

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/20/2025
NAME OF PROVIDER OR SUPPLIER  Meadow Brook Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  433 East 2700 South Salt Lake City, UT 84115	

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 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not ensure each resident was free from abuse and neglect. Specifically, for 1 out of 29 sampled residents, a resident was left in a sling unattended by staff and the same resident experienced staff yelling at them. Resident identifiers: 15 and 18. Findings included: Resident 15 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, extrapyramidal and movement disorder, and dementia. 1. The facility reported to the State Survey Agency (SSA) on 8/7/25 at 8:00 PM, resident 15 was left in a Hoyer lift for approximately one hour after the Certified Nursing Assistant (CNA) became frustrated with resident 15. Resident 15's medical record was reviewed on 9/22/25 through 9/29/25. Resident 15's progress notes were reviewed and there were no progress notes regarding resident 15 being left in the lift. A care plan dated 11/8/23 and revised on 10/12/24, revealed resident 15 had an activity of daily living performance deficit related to cognitive impairment, impaired mobility, arthritis, schizophrenia, dementia, and anemia. One of the interventions included Transfers: Provide dependent assistance with two staff for Sit To Stand with transfers. According to the facility reported incident investigation, the incident was an improper transfer procedure. The description of the How Injury/Critical Incident Occurred revealed a CNA was preparing resident 15 for bed. The CNA got resident 15 in the hoier lift and left her there for approximately an hour after getting frustrated with resident 15. The standard suspension process was started until the schedule was reviewed and the CNA had already put in her resignation and no additional shifts were completed. The five day investigation report provided to the SSA revealed resident 15 was in the sit-to-stand lift and a CNA heard resident 15 calling out for help. The CNA that left resident 15 in the lift unattended refused to talk to management about the incident and resigned immediately. The incident was not verified as abuse or neglect. The rationale was cut off on the final investigation. On 9/25/25 at 1:12 PM, an interview was conducted with CNA 4. CNA 4 stated when using a mechanical lift there needed to be two CNA's. CNA 4 stated a staff member should never leave a resident unattended in the mechanical lift but heard a CNA left a resident in a sit-to-stand lift. On 9/29/25 at 9:58 AM, an interview was conducted with resident 18. Resident 18 was resident 15's roommate at the time of the incident. Resident 18 stated the CNA left resident 15 alone in a lift because she got frustrated with resident 15. Resident 18 stated she noticed resident 15 was getting frustrated because the CNA was not using the lift correctly and it was hurting her. Resident 18 stated she noticed resident 15 was alone in the lift and she alerted other CNA's who came and attended to resident 15. On 9/29/25 at 10:03 AM, an interview was conducted with the CNA coordinator. The CNA coordinator stated there needed to be two staff when conducting a mechanical lift transfer. The CNA coordinator stated one CNA needed to be a spotter and the other to operate the lift. The CNA coordinator stated there was an incident with a CNA leaving a resident in a lift. The CNA coordinator stated resident 15 was placed in a hoier lift above the bed. The CNA coordinator stated immediate education was provided to all staff since the incident. On 9/29/25 at 10:25 AM, a phone interview was conducted with Nursing Assistant (NA) 1. NA 1 stated she was in the dining room and another CNA stated the resident was upset with her. NA 1 stated resident 15 was left in the sit-to-stand lift. NA 1 stated there always needed to have two CNA's to transfer. NA 1 stated education was not provided after the incident. NA 1 stated resident 15 seemed stressed afterwards. The CNA coordinator provided education to the CNA's dated 5/21/24, which revealed Hoyer lifts must be operated by two or more trained staff members to minimize the risk of injury to both residents/patients and medical personnel. Additionally, if a Hoyer lift or sit to stand device were not being used immediately after a transfer, it should be returned to the designated storage area to ensure safety and accessibility for future use. On 9/29/25 at 1:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated all residents should have two staff members during transfers with mechanical lifts. The DON stated there was an incident reported to the SSA. The DON stated the CNA was educated on using the sit-to-stand with two staff members but failed to comply. The DON stated resident 15 was left alone in a lift for about an hour. The DON stated she was not part of the investigation so she did not know where the resident was left. The DON stated she would have substantiated the allegation as neglect. On 9/29/25 at 2:05 PM, an interview was conducted with the Administrator. The Administrator stated he was not sure why the allegation of resident 15 being left in the lift alone was not substantiated. The Administrator stated the previous Administrator did the investigation and he guessed it was because there were no signs and symptoms of psychological stress. The facility reported to the SSA</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility did not ensure residents were offered the Coronavirus disease 2019 (COVID-19) vaccines. Specifically, for 3 out of 5 sampled residents, no documentation was located to demonstrate how the residents accepted or refused the COVID-19 vaccination. Resident identifiers: 2, 6, and 31. Findings included:1. Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included quadriplegia, protein-calorie malnutrition, and anxiety disorder. Resident 6's medical record was reviewed on 9/29/25. There was no information that the COVID-19 vaccine was offered or refused for 2024.2. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus, protein-calorie malnutrition, morbid obesity due to excess calories, and schizoaffective disorder. Resident 2's medical record was reviewed on 9/29/25. There was no information that the COVID-19 vaccine was offered or refused for 2024.3. Resident 31 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included major depressive disorder, dementia, and adult failure to thrive. Resident 31's medical record was reviewed on 9/29/25. There was no information that the COVID-19 vaccine was offered or refused for 2024. On 9/29/25 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was no documentation that the residents were offered or refused the COVID-19 vaccine. The DON stated if a resident refused a vaccine there should be a form completed regarding refusal.</p>