STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465157	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millard County Care and Rehabilitation	150 South White Sage Avenue Delta, UT 84624

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was found that for 4 out of 20 sampled residents, the facility failed to ensure that each resident had the right to be informed of, and participate in, his or her treatment, including the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Specifically, five residents or resident representatives were not informed of risks and benefits, treatment or treatment alternatives or options in advance of starting psychotropic medications. Resident identifiers: 4, 6, 8, and 54. 1. Resident 8's medical record was reviewed 4/27/26 through 4/30/26.Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, psychotic disorder with delusions due to known physiological condition, dementia, and major depressive disorder.Physician orders were reviewed and indicated resident 8 was started on the following psychotropic medications:Haloperidol lactate injection solution on 2/8/26 at 9:10 AM,Donepezil HCl (hydrochloride) oral tablet on 4/15/26 at 3:51 PM,Buspirone HCl oral tablet on 7/30/25 at 2:00 PM,Quietiapine fumarate oral tablet on 9/18/25 at 6:00 PM, andSertraline HCl oral tablet on 4/19/25 at 6:00 AM.No documentation that indicated the resident or resident representative was informed of the risks and benefits, treatment or treatment alternatives or options in advance of starting any psychotropic medications was found in the medical record or provided by staff.On 4/30/26 at 8:35 AM, an interview was conducted with the Director of Nursing (DON) who stated they notify the family when residents start or change the medication doses, but they do not discuss risks and benefits, give alternative options or have them sign a consent.2. Resident 4 was admitted [DATE], and readmitted [DATE] with diagnoses including, but not limited to unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety disorder unspecified.Resident 4's medical record was reviewed from 4/27/26 through 4/30/26.Physician orders were reviewed and indicated resident 4 was started on the following psychotropic medications:Zaleplon Oral Capsule on 1/22/26 at 6:00pmQuetiapine Fumarate Oral Tablet on 1/22/26 at 6:00pm, andBusprione HCl (hydrochloride) Oral Tablet on 2/23/26 at 2:00pmNo documentation that indicated the resident or resident representative was informed of the risks and benefits, treatment or treatment alternatives or options in advance of starting any psychotropic medications was found in the medical record or provided by staff.3. Resident 54 was admitted [DATE], readmitted [DATE] with diagnoses including, but not limited to Alzheimer's disease with early onset and dementia in other diseases classified elsewhere.Resident 54's medical record was reviewed from 4/27/26 through 4/30/26.Physician orders were reviewed and indicated resident 54 was started on the following psychotropic medications:Sertraline HCl (hydrochloride) oral tablet on 9/19/24 at 6:00am, andQuetiapine Fumarate oral tablet on 3/10/26 at 6:00pm No documentation that indicated the resident or resident representative was informed of the risks and benefits, treatment or treatment alternatives or options in advance of starting any psychotropic medications was found in the medical record or provided by staff.4. Resident 6 was admitted to the facility on [DATE] and readmitted (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] with diagnoses which included Parkinson's disease without dyskinesia. Review of resident 6's medical record was completed on 4/27/26 through 4/30/26.Physician orders were reviewed and indicated resident 6 was started on the following psychotropic medications:Buspirone HCl Oral Tablet on 6/27/25,Seroquel Oral Tablet on 1/22/26, andSertraline HCl Oral Capsule on 6/27/25.No documentation that indicated the resident or resident representative was informed of the risks and benefits, treatment or treatment alternatives or options in advance of starting any psychotropic medications was found in the medical record or provided by staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that for 3 out of 20 sampled residents, that the facility did not ensure that residents who use psychotropic drugs received gradual dose reductions and did not ensure that PRN (as needed) orders for anti-psychotic drugs were limited to 14 days. Specifically, the facility did not document a gradual dose reduction attempt of psychotropic medications for two residents prior to January 2026 and one resident had an antipsychotic medication prescribed for more than 14 days. Resident identifiers: 4, 8, and 54. 