STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A072	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garfield County Nursing Home	200 North 450 East Panguitch, UT 84759

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 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** 3. Resident 5 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, depression and insomnia disorder. Resident 5's medical record was reviewed. A physician's order dated 1/29/19, documented sertraline (Zoloft) 25 mg. Administer 12.5 mg daily for a diagnosis of depression. A physician's order dated 1/29/19, documented zolpidem (Ambien) 5 mg daily at bedtime for a diagnosis of insomnia. A physician's order dated 2/14/20, documented diphenhydramine (Banophen) 25 mg daily at bedtime for a diagnosis of allergies and insomnia. A physician documented clinical contraindication was unable to be located and the medications had not received the appropriate GDR. 4. Resident 14 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, anxiety. Resident 14's medical record was reviewed. A physician's order dated 3/22/23, documented quetiapine (Seroquel) 25 mg daily for a diagnosis of agitation. A physician's order dated 3/22/23, documented quetiapine 50 mg daily at bedtime for a diagnosis of agitation. A physician's order dated 3/22/23, documented mirtazapine (Remeron) 30 mg daily at bedtime for a diagnosis of insomnia. A physician's order dated 11/17/23, documented lorazepam 1 mg twice daily (BID) for a diagnosis of anxiety. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 7/16/24, documented lorazepam 0.5 mg BID for a diagnosis of anxiety. It should be noted the dosage was initially prescribed on 11/17/23. On 6/17/25 at 11:00 AM, a LTC Psychotropic Medication Review note documented no GDR on medications and stable on all medications. It should be noted that all of resident 14's LTC Psychotropic Medication Review notes documented no GDR on medications and stable on all medications. A physician documented clinical contraindication was unable to be located and the medications had not received the appropriate GDR. The antipsychotic medication Seroquel did not have the appropriate indication for use. On 6/24/25 at 10:35 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident behaviors were addressed in the Interdisciplinary Team meeting. The DON stated If staff were doing rounds they could add a note for agitation. The DON stated that under caregiver rounding the staff would document behaviors. The DON stated she did not know how GDRs were done because she was not involved with them at all. The DON stated the pharmacist was involved in the psychotropic meetings. On 6/24/25 at 10:56 AM, an interview was conducted with the Nurse Administrator. The Nurse Administrator stated that when the physicians did their resident rounds they would put the GDR in their summary and the pharmacist would address the medications monthly. On 6/24/25 at 11:36 AM, a follow up interview was conducted with the Nurse Administrator. The Nurse Administrator verified the staff would use a progress note and what ever the physician documented on their rounds to determine GDRs. Based on interview and record review, the facility did not ensure that residents who use psychotropic drugs received a gradual dose reduction (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Specifically, for 4 out of 12 sampled residents, residents did not have an attempted GDR for psychotropic medications. Additionally, residents were given an antipsychotic medication without an appropriate diagnosis. Resident identifiers: 5, 7,14, and 15. Findings included: 1. Resident 7 was admitted to the facility on [DATE] with diagnoses which included depression. Resident 7's medical record was reviewed on 6/22/25 through 6/25/25. A physician's order dated 4/17/24, documented fluoxetine 20 milligram (mg) daily for depression. A physician documented clinical contraindication was unable to be located and the medication had not received a GDR. 2. Resident 15 was admitted to the facility on [DATE] with diagnoses which included dementia and insomnia. Resident 15's medical record was reviewed on 6/22/25 through 6/25/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 7/29/24, documented Seroquel 25 mg at bedtime for insomnia/agitation. On 6/5/25 at 8:23 AM, a Long Term Care (LTC) Psychotropic Medication Review note documented no GDR on Seroquel and that the resident was stable on the medication. It should be noted that all of resident 15's LTC Psychotropic Medication Review notes documented no GDR on medication and stable on medication. A physician documented clinical contraindication was unable to be located and the medication had not received the appropriate GDR. The antipsychotic medication Seroquel was administered without the appropriate indication for use.