STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465169	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thatcher Brook Rehabilitation & Care Center	1795 South Chelemes Way Clearfieldd, UT 84015

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that for 1 of 26 sampled residents, that the facility did not treat each resident with respect and dignity and care for each resident in a manner and environment that promoted maintenance or enhancement of their quality of life, recognizing each resident's individuality. Specifically, an observation was made of staff standing while feeding a resident. Resident identifier: 35. Findings included: Resident 35 was admitted to the facility on [DATE] with diagnoses which included cellulitis, sepsis, and hypertension. On 7/21/25 at 12:21 PM, an observation was made of resident 35 laying in bed with the head of the bed elevated. Resident 35's bed was in the highest position. Certified Nursing Assistant (CNA) 1 was observed to be standing to the left side of resident 35's bed feeding the resident. On 7/23/25 at 8:22 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 35 required assistance with eating. CNA 2 stated that because resident 35 was a hoyer lift, staff had to stand next to the bed to feed her. On 7/23/25 at 8:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 35 struggled with feeding herself and when a food tray was set in front of her she struggled with dexterity and could not get food into her mouth. The DON stated that when CNAs were feeding the resident they should be sitting down and not standing.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 of 26 sampled residents, the facility did not notify the resident or the resident's representative of the transfer or discharge, and the reason, in writing at the time of discharge. Additionally, the resident was not informed of the bed hold policy in writing with specification of the duration during which the resident was permitted to return and resume residence in the facility. Specifically, a resident who was discharged to the hospital was not provided discharge documentation. Resident identifier: 2Findings included: Resident 2 was admitted to the facility on [DATE] with diagnoses that included fracture of left tibia and fibula, respiratory failure with hypoxia, neuralgia, and neuritis, type 2 diabetes, anxiety disorder, epilepsy and morbid obesity.Resident 2's medical records were reviewed between 7/21/25 - 7/23/25.A progress note dated 7/20/25 at 12:30 PM revealed, resident 2 was discharged to the hospital after the family informed staff she was having what appeared to be a seizure. Resident 2 was transported via emergency medical services and was unresponsive. Internal discharge paperwork was completed. No discharge documentation was located in resident 2's medical record.The facilities Transfer or Discharge, Facility-Initiated policy was reviewed. Under the Notice of Transfer or Discharge (Emergent or Therapeutic Leave) the following was documented:1. When residents who are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers, NOT discharges, because the resident's return is generally expected.2. Residents who are sent emergently to an acute care setting, such as a hospital, are permitted to return to the facility.3. Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: . c. An immediate transfer or discharge is required by a resident's urgent medical need; or d.A resident has not resided in the facility for 30 days.4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements). 5. Notice of Facility Bed-Hold and Return policies are provided to the resident and representative within 24 hours of emergency transfer.6. Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments.7. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.On 7/23/25 at 10:04 AM, an interview was conducted with the DON who stated that resident 2 was discharged on 7/20/25 to the hospital after she was found shaking in her room. The DON stated resident 2's sister was visiting at the time. The DON stated the paperwork prepared and sent with the resident included a face sheet, the resident orders, and a POLST [Patient Orders for Life Sustaining Treatment] form. The DON stated the provider and family would be notified after the resident was prepared to go to the hospital. The DON stated resident family or representatives were notified of the facility bed hold policy verbally when they called to notify them of the resident going to the hospital. The DON stated she was unaware if that information was included in the admission packet that the resident reviewed upon admission. The DON stated they did not send any kind of transfer or discharge paperwork with the resident, nor did they provide it to them after their hospitalization. The DON stated the facility always wanted to take the resident back if they could. On 7/23/25 at approximately 2:00 PM, an interview was conducted with the Administrator. The Administrator stated the facility did not send a bed hold agreement with residents that were discharged to the hospital.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined, for 2 out 26 sampled residents, that the facility did not provide an ongoing program to support residents in their choice of activities both facility-sponsored group and individual activities and independent activities designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community based on the comprehensive assessment and care plan. Specifically, there were no activities besides bingo three times a week and residents complained of not enough activities. Resident identifiers: 25 and 30.Findings included:1. Resident 30 was admitted to the facility on [DATE] with diagnoses which included generalized anxiety disorder, major depressive disorder, and weakness. On 7/21/25 at 9:37 AM, an interview was conducted with resident 30. Resident 30 stated that there were no activities other than bingo and that there were some days with no activities. On 7/21/25 at 9:39 AM, an observation was made of the facility’s July 2025 activities calendar. The only activity noted on the calendar was bingo. Bingo was scheduled on: 7/2, 7/7, 7/9, 7/14, 7/21, 7/23, 7/25, 7/28, and 7/30. The remaining weekdays stated “No Activity.” It should be noted the calendar weekends were left blank. Resident 30’s medical record was reviewed 7/21/25 through 7/23/25. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed that staff assessed resident 30's activity preferences as doing things with groups of people and participating in religious activities or practices. Resident 30’s care plan revealed a problem of Psychosocial Well-Being with a start date of 6/20/25 Adjustment to Placement. Interventions included acquaint with facility, services, and routines. 