] agreed, orders have been updated.</p> <p>It should be noted resident 6's medical record did not contain lab results for serum phenytoin or serum phenobarbital.</p> <p>On 4/16/25 at 8:22 AM, an interview was conducted with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC). The DON stated that staff sent all diagnostic results to medical records to be scanned into the resident's chart. The RNC stated that once medical records received the results, it typically took about a week to upload them into the resident's medical record.</p> <p>On 4/16/25 at 9:49 AM, an interview was conducted with Medical Records. Medical Records stated that once she received the results from staff, she uploaded them to the electronic medical record and then destroyed the originals. Medical Records stated she was instructed to upload records as quickly as possible and aimed to complete them the same day.</p>		

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<p>F 0779</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep signed and dated reports of x-rays and other diagnostic services in the residents record.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not file in the resident's clinical record signed and dated reports of radiological services. Specifically, for 1 out of 41 sample residents, a resident's x-ray report was not located in the medical record. Resident identifier: 40</p> <p>Findings included:</p> <p>Resident 40 was admitted to the facility on [DATE] with diagnoses which included, chronic respiratory failure with hypoxia, transient cerebral ischemic attack, and chronic obstructive pulmonary disease.</p> <p>A review of resident 40's medical record revealed the following:</p> <p>a. On 3/18/25 an order for Amoxicillin-Pot (Potassium) Clavulanate Tablet 875-125 MG (milligram) Give 1 tablet by mouth two times a day for infectious pneumonitis for 7 days</p> <p>b. On 3/21/25 an order for Doxycycline Hyclate Oral Tablet 100 MG Give 1 tablet by mouth two times a day for Pneumitis (sic) for 10 days</p> <p>c. On 3/21/25 at 9:35 PM, a nurses note documented, [name redacted] NP [nurse practitioner] new order: Doxycycline 100mg PO [by mouth] BID [two times a day] x [times] 10 Days for Pneumonia.</p> <p>It should be noted that no chest x-ray results were located in the resident 40's medical record.</p> <p>On 4/15/25 at 1:14 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 40 had pneumonia which was why he had been taking two different antibiotics. RN 1 stated staff monitored him for and negative side effects of the antibiotics and for any signs of shortness of breath.</p> <p>On 4/16/25 at 8:22 AM an interview was conducted with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC). The RNC stated that resident 40 was on two different antibiotics for pneumonia. The RNC stated that the Medical Director would have ordered a chest x-ray to confirm the pneumonia diagnosis before starting the antibiotics. The DON stated she would contact the mobile radiology company to obtain the chest x-ray results.</p> <p>On 4/16/25 at 9:57 AM, the DON emailed a copy of the chest x-ray results. This report was not signed or dated.</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>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 14 out of 41 sample residents, salad was not kept at the correct temperature while serving tray line, residents complained of food quality, a test tray not attractive or palatable and resident council minutes and grievance forms revealed complaints of food quality. Resident identifiers: 2, 7, 18, 21, 30, 33, 46, 49, 60, 66, 89, 70, 73, and 145.</p> <p>Findings include:</p> <p>On 4/13/25 at 11:23 AM, an interview was conducted with resident 30. Resident 30 stated the food is not very good. Resident 30 stated that the food is awful and cold, but people eat it because that is all that they have when you can't get anything else.</p> <p>On 4/13/25 at 11:45 AM, an interview was conducted with resident 21 who stated the food was usually cold and just all around not good.</p> <p>On 4/13/25 at 10:11 AM, an interview was conducted with resident 33. Resident 33 stated that the food was okay, but did not have much flavor or look appealing.</p> <p>On 4/13/25 at 10:45 AM, an interview was conducted with resident 60. Resident 60 stated that the food served tasted awful and was never warm.</p> <p>On 4/13/25 at 11:30 AM, an interview was conducted with resident 49. Resident 49 stated the food was awful and she would not recommend eating it. Resident 49 stated the food looked like mystery meat and roadkill.</p> <p>On 4/14/25 at 8:00 AM, an interview was conducted with resident 66. Resident 66 stated the food tasted bad and was often cold.</p> <p>On 4/14/25 at 8:26 AM, an interview was conducted with resident 7. Resident 7 stated that the food was mediocre in taste and often looked unappetizing.