1. Resident 4 was admitted on [DATE], and readmitted on [DATE] with diagnoses including, but not limited to unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety disorder unspecified.Resident 4's medical record was reviewed from 4/27/26 through 4/30/26. The facility completed a psychotropic medication review and gradual dose reduction attempt in January 2026. There were no other documented gradual dose reduction attempts in the residents medical record.2. Resident 54 was admitted on [DATE], and readmitted on [DATE] with diagnoses including, but not limited to Alzheimer's disease with early onset, dementia in other diseases classified elsewhere mild with anxiety, and psychotic disorder with hallucinations due to known physiological conditions.Resident 54's medical record was reviewed from 4/27/26 through 4/30/26. The facility completed a psychotropic medication review and gradual dose reduction attempt in January 2026. There were no other documented gradual dose reduction attempts in the residents medical record.On 4/29/26 at 9:34 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the most recent psychotropic review and gradual dose reduction attempts at the facility were conducted in January 2026. The DON stated that the facility did not complete any gradual dose reduction attempts or psychotropic reviews prior to January 2026, but that they should be completed quarterly. 3. Resident 8's medical record was reviewed 4/27/26 through 4/30/26.Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, psychotic disorder with delusions due to known physiological condition, dementia, and major depressive disorder.A physician's order dated 2/8/26 at 9:10 AM indicated haloperidol lactate (an antipsychotic/antimanic agent) injection solution 5 MG/ML (milligrams/milliliter). Inject 0.2 ml intramuscularly every 12 hours as needed (PRN) for delusions, hallucinations, paranoia, and agitation. No end date was given in the order.The medication administration record (MAR) was reviewed for the months of February 2026, March 2026, and April 2026 the MARs indicated resident 8 received the PRN haloperidol lactate injection on 2/8/26 at 9:15 AM and 4/21/26 at 4:35 PM. No end date was documented on the MAR.On 4/30/26 at 8:48 AM, an interview was conducted with the Director of Nursing (DON) who stated her PRN haldol was more than 14 days because it was only used for extreme reasons, but that it should have been limited to 14 days and that the doctor did not document a reason for the extended order.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was found that for 4 out of 20 sampled residents, the facility failed to ensure all alleged violations of abuse, including injuries of unknown source, were reported immediately to the State Survey Agency and other officials in accordance with State law. Specifically, the facility failed to report an allegation of sexual abuse and incidents involving major injuries to the State Agency, which prevented a timely investigation and oversight of resident safety. Resident Identifiers: 3, 6, 19, and 59.1. Resident 59 was admitted to the facility on [DATE], readmitted on [DATE], and discharged [DATE] with diagnoses which included hemiplegia and hemiparesis.Review of resident 59's medical record was completed on 4/27/26 through 4/30/26.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 59 had a Brief Interview of Mental Status (BIMS) score of 6 which indicated severely impaired cognition.On 1/31/26 at 5:22 PM, a Nursing Note revealed the following, his roommate called the bell to say he had fallen, staff found him on the floor between his bed and the window. He had tried to get out of bed by himself and hurt his knees and felt a pop in themboth. Staff assisted him up and onto the gurney to take him to the ER [emergency room] for eval [evaluation] of injuries. DON [Director of Nursing], Son [name redacted] and Dr. [name redacted] notified. He was taken over to the [name redacted] Hospital for eval at 1600 [4:00 PM].On 2/1/26 at 5:20 PM, a Nursing Note revealed the following, He got back from the ER [emergency room] at 1407 [2:07 PM] via hospital bed and staff X [times] 2 and one of our staff. He is comfort cares and had his regular meds DC'd [discontinued].He moaned out in pain when transferred to his bed on readmit.He has immobilizing braces on both legs d/t [due to] fractures of both femurs post fall yesterday and an indwelling. He has heel protectors on both feet. His bones are not strong enough to have surgery so is now on comfort cares. He opened his eyes a couple of times but has not replied back with words to staff- just grunting.On 4/30/26 at 12:44 PM, an interview was conducted with the Administrator (ADM).The ADM stated that he reported the incident involving resident 59 on the state's patient safety website, but not to the State Survey Agency's incident reporting website. 2. Resident 6 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included Parkinson's disease without dyskinesia. Review of resident 6's medical record was completed on 4/27/26 through 4/30/26.