2. Resident 25 was admitted to the facility on [DATE] with diagnoses that included fracture of left femur, encounter for orthopedic aftercare, type 2 diabetes, and chronic kidney disease. On 7/21/25 at 12:56 PM an interview was conducted with resident 25 who stated she would like to do other activities, but all that was offered was bingo, there were no other activities on the calendar. Resident 25’s medical records were reviewed between 7/21/25 through 7/23/25. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed it was somewhat important for resident 25 to do things with groups of people and participate in her favorite activities. Resident 25’s care plan revealed a problem of Psychosocial well-being with a start date of 6/23/25 adjustment to placement. Interventions included, “acquaint with facility, services, routines, staff, roommate and other residents.” (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/22/25 at 1:38 PM, an interview was conducted with the AD who stated she had been doing activities for about 1 ½ years. The AD stated when a resident was admitted to the facility she interviewed the residents to find out what their interests were and what activities they enjoyed. The AD stated she offered activity packets to each resident every morning that included crossword puzzles and other word games. The AD stated most residents enjoyed bingo and the socializing that went along with it so that was the activity that was being offered at the facility. The AD stated she had some requests for Yahtzee, or other card games. The AD stated that occasionally residents will bring their own games. The AD stated other activities that were available in the facility were books to read, painting supplies, board games, and coloring pages. The AD stated she did not have any helpers for activities, and had not had any training. On 7/23/25 at 8:49 AM, an interview was conducted with the Administrator (Admin) who stated it was hard to encourage residents to come out for activities. The Admin stated bingo was the biggest hit in the facility, which was why that was the activity that was offered the most. The Admin stated activity packets were available for residents to utilize if they wanted something to do when no activity was available. The Admin stated they had not informed residents about other activities that were available for residents to do in their free time.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined, for 1 of 26 sampled residents, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision to prevent accidents. Specifically, a resident did not have new interventions implemented after falls. Resident identifier: 30. Findings included: Resident 30 was admitted to the facility on [DATE] with diagnoses which included lack of coordination, weakness, and white matter disease. Resident 30's medical record was reviewed 7/21/25 through 7/23/25. On 6/22/25 a Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) assessment was completed on resident 30. Resident 30 scored a 5 which indicated severe cognitive impairment. A review of resident 30's progress notes revealed the following falls: a. On 6/24/25 at 1:04 PM, [Resident 30] was found on the floor in her bathroom. She was pulling her pants down when she fell. She denies feeling dizzy or light headed prior to fall b. On 7/3/25 at 5:40 PM, [AGE] year old was being assisted by daughter to bathroom when she slipped to the floor. Denies hitting head, no injuries noted. Assisted to Bathroom by staff and then back to bed. Call light and fluids in reach. c. On 7/12/25 at 5:49 PM, [AGE] year old female, admitted due to a GI [gastrointestinal] bleed, peptic ulcer. While being assisted to the bathroom resident fell and hit her head. No injuries noted Neuros started. She is alert and oriented with moments of confusion, able to make her needs known. She is a full code status. A review of resident 30's care plan revealed: a. A problem dated 6/20/25 indicated, I [resident 30] am at risk for falls d/t [due to] generalized weakness, recent hospitalization. Interventions dated 6/20/25 included physical and occupational therapy, gait belts for transfers, frequent checks for safety, and bilateral turning and repositioning bars for increased independence, comfort, and safety. b. An intervention dated 6/24/25 indicated, Encourage resident to use call light to call for assistance. c. Interventions dated 7/21/25 indicated, Neurological status will remain within normal limits with no signs of deterioration. Patient will demonstrate safe transfer techniques with appropriate staff assistance. It should be noted that there were no interventions addressing the falls on 7/3/25 and 7/12/25. On 7/22/25 at 12:00 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 30 had a new diagnosis of dementia and had falls because she was off balance. RN 1 stated that resident 30 was good at ambulating on her own but was impulsive and required staff to help balance her. RN 1 stated that resident 30 needed constant reminders to use her call light and to wear nonskid socks. On 7/22/25 at 12:05 PM, an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated that resident 30 was a fall risk and required one person to transfer with. CNA 4 stated that resident 30 should not be left alone in the bathroom. CNA 4 stated that resident 30 required extra supervision because she had fallen while at the facility. On 7/22/25 at 12:15 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that when a resident fell an event was created in the resident's medical record to ensure that the necessary documentation was done. The DON stated that she made sure that there were interventions after every fall and that documentation was completed. On 7/23/25 at 7:36 AM, an interview was conducted with the Assistant Director of Nursing (ADON) 1 . ADON 1 stated that all interventions were care planned after a fall occurred. ADON 1 stated that interventions were not updated unless the resident was having more falls. ADON 1 stated that staff were told verbally about what interventions residents required. ADON 1 stated that the nurses were expected to verbally communicate the interventions through shift to shift report. ADON 1 stated that care plans were reviewed every 30 days. On 7/23/25 at 8:26 AM, a follow-up interview was conducted with the DON. The DON stated that resident 30 was a difficult resident and had been at the facility in the past. The DON stated that resident 30 had falls every time she came to the facility. The DON stated that resident 30 had a lot of falls because she got up and took herself to the bathroom. The DON stated that interventions for the fall on 6/24/25 were monitoring the resident for 72 hours and completing neurological checks. The DON stated that there were no interventions for the fall that occurred on 7/12/25.