| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465109 | A. Building<br>B. Wing | 03/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Holladay Healthcare Center | 4782 South Holladay Boulevard<br>Salt Lake City, UT 84117 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was found that the facility failed to ensure that a resident received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically, 1 of 37 sampled residents, did not have an intervention for podus boots implemented to prevent pressure ulcers. Resident identifier: 37.<br><br>Findings include:<br><br>Resident 37 was admitted to the facility on [DATE] with diagnoses which included dementia with anxiety, weakness, constipation, and urinary tract infection.<br><br>Review of resident 37's records was completed on 3/17/25 through 3/24/25.<br><br>A quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 37 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognition was intact.<br><br>A nursing note dated 2/1/25 at 3:09 PM revealed that certified nursing assistant (CNA) let this nurse know that redness was found on the left lateral malleolus. Nurse identified this was blanchable redness. Nurse practitioner (NP) notified and podus boots applied as preventative measure.<br><br>A physician's order dated 2/1/25 stated podus boots in place as preventive measure for pressure injury to left lateral ankle. The boots were to be applied every shift for preventative to pressure injury.<br><br>Resident 37's face sheet revealed under Special Instructions: Skin breakdown prevention: Apply moisturizing lotion to BUE [bilateral upper extremities] qd [every day], Offer/encourage long sleeves or geri-sleeves to BUE as a preventative measure for skin breakdown One-person physical assistance with all transfers; podus boots<br><br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465109 | A. Building<br>B. Wing | 03/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Holladay Healthcare Center | 4782 South Holladay Boulevard<br>Salt Lake City, UT 84117 |

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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 37's had a care plan initiated on 8/2/24 that revealed resident 37 had a potential risk for pressure ulcer development related to non-ST-segment elevation myocardial infarction (NSTEMI), asthma, elevated troponin, arrhythmia, high blood pressure (HTN), impaired mobility, obesity, possible lung cancer (CA), weakness, preference to not have Low Air Loss (LAL) mattress in place following education on risks associated with preference. The goal was that resident 37 would have intact skin, free of redness, blisters or discoloration by/through review date of 5/18/25. The interventions developed were that resident 37 would notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care, created on 8/2/24 and podus boots as ordered, created on 2/3/25.<br><br>An observation was made on 3/17/25 at 3:06 PM, that resident 37's left lateral ankle was red.<br><br>Observations were made on 3/17/25 at 3:06 PM, 3/20/25 at 10:25 AM, and 3/20/25 at 1:59 PM, of resident 37 in bed and podus boot was not applied to left foot. Podus boot was located in the corner against the wall of resident 37's room.<br><br>A review of the Treatment Administration Record (TAR) revealed that resident 37 had podus boot in place on 3/17/25 and 3/20/25.<br><br>On 3/17/25 at 3:06 PM, an interview with resident 37 was conducted. Resident 37 stated she had a boot that she needed to have on her left foot since she had a sore spot on her left ankle. Resident 37 stated that she felt like she was getting a wound and they were not doing anything about it.<br><br>On 3/20/25 at 2:19 PM, an interview was conducted with the staff development (SD). The SD stated the way Certified Nursing Assistants (CNA) were made aware when residents were to have podus boots placed was that the nurses told CNAs during report or there was also an alert on the resident's chart under Special Instruction. The SD stated that the special instructions were located on the face sheet of the resident's electronic medical record.<br><br>On 3/20/25 at 2:58 PM, an interview with Licensed Practical Nurse (LPN) 1 was conducted. LPN 1 stated that she informed the CNAs at the beginning of the shift on which residents had orders for podus boots or who needed their heels floated. LPN 1 stated the CNAs came and told her when the podus boots had been applied she went to the resident and verified that the resident had podus boots. LPN 1 stated she then marked off the task or order for the shift on the TAR.