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 6 had a Brief Interview of Mental Status (BIMS) score of 0 which indicated resident us rarely/never understood.On 11/1/25 at 6:30 PM, an Incident Nursing Note revealed the following, resident was sitting in w/c [wheelchair] in [sic] north side dining room. resident alarm went off, found in supine position on floor, denies hitting head, denies injury, assisted off ground and into chair, able to bear weight, no signs of injury noted. resident moved to nurses station deskOn 11/4/25 at 1:51 PM, a Nursing Note revealed the following, When aides were trying to get [resident 6] out of bed, they stated that he was c/o [complaining of] of [sic] pain in his left leg. I went in to assess and he did has [sic] some tenderness and wince when moving the left leg. 2 person assist to get resident up out of bed and into the bathroom. Resident was able to bear weight on both legs.Transferred to recliner, noticed that he is still complaining of pain in his left leg, rubbing his upper thigh .Notfied [sic] MD [medical doctor], to see if we could get an xray of his left hip and leg d/t [due to] increased complaint of pain when transferring or moving left leg.On 11/4/25 at 4:59 PM, a Nursing Note revealed the following, Notified daughters that [name redacted] was c/o [complaining of] pain in his left leg and asked if it was ok to have xrays done .Dr. [name redacted] gave order to xray left hip and upper leg. Transferred into w/c [wheelchair] and taken to hospital forxrays [sic]. Xray results sent to Dr. [name redacted], there is a femur fracture .They don't want to do any surgery.On 4/30/26 at 12:44 PM, an interview was conducted with the ADM.The ADM stated that he reported the incident involving resident 6 on the state's patient safety website, but not to the (continued on next page)

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	465157	A. Building B. Wing	04/30/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	State Survey Agency's incident reporting website. 3. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease and scoliosis. Review of resident 3's medical record was completed on 4/27/26 through 4/30/26.A Quarterly MDS dated [DATE] revealed that resident 3 had a BIMS score of 7 which indicated severely impaired cognition.On 4/6/25 at 3:31AM, an Incident Nursing Note revealed the following, 0310 [3:10 AM] resident bed alarm went off, when staff went down, resident found in kneeling [sic] position leaning into her recliner. resident [sic] states her walker didn't go where she was going. resident [sic] states she was getting up from bed to go to [sic] bathroom. able to stand, c/o [complaint of] left knee, left elbow pain- no visible injury, right pinky pain no visible injury, right ring finger abrasion.On 4/16/25 at 4:24 PM, a Nursing Note revealed the following, Resident had ORIF [Open Reduction and Internal Fixation] to R [right] 4/5 [fourth and fifth] MC [metacarpal] Fx [fractures], at [name redacted] this AM. She returned to [name redacted] from surgery at 12:50.On 4/30/26 at 12:44 PM, an interview was conducted with the ADM. The ADM stated that he reported the incident involving resident 3 on the state's patient safety website, but not to the State Survey Agency's incident reporting website. 4. Res 19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included dementia, adjustment disorder with anxiety, hearing loss, visual loss, and age-related physical debility.A 1-page document was located in the facility's abuse binder titled with resident 19's name, a date of 2/23/24 [sic], and Outside person - possible molest. It indicated that on 2/23/25 at 5:34 PM, resident 19's nephew called the Administrator (ADM) and notified him that his mother, who was resident 19's sister, was riled up and anxious and had told him that she felt like [resident 19] had reported she had been molested. He then stated he, [nephew's name redacted] felt his mother was emotionally ill right now and not able to be reasonable or competent and was not far from having a breakdown. He stated several times that in the conversation that he did not think [resident 19] had been molested, sexually or otherwise. He just said he felt like the nurse who addressed the concerns with his mother, [resident 19's sister's name redacted] had tried to reassure her and told her, [resident 19's sister's name redacted] that she had been delusional several times the last month and that she had almost never been in her room the last few days and that she probably had not been molested, but then offered several ideas for watching her and monitoring for risk. [Resident 19's nephew's name redacted] felt like that conversation had just made things worse for his mothers' lack of well-being. He didn't blame the nurse, he just stated that we needed to try to help his mom feel heard, rather than be dismissive. This because there had been some sexual misconduct in [resident 19's] life several decades ago by a person in a position of authority. I confirmed with [resident 19's nephew's name redacted] that he thought [resident 19] was delusional