STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465187	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Davis Specialty Care	481 South 400 East Bountiful, UT 84010

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the food was not served in a sanitary manner. Findings included: On 12/10/25, during the tray line of lunch service the following was observed:a. At 12:04 PM, the cook was observed to don gloves and was then observed to pick up a packet of papers and flip through them with gloved hands. The cook was then observed to pick up 2 breadsticks with the dirty gloved right hand and then placed the breadsticks on the resident's plate. b. At 12:06 PM, the Dietary Aide (DA) was observed to don gloves and was then observed to touch a kitchen exit door, the door to the food cart, and the aluminum foil box. The DA was then observed to pick up a bowl using the pinching method with her thumb on the outside of the bowl and her pointer and middle finger on the inside of the bowl. The DA was then observed to give the bowl to the cook who filled it with soup and placed it on a resident's lunch tray.c. At 12:07 PM, the cook was observed to walk over and open a cupboard with gloved hands and get a food scoop and return to the tray line. The cook was then observed to scoop chicken from a container and put it on a plate and was then observed to reposition the chicken on the plate with the dirty gloved hands. d. At 12:17 PM, the cook was observed to heat some rice and tomato soup in the microwave. The rice was then retrieved from the microwave and the rim of the bowl was cleaned with a washcloth that was used to wipe the counter. The rice was then taken to the tray line for use. e. At 12:20 PM, The DA was observed to touch the aluminum foil box, the refrigerator door, and the kitchen exit door. The DA was then observed to pick up a bowl using the pinching method and touch the inside of the bowl using the pointer and middle finger of the dirty gloves. The bowl was then filled with food and placed on the residents lunch tray. On 12/10/25 at 12:41 PM, an interview was conducted with the Dietary Manager (DM) who stated the staff were not supposed to touch the inside of the dishes at any time, especially not when they were serving the residents. The DM stated she would educate the staff again. On 12/11/25 at 8:59 AM, a follow up interview was conducted with the DM who stated the staff should not be touching other objects in the kitchen with gloved hands and then touching the food or the inside of the dishes where the food would go. The DM stated that the staff had been educated on this and that she would have an in service tomorrow to educate them again. DM stated the staff were cross trained and educated in all areas of the kitchen so they were able to cover when needed.

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined, for 1 out of 27 sampled residents, the facility failed to ensure that a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Specifically, one resident was observed to have their head of bed lower than 30 degrees when the tube feeding was being administered. Resident identifier: 8. Findings included:Resident 8 was admitted to the facility on [DATE] with diagnoses which included spastic quadriplegic cerebral palsy, acute and chronic respiratory failure, Familial Dysautonomia, epileptic spasms, dysphagia, gastrostomy, and gastro-esophageal reflux. On 12/8/25 at 11:10 AM, an observation was made of resident 8 laying in her crib with her head of the bed elevated to what appeared to be 10 degrees. Her tube feeding was observed to be infusing on a pump at a rate of 72 milliliters/hour (mL/hr). On 12/9/25 at 10:36 AM, an observation was made of resident 8 laying in her crib on her right side with the head of the bed in the flat position. Her tube feeding was observed to be infusing on a pump at a rate of 72 mL/hr. On 12/10/25 at 2:39 PM, an observation of resident 8 and an interview was conducted with Registered Nurse (RN) 1. Resident 8 was observed to be laying in her crib with her bed at a level that appeared to be slightly less than 30 degrees and her tube feeding was infusing on a pump. RN 1 stated that the head of her bed appeared to be a little lower than 30 degrees and proceeded to elevate her head of the bed to 30 degrees. RN 1 stated that her head of bed was at about 25 degrees before he raised it. RN 1 stated the head of the bed should be at least 30 degrees high during, and for 1 hour after, tube feeding to decrease the risk of aspiration. Resident 8's medical record was reviewed from 12/8/25 through 12/11/25. A Care Plan Report initiated on 8/8/24, indicated a Focus of Requires tube feeding r/t [related to] inadequate oral intake due to disease. potential GI [gastrointestinal] discomfort. It indicated a Goal of Will remain free of side effects or complications related to tube feeding through review date. Interventions included, Elevate HOB [head of bed] at least 30-45 degrees at all times during feeding. A Quarterly Minimum Data Set assessment dated [DATE], documented that resident 8 had a feeding tube and received an average fluid intake per day by tube feeding of 501 cubic centimeters/day or more. A physician's order dated 4/25/25, indicated, Enteral Feed every shift Pediasure Reduce Calorie 335mL @ [at] 72mL/hr. A Treatment Administration Record dated 12/1/2025 through 12/31/2025, indicated, Enteral Feed Order every shift Head of bed elevated 1/2 [half] hour before and after feedings every shift. On 12/10/25 at 2:46 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated residents needed to have their head of bed elevated to 30 degrees during tube feedings, even if she was laying on her side. On 12/11/25 at 11:41 AM, an interview was conducted with the Director of Nursing (DON). The DON stated it was a standard of care for the head of the bed to be at 30 degrees when tube feeding was being infused. The DON stated resident 8 should have had her head elevated to 30 degrees to prevent aspiration.