<br><br>On 3/20/25 at 3:04 PM, an interview with Assistant Director of Nursing (ADON) 1 was conducted. ADON 1 stated that podus boots were ordered by the physician and were in the orders. ADON 1 stated that orders for podus boots were located on the care sheet or treatment record and also as an alert on the resident's face sheet. ADON 1 stated there were special instructions located on the residents' face sheet when the chart was opened, important treatments were placed there to alert staff. ADON 1 stated that he would expect the nurse to check and verify the boots were on the resident due to it being a physician's order, and it needed to be followed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465109 | A. Building<br>B. Wing | 03/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Holladay Healthcare Center | 4782 South Holladay Boulevard<br>Salt Lake City, UT 84117 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>Based on observation, interview and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents and had an environment that was as free from accident hazards as was possible. Specifically, tools were left in the bathroom of a cognitively impaired resident. In addition, a staff member was observed to carry oxygen tanks down the hallway that were unsecured. Resident identifier: 47.<br><br>Findings include:<br><br>1. Resident 47 was admitted to the facility on [DATE] with diagnoses which included dementia with behavioral disturbance, anxiety disorder, major depressive disorder and cognitive communication deficit.<br><br>Resident 47's medical record was reviewed 3/17/25 through 3/24/25.<br><br>On 3/20/25 at 2:36 PM, a phone interview was conducted with resident 47's family member. The family member stated resident 47's bathroom was out of use for 4 days. The family member stated the bathroom had tools, feces and the toilet was not secured to the floor. The family member stated resident 47 had dementia and it was not safe to have tools and an unsecured toilet available to her.<br><br>A quarterly Minimum Data Set (MDS) dated [DATE] documented resident 47 had a BIMS (Brief Interview of Mental Status) score of 7, a score between 0-7 indicated severe cognitive impairment. And that resident 47 required a one person physical assist with transfers and toilet use.<br><br>A nurses note dated 2/4/25 documented, Spoke with daughter to address concerns, on [resident 47's] noted decline including refusal of medications at times, refusal of food/fluids at times, aggression with cares/showers and cognitive decline.<br><br>On 3/20/25 at 2:17 PM, an interview was conducted with the Maintenance Director (MD). The MD stated if something needed to be fixed it was put in the tells program which alerted him 24/7. The MD stated there have been several cases when the main sewer line was clogged. The MD stated resident 47's toilet was clogged and he tried to unclog it but had to call a plumber. The MD stated there were several briefs and wipes that had clogged the line. The MD stated he had removed towels, pull ups and wipes from resident 47's toilet. The MD stated resident 47 had to use another bathroom until it was cleared. The MD stated he possibly left tools in the bathroom.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465109 | A. Building<br>B. Wing | 03/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Holladay Healthcare Center | 4782 South Holladay Boulevard<br>Salt Lake City, UT 84117 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/20/25 at 2:48 PM, an interview was conducted with Assistant Director of Nursing (ADON) 1 who stated resident 47 was a 1 person assist in terms of Activities of Daily Living (ADLs), she would walk for hours and hours and was not redirectable. ADON 1 stated she would wander all the time even with medical intervention and she would flush everything down the toilet. ADON 1 stated he doubted that there was feces on the bathroom floor but there may have been tools on the floor. ADON 1 stated he was called by the family about the issue. When he came in he blocked off the bathroom door with caution tape. ADON 1 stated the incident happened on either Friday night or Saturday morning and the residents were moved to another room on Sunday or Monday. ADON 1 stated the residents would use the shower room when they needed a toilet.<br><br>On 3/20/25 at 3:27 PM, an interview was conducted with the Resident Advocate (RA) who stated resident 47 was really confused and wandered into rooms and she was placed on a one to one for the last few weeks she was in the facility.<br><br>A follow up interview was conducted with the RA on 3/24/25 at 9:49 AM. The RA stated that she was not in the facility when it happened, the daughter called her. The RA stated there was a flood from resident 47's room and it drained into the Director of Nursing's (DON's) office. The RA stated maintenance was fixing the toilet and they left the hole where the toilet used to be open in the floor and tools were left on the floor of the bathroom. The RA stated that You can not do that with a dementia patient. The RA stated there was no way to lock the bathroom door and the residents should have been moved to another room. The RA stated that she did not know if resident 47 went in to the bathroom but she would be physically able to do that and it would not be safe. The RA stated the resident's daughter had sent her a picture that showed tools and the toilet on the floor. The RA stated she could not remember if there was any dirt or feces in the bathroom.