and confused and had not been sexually assaulted and that his mother was not in a good place emotionally right now. I assured [resident 19's nephew's name redacted] I would nonetheless, investigate, in a non-urgent way as it was not a viable allegation. It further indicated, I have known [resident 19's nephew's name redacted] for over 30 years and known [resident 19's sister] superficially for same. Because [resident 19's nephew's name redacted] reported he did not think the report he got from his mom was credible, [name redacted] did not report initially to any of the agencies or law enforcement. After talking to the resident, [resident 19] it is felt the sister is not in a good place emotionally and may have been triggered by something and reliving a memory from decades ago. [Resident 19's] interview does not support any credible allegation of sexual abuse/molestation. The document was signed by the ADM.Resident 19's medical record was reviewed 4/27/26 through 4/30/26 and there was nothing documented regarding this incident.On 4/29/26 at 1:54 PM, an interview was conducted with the ADM who stated resident 19's nephew called to tell him that his mother, who was resident 19's sister and POA (Power of Attorney), was getting confused and had worsening dementia and requested to have resident 19's sister, his mother, taken off as POA and the nephew took over as POA during that call. The ADM stated that he believed the main reason for the call was to change resident 19's POA, and that the abuse allegation was (continued on next page)

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	465157	A. Building B. Wing	04/30/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported just to show how confused his mom, resident 19's sister, was getting. The ADM stated he interviewed resident 19 and she denied it and that nobody had touched her. The ADM stated that resident 19's sister came into the facility and that she was unable to provide any more details besides resident 19 reporting that a man had groped her breast. The ADM stated he specifically asked resident 19 if a man had groped her breast and she said no. The ADM stated that resident 19 had said a housekeeper was mean to her and that he asked to clarify that it was a housekeeper here and she said, no, it was up in [City name redacted]. The ADM stated he did not report it because he felt it was not a credible allegation of abuse because there was more story to it, about resident 19's sister's dementia progressing and that he could not get anymore information out of resident 19's sister and because resident 19 denied it. The ADM stated that resident 19's nephew had told him that resident 19 had been assaulted at another facility in [City name redacted] when resident 19's sister was her POA and that resident 19's nephew thought resident 19's sister was just reliving that and getting that confused.

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	465157	A. Building B. Wing	04/30/2026

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was found that for 3 out of 20 sampled residents, the facility failed to ensure all alleged violations involving abuse and injuries of unknown sources were thoroughly investigated. Specifically, the facility failed to initiate or document an investigation into an allegation of sexual abuse and three separate incidents involving major injuries to determine the cause, identify responsible parties, or implement corrective actions to prevent further potential abuse. Resident Identifiers: 3, 6, and 59.1. Resident 59 was admitted to the facility on [DATE], readmitted on [DATE], and discharged [DATE] with diagnoses which included hemiplegia and hemiparesisReview of resident 59's medical record was completed on 4/27/26 through 4/30/26.A Quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 59 had a Brief Interview of Mental Status (BIMS) score of 6 which indicated severely impaired cognition.On 1/31/26 at 5:22 PM, a Nursing Note revealed the following, his roommate called the bell to say he had fallen, staff found him on the floor between his bed and the window. He had tried to get out of bed by himself and hurt his knees and felt a pop in themboth. Staff assisted him up and onto the gurney to take him to the ER [emergency room] for eval [evaluation] of injuries. DON [Director of Nursing], Son [name redacted] and Dr. [name redacted] notified. He was taken over to the [name redacted] Hospital for eval at 1600 [4:00 PM].On 2/1/26 at 5:20 PM, a Nursing Note revealed the following, He got back from the ER [emergency room] at 1407 [2:07 PM] via hospital bed and staff X [times] 2 and one of our staff. He is comfort cares and had his regular meds DC'd [discontinued].He moaned out in pain when transferred to his bed on readmit.He has immobilizing braces on both legs d/t [due to] fractures of both femurs post fall yesterday and an indwelling. He has heel protectors on both feet. His bones are not strong enough to have surgery