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure an assessment accurately reflected the resident's status. Specifically, for 3 out of 12 sampled residents, residents were coded as taking antipsychotic medications when they were not taking them. Resident identifiers: 1, 8, and 12. Findings included: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses which included, traumatic brain injury and depression. Resident 1's medical record was reviewed on 6/22/25 through 6/25/25. On 5/16/25, a quarterly Minimum Data Set (MDS) assessment documented that resident 1 was taking an antipsychotic medication. On 5/14/25 at 9:24 AM, a Long Term Care (LTC) Psychotropic Medication Review documented resident 1 was taking: a. nortriptyline 30 milligrams (mg) at bedtime with a diagnosis of depression. b. Effexor 37.5 mg twice daily with a diagnosis of depression. It should be noted that these medications were not classified as antipsychotic medications. 2. Resident 8 was admitted to the facility on [DATE] with diagnoses which included, dementia and depression. Resident 8's medical record was reviewed on 6/22/25 through 6/25/25. On 5/1/25, an annual MDS assessment documented that resident 8 was taking an antipsychotic medication. On 4/22/25 at 9:49 AM, a LTC Psychotropic Medication Review documented resident 8 was taking Zoloft 50 mg daily with a diagnosis of depression. It should be noted that this medication was not classified as an antipsychotic medication. 3. Resident 12 was admitted to the facility on [DATE] with diagnoses which included, depression and anxiety. Resident 12's medical record was reviewed on 6/22/25 through 6/25/25. On 4/16/25, a quarterly MDS assessment documented that resident 12 was taking an antipsychotic medication. On 4/2/25 at 10:09 AM, a LTC Psychotropic Medication Review documented resident 12 was taking: (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Welbutrin 150 mg once daily for anxiety and depression. b. Celexa 20 mg once daily for anxiety and depression. c. clonazepam 0.25 mg three times daily for anxiety. d. Remeron 15 mg at bedtime for insomnia. It should be noted that these medications were not classified as antipsychotic medications. On 6/24/25 at 9:21 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that the pharmacist performed the psychotropic medication reviews for the residents. The MDS Coordinator stated that residents 1, 8, and 12 were not taking an actual antipsychotic medication. The MDS Coordinator stated that she reviewed this with the pharmacist and was informed that she should mark on the MDS assessment that the residents were taking antipsychotic's. On 6/24/25 at 10:47 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she believed that the medications that residents 1, 8, and 12 were taking were antipsychotic's. The DON stated that she did not know why the MDS assessment was marked that the residents were taking an antipsychotic when they were not.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, there was undated food in the refrigerator and freezer, kitchen staff were observed to not be wearing hairnets and beard coverings, and the sanitizer bucket was not testing at the required sanitation levels.Findings included:On 6/22/25 at 12:07 PM, an initial tour of the kitchen was conducted. The following observations were made:a. An open energy drink was out on the food prep table.b. Three bags of bread slices were unlabeled and undated in the refrigerator. c. Two slices of cheese and ham were in a bag that was undated and unlabeled in the refrigerator.d. Turkey breast was in a bag and was not dated in there refrigerator.e. Hotdog's were opened in a bag and were not labeled or dated in the refrigerator.f. A plastic bag that was undated and unlabeled with turkey and swiss cheese in the refrigerator.g. An opened bag of sausage patties and links were undated in the refrigerator.h. A bag of roast beef and cheese were undated and had a strong smell to them in the refrigerator.i. Five bags of frozen soup were unlabeled and undated in the refrigerator.j. Cheesecake bites with a use by date of 6/19/25, were in the freezer.k. Three boxes of cheesecake were undated and opened in the freezer.l. Four loaves of bread were unlabeled and undated in the freezer.m. Three pie crusts were open to air, unlabeled, and undated in the freezer.n. A package of omelets were undated in the freezer.o. A bin was filled with roasted pan sauce with a date of 11/22/24, in the freezer.On 6/22/25 at 12:37 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that the sanitary buckets were changed every two hours or as needed. It was observed that the DM was not wearing a hairnet. On 6/22/25 at 12:40 PM, an observation was made of the cook cleaning the counter top prep area and placing a rag in the sanitary bucket.On 6/22/25 at 12:43 PM, an observation was made of the cook testing the sanitary bucket. The sanitary bucket strip turned orange. The cook stated that the level was 100 parts per million (PPM) and should be between 200-400 PPM. On 6/22/25 at 2:08 PM, a concurrent observation and interview were conducted with the cook. The cook was observed to have a beard and was not wearing a beard covering. The cook stated that all things in the fridge should have dates on them. The cook stated that he was unsure of the opened date of the