<br><br>On 3/24/25 at 10:13 AM, an interview was conducted with the DON and ADON 1. The DON stated resident 47 had gotten to a point where her behaviors were exacerbated. The DON stated that they put measures in place for her safety but she progressively got worse over time, she was very impulsive. The DON stated that resident 47's toilet was being repaired, the toilet was taken out over the weekend and replaced on Monday. The DON stated resident 47 stayed in the room over the weekend and the staff were taking her to the shower room to use the restroom. ADON 1 stated he believed there was not a toilet in the room and was unsure if there were any tools on the floor. ADON 1 stated he taped off the room when he came in over the weekend.<br><br>On 3/24/25 at 10:23 AM, a follow up interview was conducted with a MD who stated that they did leave the toilet in the room and maybe the snake was left in there. The MD stated the resident would have been able to get into the bathroom while the toilet and tools were in there. The MD stated he had told the staff to put a bedside commode in bathroom if the resident needed to use it but to take her to the shower room if possible.<br><br>On 3/24/25 at 11:03 AM, an interview was conducted with CNA 3 who stated that resident 47 wandered and was a full assist with cares. CNA 3 stated resident 47 was eventually put on a one on one supervision to keep her safe. CNA 3 stated she was not part of the toilet incident. CNA 3 stated residents 47 should be taken to the shower room if their bathroom was not working.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465109 | A. Building<br>B. Wing | 03/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Holladay Healthcare Center | 4782 South Holladay Boulevard<br>Salt Lake City, UT 84117 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 3/24/25 at 11:06 AM, an interview was conducted with Licensed Practical Nurse (LPN) 3 who stated resident 47 had extreme anxiety that they tried to manage with medications but that did not work. LPN 3 stated the staff took the residents to the shower room if their bathroom was not working. LPN 3 stated it would have been unsafe for tools to be left within reach of resident 47.<br><br>On 3/24/25 at 11:10 AM, an interview was conducted with CNA 4 who stated near the end of resident 47's stay, her dementia worsened. CNA 4 stated prior to this resident 47 was confused but manageable with redirection. CNA 4 stated she was not aware of resident's toilet not working and stated it would have been dangerous for tools to be left in reach of resident 47 since she was so impulsive.<br><br>On 3/24/25 at 11:13 AM, an interview was conducted with the CNA Team Lead (CNATL) who stated they would take resident 47 to the shower room while her bathroom was being fixed. CNATL stated, To be honest, yes. The toilet was lying on the floor, there was an open hole in the floor and there were random tools on the floor in the bathroom. The CNATL stated that resident 47 would not have been safe to go in there with tools and the toilet lying on the ground.<br><br>2. On 3/17/25 at 12:16 PM, an observation was made of Registered Nurse (RN) 1. RN 1 was observed to carry an oxygen tank from room [ROOM NUMBER] through the hallway to a closet by the nurses station. RN 1 was observed to get an oxygen tank from the closet and walked back through the hallway to room [ROOM NUMBER].<br><br>On 3/18/25 at 3:16 PM, an interview was conducted with Clinical Resource Nurse (CRN) 1 and ADON 1. CRN 1 and ADON 1 stated oxygen needed to be in a dolly and not carried in staffs arms. CRN 1 stated the concern would be dropping the oxygen tank when it was being carried. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465109 | A. Building<br>B. Wing | 03/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Holladay Healthcare Center | 4782 South Holladay Boulevard<br>Salt Lake City, UT 84117 |

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 0728<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training.<br><br>Based on interview and record review, the facility did not ensure that any individual working in the facility as a nurse aide for more that 4 months, on a full-time basis, was competent to provide nursing and nursing related services; and completed a training and competency program, or a competency evaluation program approved by the State. Specifically, a Nurse Aide (NA) was employed at the facility on a full-time basis, for approximately 8 months with out completion of training and competency evaluation program.<br><br>Findings include:<br><br>On 3/20/25, staff member (SM) 1's employee record was reviewed.<br><br>SM 1 was hired on 2/9/24 as a NA.<br><br>The Nursing Assistant registry revealed a NA certification was issues on 10/8/24.<br><br>On 3/24/25 at 11:55 AM, an interview was conducted with Regional Nurse Consultant (RNC) 1. RNC 1 stated that she did not know why SM 1 was employed longer than 4 months without certification. RNC 1 stated there may have been some confusion with the staffing waiver. |