so is now on comfort cares. He opened his eyes a couple of times but has not replied back with words to staff- just grunting.On 4/30/26 at 12:44 PM, an interview was conducted with the Administrator (ADM). The ADM stated that he was made aware of resident 59's bilateral femur fractures. The ADM stated that resident 59 was totally dependent for any type of transfer. The ADM stated that looking back, resident 59 had a change in condition and thought he could get up, which could have caused the fall. The ADM stated that he did not feel there was any neglect or abuse that caused the major injury for resident 59. The ADM stated that he did not investigate the cause of the injury regarding resident 59.2. Resident 6 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included Parkinson's disease without dyskinesia.Review of resident 6's medical record was completed on 4/27/26 through 4/30/26.A Quarterly MDS dated [DATE] revealed that resident 6 had a BIMS score of 0 which indicated resident us rarely/never understood.On 11/1/25 at 6:30 PM, an Incident Nursing Note revealed the following, resident was sitting in w/c [wheelchair] in [sic] north side dining room. resident alarm went off, found in supine position on floor, denies hitting head, denies injury, assisted off ground and into chair, able to bear weight, no signs of injury noted. resident moved to nurses station deskOn 11/4/25 at 1:51 PM, a Nursing Note revealed the following, When aides were trying to get [resident 6] out of bed, they stated that he was c/o [complaining of] of [sic] pain in his left leg. I went in to assess and he did has [sic] some tenderness and wince when moving the left leg. 2 person assist to get resident up out of bed and into the bathroom. Resident was able to bear weight on both legs.Transferred to recliner, noticed that he is still complaining of pain in his left leg, rubbing his upper thigh .Notfied [sic] MD [medical doctor], to see if we could get an xray of his left hip and leg d/t [due to] increased complaint of pain when transferring or moving left leg.On 11/4/25 at 4:59 PM, a Nursing Note revealed the following, Notified daughters that [name redacted] was c/o [complaining of] pain in his left leg and asked if it was ok to have xrays done .Dr. [name redacted] gave order to xray left hip and upper leg. Transferred into w/c [wheelchair] and taken to hospital forxrays [sic]. Xray results sent to Dr. [name redacted], there is a femur fracture .They don't want to do any surgery.On 4/30/26 at 12:44 PM, an interview was conducted with the ADM. The ADM (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that he was made aware of resident 6's left femur fracture. The ADM stated that he did not feel there was any neglect or abuse that caused the major injury for resident 6. The ADM stated that he did not investigate the cause of the injury regarding resident 6.3. Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease and scoliosis. Review of resident 3's medical record was completed on 4/27/26 through 4/30/26.A Quarterly MDS dated [DATE] revealed that resident 3 had a BIMS score of 7 which indicated severely impaired cognition.On 4/6/25 at 3:31AM, an Incident Nursing Note revealed the following, 0310 [3:10 AM] resident bed alarm went off, when staff went down, resident found in kneeling [sic] position leaning into her recliner. resident [sic] states her walker didn't go where she was going. resident [sic] states she was getting up from bed to go to bathroom [sic]. able to stand, c/o [complaint of] left knee, left elbow pain- no visible injury, right pinky pain no visible injury, right ring finger abrasion.On 4/16/25 at 4:24 PM, a Nursing Note revealed the following, Resident had ORIF [Open Reduction and Internal Fixation] to R [right] 4/5 [fourth and fifth] MC [metacarpal] Fx [fractures], at [name redacted] this AM. She returned to [name redacted] from surgery at 12:50.On 4/30/26 at 12:44 PM, an interview was conducted with the ADM. The ADM stated that he was made aware of resident 3's fractures to her right wrist. The ADM stated that resident 3 is very independent and she would want to be able to wander the facility at her leisure. The ADM stated that he did not feel there was any neglect or abuse that caused the major injury. The ADM stated that he did not investigate the cause of the injury.