STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465159	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Ridge Transitional Rehab	963 East 6600 South Murray, UT 84121

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review it was determined, for 1 of 21 sampled residents, that the facility did not ensure that the resident received treatment and care in accordance with professional standards of practice. Specifically, a resident reported constipation with no bowel movement for 4 days and treatment was not provided. Resident identifier: 13. Findings included: Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of displaced intertrochanteric fracture of right femur, sondylosis, chronic kidney disease, and malignant neoplasmof prostate. On 1/14/25 at 9:43 AM, an interview was conducted with resident 13. Resident 13 stated that he was constipated from his narcotic pain medication and it had been 4 days since he had a bowel movement. Resident 13 stated that they gave him some medication this morning for the constipation. On 1/1/25, the admission Minimum Data Set (MDS) assessment documented that resident 13 required supervision with toileting. Review of resident 13's point of care (POC) documentation for bowel and bladder documented the following: a. On 1/1/25 - no bowel movement (BM). b. On 1/6/25 - no bowel movement. c. On 1/7/25 - no bowel movement. Resident 13's vital signs under output - bowel movement documented the following: a. On 12/30/24 at 10:59 AM, resident 13's documentation for BM documented a large BM. b. On 1/7/25 at 2:04 PM, resident 13's documentation for BM documented a small BM. Resident 13's physician orders revealed the following: (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Senna tablet 8.6 milligram (mg), Give 1 tablet by mouth two times a day for constipation and oxycodone use. b. Day 3 (Bowel Brigade) = Administer Milk of Magnesia 30 cubic centimeters (cc) by mouth in the morning as needed. c. Day 4 (Bowel Brigade) = Administer Dulcolax 10 mg by mouth or per rectum in the morning as needed. d. Day 5 (Bowel Brigade) = Administer Fleets Enema or Enemeez as needed in the morning. e. Day 6 (Bowel Brigade) = If no BM in greater than 5 days, notify the physician for further orders. Resident 13's January Medication Administration Record (MAR) revealed: a. On 1/4/25 at 9:36 AM, the Bowel Brigade Day 3 was administered and was documented as SE (Semi-effective). b. On 1/7/25 at 8:19 AM, the Bowel Brigade Day 3 was administered and was documented as not effective. c. On 1/7/25 at 11:35 AM, the Bowel Brigade Day 4 was administered and was documented as not effective. d. On 1/7/25 at 1:37 PM, the Bowel Brigade Day 5 was administered and was documented as effective. On 1/7/25 at 1:46 PM, resident 13's nursing progress note documented, Pt [patient] has not had BM for 6 days, MOM [Milk of Magnesia] given, no BM, suppository given, still no BM, Enema given, in house provider notified. On 1/7/25, the abdomen xray for resident 13 documented increased fecal material noted throughout the colon, no evidence of mechanical obstruction. On 1/15/25, resident 13 had a care plan initiated for Alteration in Elimination: Patient had constipation. Interventions included assist resident to utilize the toilet, commode or bedpan as needed; keep accurate records of bowel movements to avoid complications; administer medications per the physician orders; encourage fluids as allowed; and follow facility bowel protocol. On 1/16/25 at 8:41 AM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 13 had just started walking to the bathroom with therapy the day before yesterday. CNA 1 stated that prior to walking to the bathroom resident 13 used a bedside commode. CNA 13 stated that they were encouraging resident 13 to go to the bathroom with assistance, and he required a two-person assist with toileting. CNA 1 stated that she charted documented the resident BM in the chart. CNA 1 stated that the nurse would also ask to make sure he had one. CNA 1 stated that resident 13 had complained of constipation yesterday and asked the nurse for a stool softener. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 8:51 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that they had a facility bowel protocol for residents if they were on opioid medications. RN 1 stated that the resident would have orders for Mirilax or Senna daily. RN 1 stated that after 3 days without a BM they would give the resident Milk of Magnesia. RN 1 stated that if the resident did not have a BM after 4 days they administered a suppository. RN 1 stated that if the resident continued to not have a BM then on day 5 they administered an enema. RN 1 stated that most residents usually had a BM after the suppository. RN 1 stated that depending on the resident they could adjust the protocol and give the suppository early on day 3. RN 1 stated that the night shift nurse monitored each resident's bowel movements and printed a report daily that indicated if the resident had not had a BM. RN 1 stated that the nurse would then report during shift change if the bowel protocol had been initiated. RN 1 stated that resident 13 was given Milk of Magnesia yesterday and it was day 4 without a BM for resident 13. RN 1 stated if the patient was alert and oriented then they told the nurse if they need something for a BM. RN 1 stated that she talked with the Nurse Practitioner (NP) and yesterday bowel brigade day 4 and MOM were administered. RN 1 stated that morning she talked to the patient and offered a suppository or enema. RN 1 stated resident 13 declined the suppository but wanted the enema. RN 1 stated the enema was administered between 7:30 AM and 8:00 AM. RN 1 stated resident 13 had a small BM twice but was complaining of lower abdominal pain. RN 1 stated she notified the NP and the NP ordered Lactulose 30 ml and an x-ray to see if resident 13 had a bowel obstruction. RN 1 stated resident 13 was taking as needed Oxycodone and he did not want to move much. RN 1 stated the NP said resident 13 might need his daily laxative dose adjusted. RN 1 stated resident 13 had complained of constipation about a week ago and was