</p> <p>On 4/14/25 at 8:35 AM, an interview was conducted with resident 18. Resident 18 stated that food is just okay and that sometimes the food is served cold.</p> <p>On 4/13/25 at 10:53 AM, an interview was conducted with resident 89. Resident 89 stated that the food was not good and often had no flavor. Resident 89 further stated that while some food is delicious, there were times she could not identify the food served. Resident 89 stated that food is often delivered at incorrect temperatures. For example, she stated that the French fries were always cold, and the ice cream was always delivered melty.</p> <p>On 4/13/25 at 11:35 AM, an interview was conducted with resident 2. Resident 2 stated that she would have liked better food, and that the food didn't taste good. Resident 2 stated that she did not think the meals provide balanced food groups: there is rarely fresh produce; a high amount of carbs; and the protein was usually processed meat. Resident 2 also stated that food was usually delivered cold.</p> <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>On 4/13/25 at 12:32 PM, an interview was conducted with resident 70. Resident 70 stated that the food is not good, and the portion sizes are too small. He stated that he has to supplement his meals with food he purchases on his own. Resident 70 stated that there was not enough protein served, and his weekly dialysis labs regularly showed he was deficient in protein. Resident 70 stated that he had requested larger portions, but it fell on deaf ears. Resident 70 stated that half of the time food was delivered cold.</p> <p>On 4/14/25 at 8:48 AM, an interview was conducted with resident 145. Resident 145 stated that the quality of the food was horrible. Resident 145 stated that there was not enough nutrition provided to sustain anyone. Resident 145 stated that the food was processed and did not taste good. He also stated that there is no variety, and the alternatives were not any better. Resident 145 stated that the food was rarely the correct temperature when it arrived.</p> <p>On 4/13/25 at 2:41 PM, an interview was conducted with resident 46 and they stated any meat served was dry and they could not chew it, carbohydrates made up most of the meal, and sometimes it was so bad they could not eat it and would be left hungry.</p> <p>On 4/13/25 at 10:11 AM, an interview was conducted with resident 73 and they stated the food was cold, dry, and the vegetables were always overcooked. Resident 73 stated the meat was always in a patty form and a mystery meat. Resident 73 stated the chicken patties were so hard they could not chew it.</p> <p>On 4/13/25 at 11:23 AM, an observation was made of the kitchen staff checking the temperatures of the food. The temperature of the salad was 66 degrees. The salads were observed to be stacked on a cart next to the tray line.</p> <p>On 4/13/25 at 11:45 AM, the Dietary Manager (DM) checked the salad temperatures, and they read 63 degrees. The staff were observed to place the salad cups in containers of ice. An immediate interview was conducted with the DM who stated the salads should be kept in the fridge until they are ready to be used and should not go above 41 degrees.</p> <p>On 4/13/25 at 11:59 AM, an observation was made of a few bowls of salad that had reached 40 degrees and were placed on trays to be served to the residents. These trays did not leave the kitchen until 12:15 PM.</p> <p>On 4/15/25 12:33 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. meatloaf with red sauce was 153.7 - bland to the taste b. pasta was 146.5 - bland to the taste c. potatoes were 160.9 - bland to the taste d. salad was 43.2 - ice cubes observed in salad e. dessert was 64.1 <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>f. milk was 43.5 - warm</p> <p>The meat was bland to taste and left a bad aftertaste. The pasta was bland to taste and not seasoned. The potatoes were bland to the taste and not seasoned. The salad was warm and had ice cubes mixed in with the lettuce. The dessert was palatable. The milk was warm.</p> <p>A review of the facility resident council minutes revealed the following complaints related to food:</p> <p>a. December 2024, suggestions to dietary were that the food was not as hot on the evenings and weekends and meal tickets not followed as thoroughly on the weekends.</p> <p>b. January 2025, suggestions to dietary were to read the meal tickets better and to use the heating plates.</p> <p>c. April 2025, suggestions to dietary were the food was often bland, milk is sour, and Shepard's pie not good at all.</p> <p>A review of the facility grievance forms revealed the following complaints related to food:</p> <p>d. May 15, 2024, complaint that a resident was not receiving the appropriate diet.