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was found that for 4 out of 20 sampled residents, the facility failed to ensure that a licensed pharmacist performed a drug regimen review at least once a month and failed to act upon the pharmacist's reports of any irregularities to the attending physician and the facility's medical director and director of nursing. Irregularities included, but were not limited to, any drug that met the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that was sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. If there was to be no change in the medication, the attending physician should have documented his or her rationale in the resident's medical record. Specifically, the facility failed to maintain documentation in the medical records to demonstrate that a pharmacist reviewed the residents' medications, identified potential irregularities, or provided recommendations to the attending physician and one resident had a recommendation by the pharmacist in November 2025 and it was not acted upon until February 2026. Resident Identifiers: 4, 6, 8, and 54.1. Resident 6 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included Parkinson's disease without dyskinesia. Review of resident 6's medical record was completed on 4/27/26 through 4/30/26.Resident 6's monthly pharmacist medication regimen review notes were reviewed. There were no monthly notes for the months of March 2026 or April 2026. 2. Resident 4 was admitted [DATE], and readmitted on [DATE] with diagnoses including, but not limited to unspecified dementia unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety disorder unspecified.Resident 4's medical record was reviewed from 4/27/26 through 4/30/26.Resident 4's monthly pharmacist medication regimen review notes were reviewed. There were no monthly notes for the months of March 2026 or April 2026. 3. Resident 54 was admitted [DATE], and readmitted on [DATE] with diagnoses including, but not limited to Alzheimer's disease with early onset and dementia in other diseases classified elsewhere.Resident 54's medical record was reviewed from 4/27/26 through 4/30/26. Resident 54's monthly pharmacist medication regimen review notes were reviewed. There were no monthly notes for the months of March 2026 or April 2026. On 4/30/26 at 1:08 PMm an interview was conducted with the Director of Nursing (DON). The DON stated that monthly pharmacist review notes should be uploaded into each resident's electronic medical record. The DON stated that the facility pharmacist had not completed pharmacy reviews for the months of March 2026 and April 2026. 4. Resident 8's medical record was reviewed 4/27/26 through 4/30/26.Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, psychotic disorder with delusions due to known physiological condition, dementia, and major depressive disorder.A nurse's note on 11/1/25 at 4:31 PM indicated, .The pharmacist called and asked how she was doing on the Seroquel vs the Abilify. I told him that she has done better with her behaviors, but she does have episodes where she gets irritable or emotional and does get the PRN [as needed] Haldol at times and her MD [medical doctor] is notified. He felt that she may benefit from a low dose of Seroquel during the day. She does tend to get more anxious towards the afternoon or when there is a lot of commotion around her.A nurse's note on 2/3/26 at 5:10 PM indicated, .[Physician name redacted] came to see resident at shift change. He asked if there were any concerns. I talked to him about her recent behaviors (yelling, hitting and resistant to care). I reminded him that he was sent a message, and I also told him that a while back, the pharmacist was doing a (continued on next page)

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	465157	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millard County Care and Rehabilitation	150 South White Sage Avenue Delta, UT 84624

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of her medications, and at that time she had the PRN Haldol. I told him that PRN psychotropics can only be for 14 days and that he recommended an alternative option by a low dose of Seroquel during the day since she has done better at night with it. He wrote an order for Seroquel 25mg [milligrams] PO [by mouth] QAM [every morning] .A physician's order dated 2/4/26 at 6:00 AM indicated quetiapine fumarate [generic name for Seroquel; an antipsychotic/antimanic medication] oral tablet 25 MG once a day.An interview was conducted on 4/30/26 at 10:08 AM with Licensed Practical Nurse (LPN) 1 and she stated that she did not talk to the doctor about the recommendation from the pharmacist in November 2025 because resident 8 had not needed PRN haldol around that time.An interview was conducted on 4/30/26 at 1:14 PM with the Director of Nursing (DON) and she stated that it did not look like the pharmacist's recommendation from November 2025 was completed until February 2026 when a nurse mentioned it to the physician. The DON stated that she does not have time to stay on top of that because she was too busy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, it was determined that the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles. Specifically, two open insulin pens were not labeled with a resident's name. Resident identifier: 56. On 4/29/26 at 10:50 AM, an observation of the south medication fridge was made where a plastic bin with resident 56's first name written on it was located, two open insulin pens were loose in the plastic bin and there was no resident name labeled on the medications. A concurrent interview was conducted with Registered Nurse (RN) 1 who stated the two insulin pens belonged to resident 56 and that they always put the names of the resident on the pen. RN 1 stated they were unsure why the labels had not been affixed. RN 1 was observed to place resident 56's identification label on both insulin pens.On 4/29/26 at 2:17 PM, an interview was conducted with the Director of Nursing (DON) who stated she threw the two previously unlabeled insulin pens away to avoid any medication errors and that the insulin pens should have been labeled.