STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465150	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
William E Christofferson Salt Lake Veterans Home	700 South Foothill Drive Salt Lake City, UT 84113

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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 dishmachine washing temperature was not meeting manufacturer requirements and sanitizer solution was not at required levels for sanitizing. In addition, there were soiled areas in the kitchen. Findings included: 1. On 3/16/26 at 9:21 AM, an initial kitchen tour of the kitchen was conducted. The following was observed: Dietary Aide (DA) 1 stated the sanitizer solution located by the 3 compartment sink was made at 8:30 AM. DA 1 stated the sanitizer was quats ammonia and needed to be between 250-260 Parts Per Million (PPM). DA 1 was observed to test the solution and stated it was at 500 PPM. DA 1 stated the sanitizer was fine if it was too high but it could not be too low. A sign hanging by the sanitizer solution revealed the sanitizer solution should test between 150-400 PPM. DA 1 was observed to wipe the trayline with the sanitizer solution. At 9:37 AM, [NAME] 1 stated DA 1 made his sanitizer solution about an hour prior. The sanitizer solution was in the food preparation area. [NAME] 1 tested the sanitizer solution and the testing strip did not change color. [NAME] 1 stated the sanitizer was at 0 PPM. [NAME] 1 was then observed to wipe the food preparation area with the solution. There was a sanitation bucket log for March 2026 which revealed staff documented 300 to 400 PPM. At the bottom of the log it revealed sanitizer was to be at 200-300 PPM and changed every 4 hours. The shelf over trayline was observed to be soiled underneath. Food was served from below the shelf. There was dust on the piping behind the stove, fryer and oven. There was food splatter on the ceiling over the trayline. 2. On 3/16/26 at 9:42 AM, an observation was made of [NAME] 1 wearing gloves and touching raw meat. [NAME] 1 was observed to remove his gloves and no hand hygiene was observed. [NAME] 1 was observed to touch cutting boards without hand hygiene after removing gloves. 3. On 3/16/26 at 9:48 AM, an interview was conducted with DA 2. DA 2 stated the dishmachine needed to be above 150 degrees Fahrenheit and the rinse above 180 degrees Fahrenheit. The following was observed: [Note: All temperatures were in degrees Fahrenheit.] At 9:50 AM, the washing cycle was 145 and the rinse cycle was above 180. There were plate bases and 1 tray that went through the cycle. The items were observed to be put away with clean dishes. At 9:51 AM, the washing cycle was 145 and the rinse was 190. There were trays and bases which were observed to be put away with clean dishes. DA 2 confirmed the washing temperature was 145. At 9:52 AM, the washing cycle was 140 and the rinse was 189. DA 2 confirmed the washing temperature reached 140 and stated she doesn't know why it does this. There were trays in the cycle and were observed to be put away with clean dishes. At 9:54 AM, the washing cycle was 140 and the rinse cycle was 190. There were trays in the cycle and were observed to be put away with clean trays. DA 2 was immediately interviewed and stated she did dishes once a week and she did not know what to do if the washing temperature was not over 150. DA 1 was immediately interviewed and stated that DA 2 needed to continue washing dishes so the temperature would rise. 4. On 3/19/26 at 1:33 PM, the dish machine was observed. The washing cycle was 145 and the rinse was 190. The dishes were observed to be put away with the clean dishes. At 1:35 PM, an observation was made of a DA documenting the washing temperature of 150 and rinse of 185 on the dishmachine temperature log. 5. On 3/19/26 at (continued on next page)

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1:41 PM, a follow up kitchen tour was conducted. The following was observed: Behind the fryer, stove and over there were pipes with dust and debris. The shelf above the trayline was soiled underneath. The shelf was above prepared food. There was food splatter on the ceiling above the trayline. On 3/19/26 at 1:42 PM, an interview was conducted with the Dietary Manager (DM). The DM stated staff were to test the dish machine prior to meals. The DM stated the dish machine needed to run 2 to 3 times for it to reach 150 for the washing cycle and 180 for the rinse. The DM stated the ceiling tiles were cleaned by maintenance monthly. The DM stated the steam table was cleaned daily and deep cleaned weekly. The DM stated the shelf above the tray line was not on the cleaning list. The DM stated the pipes behind the fryer, ovens and stove needed to be cleaned.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 2 of 32 sampled residents, the facility did not obtain laboratory services only when ordered by a physician. Specifically, a resident had a Complete Blood Count (CBC) with differential and Vitamin D, 25-Hydroxy drawn without a physician's order. Resident identifier 5. Findings included: Resident 5 was admitted to the facility on [DATE] with diagnoses which included dementia, abnormal findings of blood chemistry, post traumatic stress disorder and major depressive disorder. Resident 5's medical record was reviewed 3/19/26. Resident 5 had laboratory results for Vitamin D, 25-Hydroxy and CBC with differential on 12/8/25. There were no physician's orders for the laboratory draws. It should be noted resident 5 had a physician's order dated 7/8/26 that revealed CBC, Comprehensive Metabolic Panel (CMP) and Vitamin D level every 6 months starting on the 8th for 1 day for routine labs. There was a Vitamin D, 25-Hydroxy and CBC with manual differential completed on 1/8/26. Resident 5 received 2 blood draws which were on 12/8/25 and 1/8/26. On 3/19/26 at 2:29 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she was unable to find a physician's order for the CBC and Vitamin D, 25-Hydroxy for 12/8/25. The DON stated she thought the nurse calculated 6 months from July 2025 as 12/8/25 instead of 1/8/26.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that laboratory reports were accurately maintained and readily available within the medical record. Specifically, for 2 out of 32 sampled residents, laboratory results were not located in their medical record. Resident identifiers: 3 and 4. Findings included: 1. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hypo-osmolality, hyponatremia, and anxiety. A review of Resident 3's medical record was conducted on 3/16/26 through 3/19/26. A physician's order dated 12/28/25, revealed Additional labs for 12/29/25: ferritin level, serum iron, transferrin, and TIBC [Total Iron-Binding Capacity] one time only for anemia for 1 Day. The laboratory tests dated 12/29/25, were not located in resident 3's medical record. On 3/19/26 at 11:01 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the laboratory provider had changed their systems in October 2025. The DON stated the transitioning process was, a nightmare. The DON stated that some laboratory results had to be manually printed from an external portal and scanned into the resident's medical record. The DON stated that lab results for ferritin level, serum iron, transferrin, and TIBC dated 12/29/25, were not located in resident 3's medical record. 2. Resident 4 was admitted to the facility on [DATE] with diagnoses which included vascular dementia, depression, post traumatic stress disorder, constipation and prediabetes. A physician's order dated 1/26/26 revealed a Thyroid-Stimulating Hormone (TSH) with reflux to free Thyroxine (T4). Resident 4's laboratory results revealed T4 was completed on 1/26/26. There were no TSH results in the medical record. On 3/19/26 at 11:10 AM, an interview was conducted with the DON. The DON stated resident 4's TSH was completed but was not in the medical record. The DON stated resident 4's TSH needed to be manually printed from an external portal and then scanned into the medical record. The DON stated the TSH results should have been in the medical record.