administered the bowel protocol which included adding Senna and Miralax daily. RN 1 stated resident 13 doing okay but was constipated again. RN 1 stated that resident 13 informed her yesterday that his last BM was day 4 ago. RN 1 stated on 1/3/25 they should have started the bowel protocol for no BM. RN 1 stated that typically MOM, a suppository and an enema were not administered all in the same day. RN 1 stated that with a suppository and enema they waited a couple of hours to see if it was effective. On 1/16/25 at 9:13 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the bowel protocol standing orders for medications based on how many days a resident had not had a bowel movement. The DON stated the physician was to be contacted if the resident did not have a bowel movement for 7 days. The DON was observed to review resident 13's BM documentation. The DON stated resident 13 had a BM on 12/30/24 and no BM from 12/31/24 through 1/6/25. The DON stated resident 13 should have the bowel brigade protocol on 1/2/25 which included MOM. The DON stated a suppository was administered on 1/3/25 suppository, enema on 1/4/25, and the physician was notified on day 6. The DON stated there was not another order in place to override the bowel brigade. The DON verified with the MAR that the protocol was administered all on 1/7/25.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432 Based on interview and record review, it was determined that for 1 of 21 sampled residents that the facility did not ensure that the attending physician or prescribing practitioner documented their rationale as to why PRN [as needed] medication order was extended beyond 14 days. Specifically, the resident had a PRN order for clonazepam, an anti-anxiety medication. The order had no end date and no rationale from the prescribing practitioner was documented in the medical record as to why the order was longer than 14 days. Resident Identifier: 23 Findings Include: Resident 23 was admitted on [DATE] with diagnoses which included anxiety disorder unspecified, major depressive disorder recurrent unspecified, and unspecified mood [affective] disorder. Resident 23's medical record was reviewed from 1/14/25 through 1/16/25. A physician's order dated 12/20/24 with no end date revealed, Clonazepam - Schedule IV table; 0.5 mg [milligrams]; amt: [amount] 0.5 mg; Quantity: 42; oral Special Instructions: DX: [diagnosis] ANXIETY -DO NOT administer within 1 hour of opioids d/t [due to] risk of respiratory depression - Every 8 hours. A progress note entered by the Director of Nursing (DON) dated 12/20/24 stated, provider reviewed resident's PRN [as needed] Clonazaepam and decided to keep it on his medication regimen as resident is using it and reports that it is helping with his anxiety. The resident's physician progress notes and nurse practitioner progress notes were reviewed for the following dates: 11/15/24, 11/18/24, 11/19/24, 11/27/24, 11/29/24, 12/2/24, 12/10/24, 12/11/24, 12/12/24, 12/16/24, 12/17/24, 12/18/24, 12/24/24, 12/26/24, 12/30/24, 1/3/25, and 1/7/25. Four of the progress notes did note that Resident 23's anxiety symptoms were controlled. However, none of the notes had a documented rationale as to why the order placed for PRN Clonazepam on 12/20/24 had been in place for longer than 14 days. On 1/16/25 at 10:20 AM, an interview was conducted with the DON. The DON stated that if a resident was admitted with a PRN order for psychotropic medication, then the facility notified the facility physician and added a stop date on the order within 14 days of admission. The DON stated that after those 14 days, the physician evaluated if the resident was utilizing the medication and if the resident still needed the medication. The DON stated that if the resident was not using the medication or the medication was not working by day 14, then the order was discontinued. The DON stated that the prescribing provider should document in the resident's medical record a rationale for any PRN psychotropic medications orders. The DON stated that the facility physician or provider verbally ordered if the medication was to be continued or discontinued, but that he was unsure if the physician documented the rationale anywhere in the medical record.

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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** 47432 Based on interview and record review, it was determined that for 1 of 5 sampled residents that the facility did not ensure that the resident's medical record indicated that the resident either received the influenza immunization or did not receive the influenza vaccination immunization due to medical contraindications or refusal and that the facility did not ensure that the resident's medical record included documentation that the resident either received the pneumococcal immunization due to medical contraindication or refusal. Specifically, there was not documentation that the facility provided or that the resident refused the pneumonia and influenza immunization. Resident Identifier: 28. Findings Include: Resident 28 was admitted on [DATE] with diagnoses which included displaced intertrochanteric fracture of right femur subsequent encounter for closed fracture with routine healing, urinary tract infection, and hypertensive heart disease with heart failure. Resident 28's medical record was reviewed 1/14/25 though 1/16/25. A form labeled PNA [pneumonia], FLU [influenza], COVID [coronavirus] Psychotherapeutic Medication Consents was located in resident 28's medical record. The form was signed by resident 28 and dated 11/29/24. The form contained checkboxes to mark resident 28 as up-to-date on both the influenza and pneumonia vaccinations, to mark that resident 28 gave the facility permission to administer both of the vaccines, or to mark that resident 28 declined to give the facility permission to receive both of the vaccines. None of the checkboxes were marked on the form. On 1/16/25 at 1:32 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that nursing staff needed to ensure that the vaccination consent form was fully completed before staff or the resident signed the form.