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, it was determined for 1 of 26 sampled residents, the facility did not ensure that residents who require dialysis receive such services consistent with professional standards of practice. Specifically, the facility was not providing immediate monitoring and documentation of resident's vital signs and the status of a resident's dialysis fistula upon return from the dialysis treatment center. Resident identifiers: 4.Findings included:Resident 4 was admitted to the facility on [DATE] with diagnoses which included sepsis, end stage renal disease, and heart failure.Resident 4's medical record was reviewed on 7/21/25 through 7/23/25. On 7/21/2025 at 1:27 PM, an interview was conducted with resident 4. Resident 4 stated that after he finished his treatment at the dialysis center, vital signs and weights were collected and documented on the Dialysis Progress Note for him to give to the facility. Resident 4 stated that when he returned to the facility from the dialysis center a Certified Nursing Assistant (CNA) assisted him back to his room, vital signs were not taken, and a nurse did not assess his dialysis fistula.On 7/22/25 at 2:08 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated when resident 4 returned from dialysis, he received the Dialysis Progress Note, which contained a report from the dialysis nurse, including vital signs, weights, and new orders. LPN 1 stated that vital signs were taken in the morning before resident 4 left for dialysis and then again in the evening around 6:00 PM. LPN 1 stated that the dialysis fistula assessment was completed every day in the morning. No documentation could be located in resident 4's medical record regarding immediate vital signs and the immediate status of his dialysis fistula upon his return from the dialysis center.On 7/23/25 at 9:36 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that nurses were expected to scan and upload the Dialysis Progress Note into the resident's medical record when a resident returned to the facility from dialysis. The DON stated that nurses were expected to manually enter any new orders and weights contained in the Dialysis Progress Note into the resident's medical record. The DON stated she expected a nurse to do an assessment of the resident when they returned to the facility from dialysis and then document the findings of that assessment in a progress note. The DON stated that in addition to assessing the dialysis fistula when the resident returned from the dialysis center, nurses were expected to assess the dialysis fistula every morning.On 7/23/25 at 10:51 AM, a follow-up interview was conducted with the DON. The DON stated that an immediate nursing assessment was important to complete once a resident returned to the facility from dialysis to monitor for potential complications that can arise after completing dialysis treatments. The DON stated that some of these complications included hypotension, hypoxia, and bleeding from the dialysis fistula. The DON stated that a CNA was expected to obtain the resident's vital signs once the resident returned to the facility from dialysis and then communicate the vital signs to the nurse. The DON stated that nurses were expected to contact the dialysis center or the resident's provider if any concerns were identified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review it was determined, for 4 of 26 sampled residents, that the facility did not ensure that all drugs and biologicals were stored and labeled in accordance with accepted professional principles and included the appropriate accessory and cautionary instructions, and the expiration date when applicable. Specifically, an insulin pen and a vial of insulin were not dated with an open date or expiration date. Additionally, medications were found in the sink in the medication room and a medication cart was left unlocked and unattended. Resident identifiers: 2, 21, 24, and 31. Findings included: 1. Resident 21 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, end stage renal disease, displaced fracture of right tibia. A review of resident 21’s medication orders indicated: a. Insulin lispro solution 100 unit/mL (milliliter) Administer 4 units with meals. Start date 7/8/25. b. Insulin lispro solution 100 unit/mL Administer 12 units once a day. Start date 7/8/25. On 7/22/25 at 8:05 AM, an observation was made of resident 21’s opened insulin lispro 100 unit/mL vial. There was no open or expiration date on the vial. On 7/22/25 at 8:12 AM, an observation and interview were conducted with Registered Nurse (RN) 1. RN 1 stated that resident 21’s insulin lispro vial was opened, but there was no information as to when it was opened. RN 1 then wrote 7/22/25 as the opened date and her initials. RN 1 stated that insulin was good for 27 days once opened. 2. Resident 2 was admitted to the facility on [DATE] with diagnoses which included orthopedic aftercare, type 2 diabetes mellitus, and respiratory failure. A review of resident 2’s medication orders indicated: a. Tresiba FlexTouch U-100 insulin pen Administer 14 units at bedtime. Start date 6/30/25. End date 7/7/25. b. Tresiba FlexTouch U-100 insulin pen Administer 18 units at bedtime. Start date 7/8/25. On 7/22/25 at 8:40 AM, an observation was made of resident 2’s Tresiba FlexTouch insulin pen in the medication cart. There was no open date or expiration date documented. On 7/22/25 at 8:43 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that all insulin was kept in the medication fridge in the medication room until they were opened and used and then insulin was placed in the medication carts. LPN 1 stated that he thought insulin was good for a few weeks once opened and possibly even a month. It should be noted that resident 2 was discharged from the facility on 7/10/25. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 24 was admitted to the facility on [DATE] with diagnoses which included gastro-esophageal reflux with esophagitis, cyclical vomiting, and nausea. A review of resident 24’s medication orders revealed sucralfate 1 gm (gram) Administer 1 gm twice daily. On 7/22/25 at 10:02 AM, an observation was made of resident 24’s sucralfate bubble pack in the medication room sink. One tablet remained in the bubble pack. 4. Resident 31 was admitted to the facility on [DATE] with diagnoses which included sepsis, pneumonia, and bacteriemia. A review of resident 31’s medication order revealed Daptomycin 350 mg (milligram) recon (reconstituted) soln (solution) Administer 950 mg intravenous once a day On 7/22/25 at 10:03 AM, an observation was made of resident 31’s daptomycin compounded vials in the medication room sink. On 7/22/25 at 10:04 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that medications should not be stored in the sink in the medication room. The DON stated that the medications in the sink were to be sent back to the pharmacy. The DON stated that on the day the resident was discharged from the facility unused medications will be scanned and placed in a box for the pharmacy to take. The DON stated that the pharmacy came to the facility twice daily. The DON stated that all insulin was in the refrigerator until they were used. The DON stated that all insulin pens and insulin vials should have open dates on them and that insulin was good for 28 days once opened. 