</p> <p>e. May 16, 2024, complaint that a resident does not like the food and cannot eat the food.</p> <p>f. May 20, 2024, complaint that the milk is warm continually, too many green beans, residents getting items they are not supposed to receive.</p> <p>g. May 23, 2024, complaint that a resident does not like the food and cannot eat the food.</p> <p>h. May 24, 2024, complaint that the kitchen keeps sending dislike items and when resident requests snacks they are told they are not available.</p> <p>On 4/15/25 at 1:30 PM, the DM stated there was an in-service done with all of the dietary staff to educate them on the importance of keeping food items at the correct temperature. An observation was made of the in-service provided to the dietary staff.</p> <p>On 4/16/25 at 8:42 AM, an interview was conducted with the DM. The DM stated the salads need to be kept at the correct temperature before they are served to the residents. The DM stated the salads should have been kept in the refrigerator and brought out right before they were to be used, then the temperature of the salads would not have gotten warm. The DM stated that having to cool the salads down made lunch a little late. The DM stated she was surprised by the food complaints and thought the residents were happy with the food they provided.</p> <p>On 4/16/25 at 2:15 PM, an interview was conducted with the Administrator (ADM). The ADM stated he was unaware of the food not being kept at the correct temperature. The ADM stated he had been told by some of the residents that they did not like the food. The ADM stated this would be something they would try to improve.</p>		

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NAME OF PROVIDER OR SUPPLIER Sandy Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 50 East 9000 South Sandy, UT 84070	
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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined that, for 1 of 41 sample residents, the facility failed to provide food that accommodated resident allergies, intolerances, and preferences. Specifically, a resident was provided food that was listed as an allergy. Resident identifier: 46.</p> <p>Findings included:</p> <p>On 4/14/25 at 1:17 PM, an interview and observation were conducted with resident 46. Resident 46 was in her room with her lunch tray in front of her and there was fried rice with peas observed on her plate. Resident 46 stated she is allergic to peas because her body did not produce the enzymes that can break down the peas and it caused an upset stomach. Resident 46 stated she got served foods she was allergic to at least once a week. A meal ticket was observed on the tray that indicated, Allergies: LATEX, ORANGE JUICE, PEA [sic], SHELL FISH, STRAWBERRIES .Dislikes: .Vegetable (NO PEAS!! NO PEAS!!! NO PEAS!!! & NO BEETS).</p> <p>Resident 46's medical record was reviewed 4/13/25 through 4/16/25.</p> <p>Resident 46 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included lumbosacral root disorders, adult failure to thrive, irritable bowel syndrome (IBS), major depressive disorder, binge eating disorder, gastro-esophageal reflux disease (GERD), and bulimia nervosa.</p> <p>A care plan focus indicated, [Resident 46] is at risk for potential nutritional problem r/t [related to] Obesity, adult failure to thrive, ibs, hx [history] of binge eating, hx of bulimia, GERD, hypothyroidism Date Initiated: 10/31/2024 Revision on: 02/20/2025. It further indicated Interventions/Tasks of, Allergies: orange juice, peas, shellfish, strawberries, latex Date Initiated: 10/31/2024.</p> <p>A Grievance/Complaint Report, dated 12/30/24, indicated, stated she is still being served her allergies with her meals .educated staff on allergies and watching tickets carefully with allergies involved. DM [Dietary Manager] spoke to resident about concerns and how she will be addressing it with kitchen staff to fix the problem.</p> <p>On 4/16/25 at 2:43 PM, an interview was conducted with the DM. The DM stated allergies are highlighted in bold writing on the meal tickets and that they had had problems with residents being served listed food allergies a couple of times before. The DM stated she did not know how it got out of the kitchen because 3 staff members should have checked it. The DM stated she had recently educated staff and watched the tray line to remedy the problem and that they had not had problems for the last few months.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</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 food was not served in a sanitary manner.