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on record review and interview, it was determined that as part of their performance improvement activities, the facility failed to take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements were realized and sustained. Specifically, the facility was cited a deficiency for F756 when it failed to maintain documentation in the medical records to demonstrate that a pharmacist reviewed the residents' medications, identified potential irregularities, or provided recommendations to the attending physician for four sampled residents which was identified as a deficiency in the previous health survey in 2024.On 4/30/26 at 1:14 PM, an interview was conducted with the Director of Nursing and she stated that she did not have time to maintain documentation in the medical records to demonstrate that a pharmacist reviewed the residents' medications, identified potential irregularities, or provided recommendations to the attending physician for four sampled residents because she did not have time. This was cited during the previous survey at F756 and again on the current surveyOn 4/30/26 at 2:07 PM, an interview was conducted with the Administrator (ADM) and he stated that he did not have a performance improvement project but he had QAPI minutes that captured some of the improvement plans that they had worked on. The ADM further stated that he felt they did achieve compliance with F756, which was cited during the previous survey, and that it should have been corrected.Documents to show compliance were requested at that time but were not received as of 5/13/26.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. Specifically, staff were observed handling oral medications with bare hands during administration, and the facility failed to maintain documentation for tracking and investigating infections to identify patterns or trends. Resident identifier: 23.1. On 4/30/26 at 11:47 AM, an observation of Licensed Practical Nurse (LPN) revealed that while preparing medications for resident 23, LPN 1 popped a pill directly into her bare hand before placing it into a medication cup. LPN 1 was then observed administering the contaminated medication to resident 23. On 4/30/26 at 1:29 PM, an interview with the DON was conducted. The DON stated that staff members were expected to pop pills directly from blister packs into medication dispenser cups and to never touch medications with bare hands. The DON stated that if a medication came in contact with a staff member's bare hand, that medication was to be disposed of and replaced with a newly dispensed dose. 2. On 4/29/26 at 8:20 AM, the facility's Infection Control Surveillance Logs were requested. The DON stated that the facility had several residents contract influenza during the 2025 holiday season due to increased number of visitors.The DON stated that she kept those residents with symptoms contained to their room to reduce further spreading. The DON stated that she did not have a list of residents or rooms affected regarding the influenza outbreak. It should be noted, the requested Infection Control Surveillance Logs were unavailable for review. On 4/30/26 at 12:28 PM, an interview with the Director of Nursing (DON) was conducted.The DON stated that she also served as the facility's designated Infection Preventionist (IP). The DON stated that the facility lacked an infection control surveillance manual or organized tracking system.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to develop and implement an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use. Specifically, the facility had no established facility-wide system to ensure the appropriate indication, dose, and duration for antibiotic prescriptions, nor a process for monitoring usage and resistance data.On 4/29/26 at 8:20 AM, the facility's Infection Control Surveillance Logs were requestedIt should be noted the facility's Infection Control Surveillance Logs, including any prescribed antibiotic tracking information, were unavailable.On 4/30/26 at 12:28 PM, an interview with the Director of Nursing (DON) was conducted. The DON stated that she also served as the facility's designated Infection Preventionist. The DON stated that she did not track resident antibiotic utilization, including the specific clinical indications for the medications or the prescribed durations of treatment.