cheesecake in the freezer. The cook stated that items in the freezer are good for six months to one year. The cook stated that the bread in the freezer should have been dated. The cook stated that there should at least be a received on date for items in the freezer. The cook stated that staff should be wearing hair nets even if they have a shaved head. The cook stated that he was not sure at what length a beard needed to be to have it covered. The cook stated that the food in the plastic bag inside the refrigerator was food that the dietary manager was going to give to his dog. The cook stated that opened drinks should not be in the prep area and he was in a rush and forgot and left it there. On 6/24/25 at 7:36 AM, a follow up tour of the kitchen was conducted. The following was observed:a. An opened half loaf of bread was undated in the freezer.b. Three coconut cream pies were undated in the freezer.c. Two cheesecakes were undated in the freezer.d. Three pie shells were open to air and undated in the freezer.e. Omelets were undated in the freezer.On 6/24/25 at 7:53 AM, a concurrent observation and interview were conducted with the DM. It was observed that the DM was not wearing a hairnet or head cover. The DM stated that foods were okay to be stored on the freezer for six months. The DM stated that frozen foods should be dated when they were received and that the items in the freezer should be dated. The DM stated that he took the outdated items in the refrigerator to his dog. The DM stated that staff should be wearing a hairnet or hat while they were in the kitchen and beard nets need to be worn. The DM stated that he did not require a hairnet because he was almost bald.

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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 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, 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, for 3 out of 12 sampled residents, Enhanced Barrier Precautions (EBP) were not implemented for residents with wounds and indwelling urinary catheters. Resident identifiers: 2, 9, and 10.Findings included:1. Resident 2 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, urinary tract infection.On 6/22/25 at 1:29 PM, an interview was conducted with resident 2. Resident 2 was observed to have a down drain urinary catheter bag. Resident 2 stated the staff would wear gloves when they emptied or changed the catheter bag but the staff have never worn gowns.Resident 2's medical record was reviewed.A care plan problem initiated on 4/10/25, documented Long Term Care Urinary Incontinence Indwelling Catheter.On 4/1/25 at 12:42 PM, a History and Physical Note documented . suprapubic catheter Catheter protocols will be in place. Change once monthly.Resident 2's room was observed without EBP signage.On 6/24/25 at 10:29 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 2 was admitted with the supra pubic catheter and resident 2 has had the catheter for awhile.2. Resident 10 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, cerebral palsy.Resident 10's medical record was reviewed.On 6/17/25 at 10:26 AM, a Wound Clinic Office Note documented Patient presenting for reevaluation of stage III coccyx ulceration. Patient was last seen in the wound clinic on 4/22/25, where the wound appeared epithelialized. Wound has reopened with drainage. Facility staff report continued offloading and repositioning. Wound has been covered with an Allevyn to help manage moisture and drainage. Skin: Exposed skin normal with no rashes, stage 3 ulceration of the coccyx with slough and serous drainage. Slight maceration to periwound. Blanchable erythema to bilateral buttocks. Measurements 0.7 x 0.4 cm [centimeters].Resident 10's room was observed without EBP signage. 3. Resident 9 was admitted to the facility on [DATE] with diagnoses of recurrent urinary tract infection (UTI), and cognitive deficits.On 2/14/25 at 5:17 PM, a nursing narrative note documented, .Pt. [patient] has a super [sic] pubic catheter present on admission.On 6/22/25 at 1:10 PM, an observation was made of resident's 9 room. There was no signage indicating that resident 9 required EBP.On 6/23/25 at 7:42 AM, an interview was conducted with resident 9. Resident 9 stated that she had a suprapubic urinary catheter. On 6/25/25 at 9:35 AM, an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that resident 9 came to the facility with a supra pubic catheter in place. The MDS Coordinator stated that resident 9 had a UTI on 4/14/25. On 6/24/25 at 9:41 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that she would wear a gown when emptying resident 9's catheter. CNA 1 stated that if she was getting resident 9 dressed or changing her brief that she would just wear gloves. On 6/24/25 at 11:55 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated that EBP was for any resident that had a urinary catheter or open wounds. The IP stated that staff should know which residents were on EBP even if EBP signage was not on the door. The IP stated that signage should be up for those residents that required EBP.