</p> <p>Findings include:</p> <p>On 4/15/25 during the tray line of lunch service the following was observed:</p> <p>a. At 12:13 PM, Dietary Aide (DA) 1 was observed to Donn gloves. DA 1 was then observed to touch the thermometer, sink, refrigerator handle, and was then observed to touch the face of the plates with the same gloved right hand. [NAME] (CK) 1 was observed to place food on the plate that DA1 touched with the dirty glove.</p> <p>b. At 12:12 PM, CK 1 was observed to have gloves on and touch the oven doors, sink handles, the spatula handle and then touch the face of the plates prior to plating the food for the residents.</p> <p>c. At 12:18 PM, CK 1 was observed to slide the plates across the white cutting board in front of the tray line. CK 1 was then observed to take a scoopful of carrots and place them on the cutting board. CK 1 chopped the carrots on the cutting board with the spatula, plated the chopped carrots and they were taken to the residents. The cutting board was not cleaned before or after the chopping.</p> <p>d. At 12:22 PM, CK 1 was observed to slide plates across the cutting board. CK 1 was then observed to place a scoopful of carrots on the cutting board, chop the carrots then plate them for resident use. The cutting board was not cleaned prior to the carrots being placed on the cutting board; the area was observed to be cleaned after.</p> <p>e. At 12:25 PM, DK 1 was observed to reposition the food on the plate with gloved hands after touching the plates, covers, fridge door, cart, and sink handles. No hand hygiene was performed, and the gloves were not changed prior to touching the food.</p> <p>On 4/15/25 at 12:45 PM, an interview was conducted with CK 1. CK 1 stated the staff should not touch any of the food or the face of the plates with dirty gloves. CK 1 stated they cut the food on the white cutting board that they move the plates along for tray line. CK 1 stated they do not clean it before they chop food on it.</p> <p>On 4/16/25 at 8:42 AM, the Dietary Manager (DM) was interviewed and stated the staff should not be touching the face of the plates with dirty gloves, they should change their gloves. The DM stated the staff usually chop the food for the mechanically soft diets on the white cutting board where the plates are moved across. The DM stated they did not clean the whiteboard prior to chopping the food and stated that probably should not happen because the surface was dirty.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident was offered the influenza, pneumococcal, and the coronavirus disease 2019 (COVID-19) vaccines. In addition, residents that accepted the vaccines did not have those vaccines administered. Specifically, for 3 out of 5 sample residents, two residents had signed consent forms where they had accepted to receive the 2024/2025 COVID-19 booster, and the booster was not administered. In addition, one resident did not have documentation that they were offered vaccines for the 2024/2025 season. Resident identifiers: 4, 28, and 55.</p> <p>Findings included:</p> <p>1. Resident 4 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, epilepsy.</p> <p>Resident 4's medical record was reviewed on 4/16/25.</p> <p>A form titled 2024-2025 Seasonal Vaccination Consent was reviewed. Resident 4 marked on the form that they wished to receive the 2024-2025 COVID-19 booster. Administration documentation for the COVID-19 booster was not completed.</p> <p>No documentation was located indicating that resident 4 had received the COVID-19 booster vaccine.</p> <p>2. Resident 28 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic systolic heart failure.</p> <p>Resident 28's medical record was reviewed on 4/16/25.</p> <p>A form titled 2024-2025 Seasonal Vaccination Consent was reviewed. Resident 28 marked on the form that they wished to receive the 2024-2025 COVID-19 booster. Administration documentation for the COVID-19 booster was not completed.</p> <p>No documentation was located indicating that resident 28 had received the COVID-19 booster vaccine.</p> <p>3. Resident 55 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease.</p> <p>Resident 55's medical record was reviewed on 4/16/25.</p> <p>No documentation was located indicating that resident 55 had been offered the influenza or COVID-19 booster vaccines for the 2024-2025 season.</p> <p>(continued on next page)</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/16/25 at 1:02 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that she was also the Corporate Director of Infections. The RNC stated from 10/1/24 to 3/31/25, the vaccination consents were in the admission packet. The RNC stated if the resident was already vaccinated, she would pull that information from other systems. The RNC stated the facility would pre-order the influenza vaccine and once the vaccine was received the staff would obtain consent and administer the vaccine. The RNC stated the pneumococcal vaccine consent was obtained on admission if the resident had never received the vaccine. The RNC stated the COVID-19 booster was administered in house if a resident requested it. The RNC stated the COVID-19 vaccine was offered per the Centers for Disease Control and Prevention recommendations.