5. On 7/22/25 at 1:00 PM, an observation was made of the east hallway medication cart unlocked and unattended. The cart was located outside of room [ROOM NUMBER]. Housekeeping staff were observed nearby in room [ROOM NUMBER] cleaning. On 7/22/25 at 1:04 PM, an observation was made of the Director of Nursing (DON) walking down the hallway and past the unlocked medication cart. The DON did not lock the medication cart. On 7/22/25 at 1:12 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that Registered Nurse (RN) 1 was on lunch and should return in approximately 10 minutes. It should be noted that the unlocked medication cart was the responsibility of RN 1. On 7/22/25 at 1:23 PM, an observation was made of RN 1 returning from lunch, approaching the medication cart, and locking it. An immediate interview was conducted with RN 1. The licensor stated that she observed the medication cart unlocked and RN 1 replied that she noticed that too. RN 1 stated that she left her medication cart keys with LPN 1 when she went on break but she did not know if she had left the cart unlocked. RN 1 stated it probably wasn't him. RN 1 stated that when she stepped away from the medication cart she should lock it and make sure no patient information was visible. On 7/22/25 at 1:53 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the medication cart should be locked when unattended, no medication should be left on the cart, and no resident information should be visible on the cart.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, for 1 of 26 sampled residents, the facility did not have menus that met the nutrition needs of residents in accordance with established nutrition guidelines, and did not follow the menu for a resident with special dietary needs. Specifically, a resident who required a specialized diet was not given adequate substitutions for listed menu items. Resident identifier: 7.Findings included:On 7/21/25 at 12:41 PM, an interview was conducted with resident 7 who stated she was disappointed with her lunch. Resident 7 stated she had recently discontinued receiving tube feedings and was getting used to swallowing again. Resident 7's lunch plate was observed to have spaghetti with small pieces of meat and green peas mixed in. There was a small dish of a pudding-type dessert on the side. Resident 7 noted the menu stated spaghetti, garlic bread and a green salad was being served. There was no substitute for the garlic bread or the salad provided with resident 7's meal.Resident 7's medical record was reviewed between 7/21/25 and 7/23/25.A nutrition screening intake dated 7/3/26 revealed resident 7 was independent with meals and needed set-up assistance only. The screening revealed that resident 7 required soft-bite and pre-cut foods. This screening was approved by the Registered Dietitian (RD) on 7/3/25.On 7/8/25, a Registered Dietitian (RD) progress note revealed that resident 7's feeding tube had been removed after getting tangled up during her sleep. Resident 7 opted not to have it replaced. The RD documented the diet order as, Regular IDDSI [International Dysphagia Diet Standardization Initiative] L7 [level 7] solids, IDDSI L0 [Level 0] thin liquids. Likes: Soft wheat bread, peach, berries, well-cooked veg. [vegetables] tender/soft (MM L5 or SB L6) [Minced and Moist Level 5 or Soft and Bite Sized Level 6]. Severe inflammation. Avoid acidic foods (tomatoes, salsa, citrus, carbonation, chocolate anything, mint) as all gastric irritants. Clarified this in Resident Dining system today. Discussed the need for oral protein supplements to help her regain muscle.A review of the daily menu spreadsheet revealed the minced and moist and the soft and bite sized diet called for 1/2 cup of soft bite sized pieces of spaghetti with thickened meat sauce. The substitutions for the tossed salad with dressing called for 1/2 cup of soft steamed vegetables or mashed. The substitution for garlic French bread was pureed bread. On 7/23/25 at 10:48 AM, an interview was conducted with the Dietary Manager (DM) who stated the RD spoke with residents when they were admitted to assess their dietary needs. The DM stated if there were changes to a resident's diet the RD left a note for the kitchen staff about the diet texture and dietary staff changed the diet in the dietary computer system. The DM stated she tried to substitute food items of equal value into resident 7's meal for the food items her diet order and dietary restrictions did not allow her to eat. The DM stated she would have to go and talk with resident 7 to see what adjustments needed to be made.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, for 8 of 26 sampled residents, the facility did not provide food prepared by methods that conserve flavor and appearance or provide food and drink that was palatable, attractive, and at an appetizing temperature. Specifically, residents complained of food quality, the test tray did not appear appetizing and was not palatable. Findings included: On 7/21/25 at 10:58 AM, an interview was conducted with resident 32 who stated the food was only good some of the time and alternatives were not offered. Resident 32 stated he was not pleased with the meals. On 7/21/25 at 1:17 PM, an interview was conducted with resident 25 who stated she had not been eating much because the food did not taste good. On 7/21/25 at 12:41 PM, an interview was conducted with resident 7 who stated she was disappointed with her lunch meal. Resident 7 received a plate of spaghetti with very small pieces of meat and green peas mixed in. Her meal also included a pudding-like dessert on the side. Resident 7 stated the meal was very unappetizing. On 7/21/25 at 8:56 AM, an interview was conducted with resident 18. Resident 18 stated that he had spoken with the dietitian about the food. Resident 18 stated that he told the dietitian that the food was not good and he did not like the cooked vegetables that would come with the meals. On 7/21/25 at 9:35 AM, an interview was conducted with resident 30. Resident 30 stated that the food was not good. Resident 30 stated that the food did not look good and she didn’t like to eat it. On 7/21/25 at 9:08 AM, an interview was conducted with resident 37. Resident 37 stated that the food was usually awful and she thought that all the food the kitchen prepared was microwaved instead of cooked in an oven. Resident 37 stated that meat was very tough and that shoe leather would be more tender. Resident 37 stated that there was not enough seasoning, including salt and pepper, used when preparing the food. Resident 37 stated that not enough salt and pepper packets were sent on her tray to season the food to her liking. Resident 37 stated that she often ordered meals from food delivery company due to the quality of the facility