STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465108	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Ridge Health Care	3706 West 9000 South West Jordan, UT 84088

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for 1 out of 43 sampled residents, the facility did not ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Specifically, a resident did not have a physician order for their use of oxygen. Resident identifier: 29.Findings included:Resident 29 was admitted to the facility on [DATE] with diagnoses which included acute pyelonephritis, pneumonia due to other specified infectious organisms, and acute kidney failure.On 9/7/25 at 10:39 AM, an observation was made of resident 29, she was wearing a nasal cannula, and an operating oxygen concentrator set at 5 liters (L) was next to resident 29's bed.On 9/9/25 at 11:50 AM, an observation was made of resident 29, she was returning to the facility, she had on a nasal cannula with a portable oxygen tank set at 4 L. On 9/10/25 at 10:04 AM, an observation was made of resident 29, she was resting in bed wearing a nasal cannula, the oxygen concentrator was placed in the bathroom and was set at 4 L.Review of resident 29's medical record was completed on 9/7/25 through 9/10/25.Resident 29's oxygen saturation record revealed she received oxygen via nasal cannula since admission.Resident 29's physician orders were reviewed. There were no physician orders for use of oxygen found.On 9/10/25 at 8:28 AM, an interview with Registered Nurse (RN) 1 was conducted. RN 1 stated that during the admission process, he would get a nurse-to-nurse report from the discharging facility letting them know if a resident was on oxygen. RN 1 stated that oxygen should be listed on the admission orders. RN 1 stated that if a resident was admitted with oxygen and oxygen was not listed in the previous facility's discharge orders, the nurse would need to call the in-house physician and get an order for oxygen. RN 1 stated that oxygen always needed a physician's order.On 9/10/25 at 8:56 AM, an interview with RN 2 was conducted. RN 2 stated that during the nursing report was when he would learn if a resident was on oxygen. RN 2 stated that there should always be an order for oxygen. RN 2 stated that admitting orders were usually entered before the resident was admitted to the floor. RN 2 stated that if he noticed there was not an order for oxygen he would search for a written order, if the order was not verified, he would contact the physician and get an order in place for oxygen.On 9/10/25 at 10:28 AM, an interview was conducted with the Director Of Nursing (DON). The DON stated that she expected that when a resident was on oxygen, the resident would have a physician's order in place for oxygen. The DON stated if there was not a physician's order, she expected the nursing staff to contact the physician with regards to the resident's oxygen and obtain an order for the use of oxygen.

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 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, for 1 out of 43 sampled residents, the facility did not file in the resident's clinical record laboratory reports that were dated and contained the name and address of the testing laboratory. Resident identifier: 89Findings Included: Resident 89 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, spastic hemiplegia, immobility syndrome (paraplegic), and metabolic encephalopathy. Resident 89's medical record was reviewed on 9/7/25 through 9/10/25. A review of resident 89's progress notes revealed:On 6/24/25 at 5:35 PM, a nursing note documented, Resident was seen provider [sic] today, order received to get KUB [kidney, ureter, bladder x-ray] and UA [urinalysis]. Sample sent to lab and KUB performed, Results were related to provider.On 6/25/25 at 12:40 PM, a laboratory/radiology note documented, 6/23/24 [sic] UA [urinalysis] results back, provider notified. Set up for culture.On 6/28/25 at 7:34 AM, a nursing note documented, UA results w/ [with] culture received. MD [medical doctor] notified. ABX [antibiotics] started.A urine culture laboratory report was unable to be located in resident 89's medical record.On 9/9/25 at 9:47 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that all records were uploaded by the medical records staff into the chart. The DON stated lab results should be in a resident's medical record. On 9/9/25 at 2:34 PM, an interview was conducted with the Health Information Manager (HIM). The HIM stated that labs were uploaded to the medical record in a timely manner and no more than one week after she received them. The HIM stated she did not know why the lab result was not in the medical record.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 out of 43 sampled residents, the facility did not arrange services with an outside agency in a timely manner. Specifically, a resident did not have a follow up appointment scheduled within the timeline ordered by the provider after a surgical procedure. Resident identifier: 18.Findings included:Resident 18 was admitted to the facility on [DATE] with diagnoses which included right femur fracture, unspecified protein-calorie malnutrition, and dementia.On 9/7/25 at 10:28 AM, an interview was conducted with resident 18's family member. Resident 18's family member stated that the facility forgot about resident 18's orthopedic follow-up visit. The family member stated that resident 18's follow up visit was supposed to be two weeks after her surgery was performed. Resident 18's family member stated that the information was given to the facility when she was admitted .Resident 18's medical record was reviewed on 9/7/25 through 9/10/25. Resident 18's hospital discharge orders were reviewed. The Skilled Nursing Facility Instructions contained the orthopedic clinic's contact information and the statement: Please contact the clinic to ensure follow-up visit within 14 days of surgery for wound check and x-rays. According to the discharge orders resident 18's surgery was performed on 8/24/25. [Note: 9/7/25, was 14 days after resident 18's surgery.]On 9/8/25 at 10:23 AM, an interview was conducted with the Director of Transportation (DT). The DT stated that when a new resident was admitted to the facility he looked at the discharge paperwork for any follow-up appointments that had been ordered or scheduled. If an ordered appointment was not scheduled the DT stated that he called to set one up. The DT stated that he maintained a spreadsheet that tracked if residents' appointments had been scheduled. The DT stated that once the appointment was scheduled he would enter it into the resident's electronic medical record and the transportation calendar. The DT looked at resident 18's information on the spreadsheet and in resident 18's medical record. The DT stated that he still needed to schedule an appointment for resident 18's 14-day follow-up with the orthopedic clinic. The DT stated that he was also a Certified Nursing Assistant (CNA) Coordinator, that he had been assisting with training a new CNA Coordinator, and that the training had slowed him down.On 9/8/25 at 2:11 PM a follow up interview was conducted with the DT. The DT stated that he was able to schedule an appointment for resident 18's follow up with the orthopedic clinic on 9/19/25. [Note: 9/19/25, was 26 days after 8/24/25, the date of resident 18's surgery.] The DT stated that the appointment was not scheduled within the ordered 14 day window because training the new CNA Coordinator had taken time away from his scheduling responsibilities.On 9/9/25 at 3:10 PM, an interview was conducted with the Director of Nursing (DON) and the DT. The DON stated that they had been unable to get ahold of the orthopedic clinic to schedule resident 18's appointment, but they had left voicemail messages that had not been returned. The DON stated that they did not have control over a clinic's appointment availability, or if a clinic did not return calls. The DT stated that he had left voicemail messages at the orthopedic clinic previously, and his calls were never returned. The DON stated that progress notes were not made regarding the previous attempts to contact the clinic, and that education had been provided to the DT to make progress notes regarding phone calls.No progress notes regarding attempts to schedule resident 18's follow-up appointment at the orthopedic clinic could be located in the medical record.On 9/9/25 at 3:40 PM, a follow up interview was conducted with the DON. The DON stated that they were able to contact the orthopedic clinic and reschedule resident 18's appointment for 9/11/25. [Note: 9/11/25, was 18 days after 8/24/25, the date of resident 18's surgery.]