</p> <p>On 4/16/25 at 2:36 PM, a follow up interview was conducted with the RNC. The RNC confirmed that resident 4 and resident 28 did not receive the COVID-19 booster vaccines. The RNC confirmed that resident 55 did not have a 2024/2025 vaccination consent form completed.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation and interview, it was determined that the facility was not adequately equipped to allow residents to call for staff assistance through a communication system which relayed the call directly to a staff member or to a centralized staff work area from toilet and bathing facilities. Specifically, the 200 and north 300-hall shower rooms each had one call light that did not work and there were no cords attached to the call lights in the 100, 200, and north 300-hall shower rooms. Resident identifier: 46.</p> <p>On 4/14/25 at 1:17 PM, an interview was conducted with resident 46 and she stated that the 300-hall shower room's call light did not work and that she could get stuck in the shower.</p> <p>Findings include:</p> <p>On 4/15/25 at 9:09 AM, an observation of the 200-hall shower room was made. There were two call lights in the room, one call light was located in the first shower area and had no cord and did not activate the call system when the switch was pushed and another call light located in the second shower area had no cord.</p> <p>On 4/15/25 at 9:09 AM, an interview was conducted with Certified Nursing Assistant (CNA) 6 who was observed in the 200-hall shower room and switched the call light in the first shower area. CNA 6 stated the call light did not work but that there was another call light in the second shower area which was separated by a dividing wall.</p> <p>On 4/15/25 at 9:43 AM, an interview was conducted with Maintenance Staff. The Maintenance Staff stated the call light cords had to be long enough for the residents to reach if the resident was on the floor, which was about 3 inches from the ground.</p> <p>On 4/15/25 at 9:09 AM, an observation was made of the 100 's hall shower room call light. The call light was a switch with no cord present. The call light was activated at the time of the observation.</p> <p>On 4/15/25 at 9:25 AM, an interview was conducted with CNA 5. CNA 5 stated that some residents required set up, but did not require assistance with showering. CNA 5 stated that the CNA 's check on the residents that do not require assistance every 5 to 10 minutes.</p> <p>On 4/15/25 at 10:07 AM, an interview was conducted with resident 77. Resident 77 stated that he typically used the 200 's hall shower room. Resident 77 stated that the call light in the 200 's hall shower room did not work and did not have a cord attached to the call light switch. Resident 77 stated that the cord has been missing since the 200 's hall shower room was repaired. Resident 77 stated that staff stays in the shower room while he showers unassisted due to the call light not functioning.</p> <p>On 4/16/25 at 1:00 PM, an observation was made of the 100 's hall shower room call light. A new floor length cord was observed.</p> <p>On 4/15/25 at 9:04 AM an observation was made of the 300-hallway north shower. The shower door was propped open with a chair. In the first shower stall there was no call light cord.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/15/25 at 9:05 AM, the call light cord for the second shower in the 300-hallway north shower was pulled. A continuous observation was conducted. There was no visible light that lit up in the hallway.</p> <p>On 4/15/25 at 9:15 AM, an observation was made of staff taking a resident inside the 300-hallway north shower.</p> <p>It should be noted that no staff answered the call light for 10 minutes.</p> <p>On 4/15/25 at 9:27 AM an interview was conducted with CNA 2. CNA 2 stated that in the 300 hallway there were two shower rooms. CNA 2 stated that the north shower room was bigger and wider and lots of residents preferred to use this shower room. CNA 2 stated that only the first shower worked in the shower room.</p> <p>On 4/15/25 at 10:22 AM, an interview was conducted with the Administrator (ADM) who stated the facility had only started auditing the call light system in January. The ADM stated he was aware the north 300 hallway shower room call light had not worked in the past but he thought it had been corrected. The ADM stated the call light system was old and the bulbs went out frequently. The ADM stated until the call light system was functioning correctly an aide would stand outside the shower room if a resident was showering.</p>