meals. On 7/21/25 at 9:47 AM, an interview was conducted with resident 15. Resident 15 stated that the food was terrible, and that her toast with breakfast was hard as a rock. Resident 15 stated that she was not served what was listed on the menu and gave an example of the breakfast and lunch meal on Sunday. Resident 15 stated that the menu stated that breakfast was a casserole and she was served French toast, and the lunch menu stated spring vegetables and she was served green beans. Resident 15 stated that the meat always comes out hot, but the vegetables such as potatoes were served cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/25 at 1:35 PM, an interview was conducted with resident 49. Resident 49 stated the food was not good and she was not provided condiments. Resident 49 stated she was provided a salad for lunch with no dressing, oatmeal with no sweetener, no salt pepper on the tray, but had a ketchup packet sent with spaghetti. Resident 49 stated yesterday she was unable to identify the meat that was served and was unable to cut the meat. Resident 49 stated a family member tried to cut it for her also and struggled with cutting it because it was so tough. Resident 49 stated after tasting the meat she was still not sure what it was. On 7/22/25 at 11:55 AM, the tray line was observed in the kitchen. The menu was rosemary pork roast, wild rice pilaf, steamed asparagus, a dinner roll, apple crisp, and resident’s beverage of choice. All residents were dining in their rooms so meals were placed in meal carts and brought to the resident halls. On 7/22/25 at 12:19 PM, a test tray was requested. At 12:21 PM, the last meal cart was sent upstairs. At 12:29 PM, the test tray was received.Food temperatures and descriptions were as follows: a. [NAME] pork roast was 124.9 degrees Fahrenheit, it was observed to be brown in color with gravy. The texture was dry, grainy, and tough to chew with an unpleasant aftertaste. b. Wild rice pilaf was 133.4 degrees Fahrenheit. It was lukewarm to the taste with an unsavory flavor. c. Asparagus was 117.3 degrees Fahrenheit, overcooked with a dull green color. The asparagus was cut like green beans and bland to the taste. d. Apple crisp was 53.1 degrees Fahrenheit. It was on a plate with whipped topping covered with plastic wrap tightly. The dessert was flattened on the plate with the whipped topping smashed into the apple crisp. e. Dinner roll- 70.3 degrees Fahrenheit. On 7/22/25 at 11:28 AM, an interview was conducted with [NAME] 1 who stated the Registered Dietitian (RD) came in at least once per week and completed resident assessments. [NAME] 1 stated the RD did a tray audit to test the food, and the kitchen staff also tested the food to make sure it was good. [NAME] 1 stated they received feedback about food by word of mouth. [NAME] 1 stated meal tickets often would come back to the kitchen, and if residents had written comments on the meal tickets, the kitchen staff would adjust the meal tickets for them. On 7/23/25 at 10:48 AM, an interview was conducted with the Dietary Manager (DM) who stated the RD visited with the residents when they were admitted to the facility to find out what their diet preferences were and if they had any special dietary needs. The DM stated the RD occasionally would prepare a test tray and have a staff member critique it and provide feedback to the kitchen. The DM stated alternate menu items were available for residents that disliked the food on the menu. The DM stated the alternative menu was soups and sandwiches , small salads, and cottage cheese. The DM stated the alternate list was separate from the menu that was in the resident’s room and the Certified Nursing Assistant (CNA) could provide that list to residents who asked.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined, for 1 of 26 residents sampled, that the facility did not ensure that each resident received food that accommodated the resident allergies, intolerances, and preferences. Specifically, a resident had a food preference dislike of pork and received pork products as meal items. Resident identifier: 15.Findings included:Resident 15 was admitted to the facility on [DATE] with diagnoses which consisted of infective endocarditis, atrial fibrillation, chronic kidney disease, cystitis, type 2 diabetes mellitus, bacteremia, hypolipidemia, and hypokalemia.On 7/21/25 at 9:47 AM, an interview was conducted with resident 15. Resident 15 stated that she had a food preference that indicated a dislike of pork and the facility gave her pork products three times last week. Resident 15's medical records were reviewed. On 7/2/25, resident 15's Nutrition Screening Intake Form documented food preference dislikes as pork, ham, and sausage. On 7/22/25 at 8:27 AM, a follow-up interview was conducted with resident 15. Resident 15 stated that she was served sausage on her breakfast tray and she was not supposed to have sausage. The breakfast tray was observed with a cut up sausage patty. Resident 15's dietary meal ticket that was located on the breakfast tray documented the diet order as a Controlled Carbohydrate Diet (CCHO), heart healthy, No Added Salt (NAS), regular with double meat, fish, egg portions. The beverages documented no apple and no lemonade. The dislikes documented on the meal ticket were No Pork Of Any Kind, Nuts, Limits Dairy, Bacon, Ham, Sausage. The resident stated that the meal ticket documented no sausage as a dislike and she still received it. On 7/22/25 at 8:32 AM, an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 reviewed resident 15's breakfast tray and stated that the meat appeared to be cut up sausage. CNA 3 verified with the kitchen that the food item was cut up sausage. On 7/22/25 at 3:31 PM, an interview was conducted with [NAME] 1. [NAME] 1 stated that resident food preferences were assessed within the first 3 days of admission by the dietary manager or the kitchen staff. [NAME] 1 stated that they filled out a form that indicated the resident's dislikes and likes and that information was then placed on the resident's meal tickets. [NAME] 1 reviewed resident 15's food preferences and stated that the dislikes were nuts, broccoli, brussels sprouts, corn, cabbage, peas, cucumbers, fried foods, pasta, pork, spicy and acidic foods, milk and ice cream. [NAME] 1 stated, She is one of the more pickier people. [NAME] 1 stated that the breakfast dislikes were bacon, ham and sausage. Basically pork of any kind. [NAME] 1 stated that breakfast today had waffles, meat of choice, and a seasonal fruit cup. [NAME] 1 stated that if the resident did not like meat or pork they usually served them eggs. [NAME] 1 stated that resident 15 should not be getting pork and they overlooked that.