STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465166	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Ridge West Transitional Rehab	5323 South Murray Boulevard Murray, UT 84123

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report all allegations of abuse, neglect, exploitation, or mistreatment. Specifically, the facility failed to report an incident where a resident reported a Certified Nursing Assistant (CNA) made a resident feel threatened, and she was scared for her safety. Resident identifier: 1. On August 12, 2025, the surveyor reviewed the facility's grievance reports. A grievance report dated February 17, 2025 revealed the following:Documentation of the complaint, written by Resident 1: I called for help to use my commode and get ready for bed. [CNA 4] helped me to my commode but he seemed upset that he had to do so. I let it go, and when I called for help he got mad when I wanted to go to bed. He started to remove my sheets, and I informed him, I sleep on top of my covers. He was angry that I was correcting him. He started to grab my belongings and threw them on the chair, next to me. I was so scared and felt threatened and scared for my safety by how angry he was. I asked if i can have [CNA 5] come in and take care of the rest of my bedtime routine and he said no, she's busy with other patients and i have other people to take care of so hurry up He was so angry when I asked him to grab a pillow case for a pillow that was supposed to go under my leg. The Administrator documented that they spoke with Resident 1 on February 18, 2025, and that the employee was disciplined on February 17, 2025. The resolution section indicated, Yes, employee no longer working at the facility. Patient satisfied with investigation. On August 12, 2025, the surveyor interviewed the Administrator. The Administrator stated that he talked to Resident 1 the day after the incident. The Administrator stated that Resident 1 reported that CNA 4 presented as angry and rude, and she did not like how she was being treated. The Administrator asked Resident 1 if she felt like it was abuse, and Resident 1 stated that she did not feel like it was abuse. The Administrator stated that Resident 1 did not say that she felt unsafe. The Administrator stated that he felt like the situation was more poor customer service and not abuse. The Administrator decided to let CNA 4 go because there had been previous complaints from staff and residents regarding his customer service.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse. Specifically, the facility failed to thoroughly investigate an incident where a resident reported a CNA had made her feel threatened, and she feared for her safety. Resident identifier: 1. On August 12, 2025, the surveyor reviewed the facility's grievance reports. A grievance report dated February 17, 2025 revealed the following:Documentation of the complaint, written by Resident 1: I called for help to use my commode and get ready for bed. [CNA 4] helped me to my commode but he seemed upset that he had to do so. I let it go, and when I called for help he got mad when I wanted to go to bed. He started to remove my sheets, and I informed him, I sleep on top of my covers. He was angry that I was correcting him. He started to grab my belongings and threw them on the chair, next to me. I was so scared and felt threatened and scared for my safety by how angry he was. I asked if i can have [CNA 5] come in and take care of the rest of my bedtime routine and he said no, she's busy with other patients and i have other people to take care of so hurry up He was so angry when I asked him to grab a pillow case for a pillow that was supposed to go under my leg. The Administrator documented that they spoke with Resident 1 on February 18, 2025, and that the employee was disciplined on February 17, 2025. The resolution section indicated, Yes, employee no longer working at the facility. Patient satisfied with investigation. On August 12, 2025, the surveyor interviewed the Administrator. The Administrator stated that he talked to Resident 1 the day after the incident. The administrator stated that Resident 1 reported that CNA 4 presented as angry and rude, and she did not like how she was being treated. The administrator asked Resident 1 if she felt like it was abuse, and Resident 1 stated that she did not feel like it was abuse. The administrator stated that Resident 1 did not say that she felt unsafe. The administrator stated that he felt like the situation was more poor customer service and not abuse. The administrator decided to let CNA 4 go because there had been previous complaints from staff and residents regarding his customer service.The surveyor reviewed the facility's Abuse Policy and Procedure, and the following was revealed: The Administrator and/or Director of Nursing will complete an investigation of the incident including a written summary of the findings no later than five (5) working days of the reported occurrence.