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, it was determined for 1 out 27 sampled residents, the facility failed to ensure that in the resident's clinical record laboratory (lab) reports that were dated and contain the name and address of the testing laboratory. Specifically, one resident was missing lab reports in their medical record. Resident Identifier: 25 Findings Included: Resident 25 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia.Review of resident 25's medical record was completed on 12/8/25 through 12/11/25.On 4/17/25, a physician's order for Basic Metabolic Panel (BMP) one time only for pulmonary was marked completed.It should be noted that the lab result for the BMP on 4/17/25, was unable to be located in the medical record.On 4/17/25, a physician's order for Arterial Blood Gas (ABG) one time only for Carbon Dioxide. An ABG to be obtained for Pulmonologist to be cleared for surgery, was marked completed.It should be noted that the lab result for the ABG on 4/17/25, was unable to be located in the medical record.On 5/6/25, a physician's order for Vitamin D one time every 12 month(s) starting on the 6th for 1 day for Vitamin D Deficiency, was marked completed.It should be noted that the Vitamin D lab result for 5/6/25, was unable to be located in the medical record.On 12/11/25 at 9:13 am, an interview with the Unit Secretary (US) was conducted. The US stated that the lab would fax the results to the facility. The US stated that the Assistant Director of Nursing would review the results and inform the physician. The US stated that once the physician had reviewed the results the fax would go to medical records. The US stated that medical records would upload the lab results to the resident's medical record.On 12/11/25 at 10:21 am, an interview with the Executive Assistance (EA) was conducted. The EA stated that lab results would come via fax to the facility and the charge nurse and doctor would review the results and place them in the medical records folder, which was located at the nurses' station. The EA stated that medical records would pick up the documents, scan the documents, and upload them to the resident's medical record. The EA stated the process from the received fax results to the results being uploaded to the resident's medical record should be less than a week. The EA stated that each floor had a lab binder which tracked which labs had been completed and which were pending results. The EA stated that it was the facility's system to ensure all the ordered labs had been completed and results had been received.On 12/11/25 at 11:16 am, an interview was conducted with the Medical Records Lead (MRL). The MRL stated every morning the medical records were collected from the nurses' stations at which time they were sorted by name and the date of services. The MRL stated before the scan was uploaded to the resident's medical record it was verified that the name on the document matched the name on the file. The MRL stated that getting documents uploaded to the resident's medical record was done very quickly, from order to resident's medical record was usually less than a week. The MRL stated that around April 2025, they had a temporary remote person that was helping. The MRL stated that he should have been checking their work, but he did not do that.On 12/11/25 at 11:40 am, a follow-up interview was conducted with the ES. The ES stated that the Regional Nurse Consultant located the ABG lab results in the respiratory therapy area located in an adjacent building. The ES stated that they were contacting the laboratory for the BMP and Vitamin D lab results. The ES confirmed that the three lab results were not in resident 25?s medical record.On 12/11/25 at 11:47 am, an interview was conducted with the Director of Nursing (DON). The DON stated that a lab log was located at the nurses' station. The DON stated that when a lab was collected it was marked on the log, to ensure it had been collected and results received. The DON stated the lab results were faxed to the facility and reviewed. The DON stated that the doctor was informed of the lab results and the fax was placed in the doctor's folder for their review. The DON stated once the doctor had reviewed the faxed lab results it was placed in the medical records folder. The DON stated that medical records collected the documents, they were then scanned and placed in the resident's medical record. The DON stated that a fax or medical record from April or May of 2025 should be in the resident's medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, it was determined for 2 out 27 sampled residents, the facility failed to ensure that each resident's medical record was accurately documented and maintained. Specifically, a resident's medical document was located in another resident's medical record. Resident Identifier: 25 and 64.Findings Included: A review of resident 25's medical record was conducted. During the review it had revealed that resident 64's urinalysis with culture and sensitivity with a date of service of 4/15/25, was located in resident 25's medical record.On 12/11/25 at 11:16 am, an interview was conducted with the Medical Records Lead (MRL). The MRL stated every morning the medical records were collected from the nurses' stations at which time they were sorted by name and the date of services. The MRL stated before the scan was uploaded to the resident's medical record it was verified that the name on the document matched the name on the file. The MRL stated that around April 2025, they had a temporary remote person that was helping. The MRL stated that he should have been checking their work, but he did not do that.On 12/11/25 at 11:47 am, an interview was conducted with the Director of Nursing (DON). The DON stated that she expected that only the resident's lab results were in their medical record and not in another resident's medical record.