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the walk-in freezer and walk-in refrigerator were open to the air, the stove was not clean, the top of the oven was not clean, meat in the refrigerator was not labeled and a large bucket of pickles did not have an open date.Findings included:On 7/21/25 at 8:40 AM, an initial walk-through of the kitchen was conducted. In the tall, white, reach-in freezer, a bulk box of diced carrots was open to air and a bulk box of peas was open to air. In the tall, silver, reach-in freezer, a box of French toast was open to air and a box of frozen cookie dough was open to air. In the walk-in freezer, a box of sausage links was open to air. The stove was observed to have crumbs, debris and grease on it. On 7/23/24 at 10:26 AM, a second walk-through of the kitchen was conducted. The stove had crumbs, debris and grease on it. The top of the oven was observed to have a white powder on it. The tall, white, reach-in freezer had a bulk box of diced carrots open to air. The tall, silver, reach-in freezer had a box of French toast that was open to air, a box of chocolate chip cookie dough that was open to air, and a box of sugar cookie dough that was open to air. The walk-in freezer had a box of sausage links open to air, and a box of dinner rolls open to air. The walk-in refrigerator had a large container of chicken breasts in water that was covered with plastic wrap but was not dated, a pan with pork roast was covered with plastic wrap but was also not dated. A large 5 gallon bucket of pickles that had been opened did not have an open date on it.On 7/22/25 at 11:28 AM, an interview was conducted with the [NAME] 1 who stated the kitchen received deliveries 1-2 times per week. [NAME] 1 stated food items were dated when they were received and dated when they were opened. [NAME] 1 stated everyone who worked in the kitchen had cleaning duties and the cleaning schedule, in the Dietary Manager's (DM) office, was observed. [NAME] 1 stated the Registered Dietitian (RD) came in at least once per week and completed kitchen audits. On 7/23/25 at 10:48 AM, an interview was conducted with the DM who stated the RD conducted kitchen audits at least monthly. The DM stated food in the refrigerator should be dated even if it was going to be used the same day it was put in the refrigerator. The DM stated food in the freezer should be sealed so it would not become freezer burned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined, for 3 out of 26 sampled residents, that the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, observations were made of staff not donning Personal Protective Equipment (PPE) for residents on Enhanced Barrier Precautions (EBP), staff were observed not performing hand hygiene during dressing changes and cross contamination was observed during a dressing change with improper cleaning of the insertion site. Resident identifiers: 3, 15, and 18.Findings included:1. Resident 15 was admitted to the facility on [DATE] with diagnoses which consisted of infective endocarditis, atrial fibrillation, chronic kidney disease, cystitis, type 2 diabetes mellitus, bacteremia, hypolipidemia, and hypokalemia. Resident 15's medical records were reviewed. On 6/30/25, resident 15's physician ordered Cefazolin reconstituted solution 1 gram intravenous to be administered two times a day. On 7/1/25, resident 15's physician ordered weekly dressing changes to the central line on the right side of the chest. Resident 15's progress notes documented the following: a. On 6/30/25 at 11:32 PM, the note documented, Pt [patient] is on IV [intravenous] cefazolin twice a day for bacterial endocarditis. No ASE [adverse side effects] noted. b. On 7/01/25 at 2:42 PM, the note documented [Resident 15] is a [AGE] year-old female admitted to the skilled nursing facility following hospitalization at [name omitted] Hospital. She initially presented to [hospital name] on 06/13/2025 with generalized weakness. Blood cultures at that time were positive for Methicillin-Sensitive Staphylococcus Aureus (MSSA). The patient was diagnosed with infective endocarditis of the mitral valve. A transesophageal echocardiogram (TEE) performed on 06/19/2025 revealed mobile vegetations attached to both the anterior and posterior leaflets of the mitral valve. The patient is not considered a surgical candidate due to high risk factors. c. On 7/15/25 at 2:20 PM, the note documented, [Resident 15] continues to receive IV cefazolin for treatment of endocarditis. She is receiving this via her central line. She is tolerating well so far and denies any unpleasant side effects. She states she is currently not having any cardiac symptoms such as chest pain, shortness of breath, palpitations, etc. Central line insertion site has no complications noted. Line is flushing well. On 7/21/25 at 8:37 AM, an observation was made of resident 15’s room. The room had a green sign posted outside of the room indicating that Personal Protective Equipment (PPE) was required for the resident. The sign had a check box next to each type of PPE to indicate if gloves, a gown, or a face mask was required. The sign did not have any check marks next to what PPE was required for resident 15. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/25 at 8:43 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that the green PPE signs were for Enhanced Barrier Precautions (EBP) for catheters or wounds. RN 2 stated that if nothing was marked on the sign then no PPE was required for that resident’s care. On 7/22/25 at 9:20 AM, an observation was made of RN 1 during the administration of morning medication for resident 15. RN 1 obtained a elastomeric easy pump which contained Cefazolin 1 gram in 100 milliliter (ml) solution for intravenous infusion. RN 1 performed hand hygiene with alcohol based hand rub (ABHR). RN 1 placed the antibiotic medication ball inside her shirt pocket for transport into resident 15's room. RN 1 performed hand hygiene with ABHR and donned gloves. RN 1 cleaned the port of resident 15's central line with an alcohol pad and then flushed the line with 10 milliliters of normal saline. RN 1 swabbed the port again with an alcohol pad. RN 1 obtained the Cefazolin easy pump from her shirt pocket and attached the IV tubing to the central line port. RN 1 did not don a gown when accessing resident 15's central line. An immediate interview was conducted with RN 1 upon exit of resident 15's room. RN 1 stated that the green sign posted outside resident 15's door was for precautions for anyone with an infection. RN 1 stated that it tells the staff what kind of precautions were needed when providing care for the resident. RN 1 stated that resident 15 did not have anything that would require any additional PPE. RN 1 stated that resident 15 had endocarditis and she did not have any open wounds, foley catheters, or dressing changes of any kind. On 7/22/25 at 1:24 PM, an observation was made of RN 1 during resident 15's central line dressing change. A dressing kit with Chloraprep 3 ml was obtained. RN 1 obtained 2 surgical masks. RN 1 performed hand hygiene with ABHR. RN 1 entered resident 15's room and raised the bed to hip level. RN 1 performed hand hygiene with ABHR and donned gloves. RN 1 donned a mask and gave resident 15 a mask. RN 1 stated that the licensor did not need to wear a mask if they stayed far away. The surveyor responded that she needed to be able to view the dressing change. RN 1 then obtained a surgical mask for the surveyor. RN 1 performed hand hygiene with ABHR and donned new gloves. RN 1 removed the old dressing that covered resident 15's central line. RN 1 doffed her gloves and opened the sterile dressing kit. RN 1 donned the sterile gloves from inside the dressing kit. RN 1 did not perform hand hygiene prior to donning the sterile gloves. RN 1 removed the surgical drape from the package and placed it on top of the opened sterile glove package. RN 1 obtained the Chloraprep sponge applicator and began cleaning the central line insertion site. RN 1 started at the insertion site and worked in an outward circular motion with the Chloraprep sponge. RN 1 lifted the central line tubing and cleaned the tubing leading down to the insertion site and the skin underneath the tubing. RN 1 then went back over the insertion site after moving outward and under the insertion tubing. RN 1 then applied a Tegaderm adhesive dressing over the central line insertion site. RN 1 doffed her mask and gloves. RN 1 labeled the dressing with the date and initials. It should be noted that RN 1 did not don a gown prior to performing the dressing change on resident 15's central line. Upon exiting resident 15's room after the dressing change the green PPE sign posted outside the room now had check marks next to gloves and gown. On 7/22/25 at 1:45 PM, an interview was conducted with RN 1. RN 1 stated that she should have performed hand hygiene prior to donning the sterile gloves. RN 1 stated that she should clean in an outward motion when cleaning the insertion site of the central line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/25 at 1:53 PM, an interview was conducted with the Director of Nursing (DON) and the facility Administrator (Admin). The DON stated that the green signs posted outside of resident rooms were for enhanced barrier precautions (EBP) and were marked upon admission for residents who required it. The DON stated that EBP were to be implemented for residents that had a peripherally inserted central catheter (PICC), chronic wounds, foley catheter, or for those residents at a greater risk for infection. The DON stated that for residents on EBP staff needed to don a gown and gloves when providing care. The DON stated that the nurse should have donned a gown and gloves when administering medication through the central line and when changing the dressing for the central line. The DON confirmed that the proper technique for cleaning the central line insertion site was cleaning from the center outward. The DON stated that the nurse should have performed hand hygiene prior to donning sterile gloves. 2. Resident 3 was admitted to the facility on [DATE] with diagnoses which included acute osteomyelitis, acute kidney failure, and moderate protein-calorie malnutrition. On 7/21/25 at 8:35 AM, an observation was made of resident 3’s room. There was an EBP sign posted outside the door. On 7/21/25 at 8:48 AM, an observation was made of resident 3. Resident 3 had a feeding tube placed in his right nostril. On 7/21/25 at 11:43 AM, an observation was made of therapy staff transferring resident 3 out of his wheelchair and into his bed. No staff were observed to be wearing any personal protective equipment. On 7/21/25 at 11:21 AM, an interview was conducted with resident 3. Resident 3 stated that he had his toes amputated and had to have wound care. Resident 3 stated that he had a feeding tube and would get his tube feedings at night. On 7/22/25 at 10:23 AM, an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated that resident 3 had an infection in his feet and that they were wrapped and that he had a feeding tube. CNA 4 stated that resident 3 was unable to get himself dressed and required staff assistance with showering. CNA 4 stated that staff had to wear a gown and gloves when providing assistance to resident 3. On 7/23/25 at 7:31 AM, an interview was conducted with Physical Therapist (PT) 1. PT 1 stated that if a resident required assistance then staff would need to wear gloves and gown. PT 1 stated that there was a green paper outside of the resident's rooms which was marked with the types of precautions that were needed. PT 1 stated that if the resident required minimal assistance then she would not wear a gown. PT 1 stated that resident 3 only required staff to wear gloves. It should be noted that no orders for EBP for resident 3 could be located. 3. Resident 18 was admitted to the facility on [DATE] with diagnoses which included displaced trimalleolar fracture, chronic respiratory failure, and type 2 diabetes mellitus. On 7/21/25 at 8:35 AM, an observation was made of resident 18’s room. There was an EBP sign outside the door and green paper that had gloves checked. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/25 at 8:56 AM, an interview was conducted with resident 18. Resident 18 stated that he had an indwelling urinary catheter. On 7/21/25 at 10:16 AM, an observation was made of three therapy staff assisting resident 18 with mobility. Resident 18 was observed to be wearing a gait belt and transferring with therapy staff. Therapy staff were observed without any PPE. It should be noted that no physician's orders for resident 18’s EBP could be located. A review of resident 18’s progress nursing notes indicated: a. On 5/28/25 at 12:00 PM, “New order to place indwelling catheter due to urinary retention. Pt [patient] to follow up with urology.” b. On 7/16/25 at 9:02 AM,, “ .Pt has a foley in place that is cleaned daily…” On 7/22/25 at 1:17 PM, an interview was conducted with CNA 4. CNA 4 stated that every resident in the facility had a green or orange sign outside their door which indicated what precautions were required to be worn. CNA 4 stated that resident 18 did not need any PPE because he was finished with the antibiotic medication that he was taking. The facility policy for Enhanced Barrier Precautions (EBP) documented that EBPs were used .as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDRO's) to residents. The policy documented that a gown and gloves were to be used during high contact resident care activities. High contact care activities included: dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); and wound care (any skin opening requiring a dressing). The policy further stated that EBPs were indicated for resident with wounds and/or indwelling medical devices regardless of MDRO colonization. EBP remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. The policy was last revised in August 2022.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Thatcher Brook Rehabilitation & Care Center	1795 South Chelemes Way Clearfieldd, UT 84015

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 26 sampled residents, that the facility did not ensure that the antibiotic stewardship program included antibiotic use protocols and a system to monitor antibiotic use. Specifically, a resident was prescribed an antibiotic prophylactically for the treatment of chronic urinary tract infections (UTI) without any documented evidence that the resident was showing signs and symptoms of a current infection. Resident identifier: 30. Findings included:Resident 30 was admitted to the facility on [DATE] with diagnoses which included neoplasm of right kidney, history of urinary tract infections (UTI), and hypertension. Resident 30's medical records were reviewed. On 6/19/25, resident 30 had a physician order for Macrobid capsule 100 milligram (mg) by mouth daily. The order had special instructions that documented prophylaxis for chronic UTI. The order was discontinued on 6/26/25. On 6/27/25, resident 30 had a physician order for Macrobid capsule 100 milligram (mg) by mouth daily, and the diagnoses documented personal history of urinary tract infections. The order was open ended with no stop date was indicated. Resident 30's June and July 2025 Medication Administration Record (MAR) was reviewed. Resident 30's MAR documented that the Macrobid 100 mg was administered from June 20, 2025 through July 22, 2025. On 6/26/25 at 12:59 PM, the Nurse Practitioner (NP) note documented, Continue Macrobid (nitrofurantoin) 100mg once daily for UTI prophylaxis given history of recurrent UTIs. On 7/1/25 at 11:40 AM, the NP note documented, The patient has a relatively new diagnosis of dementia, which was made by her primary care physician [name omitted] following a UTI that caused acute delirium (hallucinations including seeing bugs on walls). While the delirium resolved with UTI treatment, her memory deficits persisted, prompting the dementia diagnosis. On 7/7/25 at 12:08 PM, the nursing progress note documented, Provider in to see Pt [patient] today with order to dip Urine. If anything found, collect UA [urinalysis] and send out- notify provider. It should be noted that no documentation was found to indicate that a urinalysis was performed and the MAR documented that the urine dip was negative. On 7/21/25 at 10:49 AM, resident 30's progress note documented, She denies any symptoms of a UTI. On 7/22/2025 1:53 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator (Admin). The DON stated that resident 30 was on prophylaxis antibiotic use and was receiving Macrobid for chronic UTIs. The DON stated that they were not supposed to use prophylaxis antibiotic. The DON stated that they stopped the antibiotic and resident 30 had another UTI. It should be noted that resident 30 did not have any documented lapse in the Macrobid treatment since admission. The Admin stated that the NP addressed the use of Macrobid prophylactically by documenting that it was for chronic UTIs. The facility policy for Antibiotic Stewardship documented that the purpose of the policy was to monitor the use of antibiotics in the residents. The policy further documented that training and education would include emphasis on the relationship between antibiotic use and: a. gastrointestinal disorders;b. opportunistic infections (e.g. C. [Clostridium} Difficile, Candida albicans, etc.);c. medication interactions; andd. the evolution of drug-resistant pathogens.The policy documented that when an antibiotic was indicated the prescriber order would include, d. Duration of treatment; (1) Start and stop date; or (2) Number of days of therapy;. The policy was last revised in December 2016.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465169	A. Building B. Wing	07/23/2025

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 5 residents sampled, that the facility did not offer a pneumococcal immunization, unless the immunization was medically contraindicated or the resident had already been immunized. Specifically, the facility did not have evidence to demonstrate that the resident was administered, offered, or declined the second dose of the pneumococcal immunization series. Resident identifier: 29.Findings included:Resident 29 was admitted to the facility on [DATE] with diagnoses which included fracture of the right fibula, congestive heart failure, chronic kidney disease, type 2 diabetes mellitus, presence of prosthetic heart valve, cardiomyopathy, and hypertension. Resident 29's medical records were reviewed. Resident 29's Preventative Health Care documented that resident 29 received the PCV -13 (Prevnar - 13) pneumococcal vaccine on 9/29/15. No documentation of a second pneumococcal vaccine administration or declination was found for resident 29. On 5/1/25, resident 29's Vaccination Consent Form documented UTD (unable to determine) for the Pneumococcal vaccine. On 7/23/25 at 8:42 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the Assistant Director of Nursing (ADON) 2 was in charge of ensuring that the resident's vaccinations were current. The DON stated that the ADON would check the Statewide Immunization Information System for all new admission and then filled out a vaccine form. The DON stated that UTD meant that the vaccine should have been verified and to ensure it was up to date. The DON stated that if a resident reported that they had already received the vaccine they would attempt to determine when and where it was administered. The DON stated that if a resident declined to have the vaccination they would have a declination form in their medical records. The DON stated that if they were unable to determine a resident's vaccination status they should have offered the vaccine or have a declination form on file. The DON stated that resident 29 received the PCV -13 on 9/29/15. The DON stated that resident 29 should have received the PCV-23 vaccination that was next in the pneumococcal series. The DON stated that they did not have documentation that resident 29 was offered or declined the second pneumococcal vaccination. The facility Pneumococcal Vaccine policy documented that upon admission the resident was assessed for eligibility to receive the pneumococcal vaccine series and when indicated were offered the vaccine within thirty days of admission unless medically contraindicated or the resident had already been vaccinated. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccinations. The policy further documented that the vaccines were administered in accordance with the current Centers for Disease Control and Prevention (CDC) recommendations. The policy was last revised in March 2022. The CDC Pneumococcal Vaccine Timing for Adults documented for adults age [AGE] years and older the complete vaccination schedule recommended the PCV-20 or PCV-21 after the initial PCV-13 dose was administered. The vaccination schedule was last updated in March 2025. https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf