| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465166 | A. Building<br>B. Wing | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Aspen Ridge West Transitional Rehab | 5323 South Murray Boulevard<br>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) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection and prevention 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 26 sampled residents, Enhanced Barrier Precautions (EBP) were not implemented for residents with wounds and indwelling medical devices. Additionally, clean linens were found to be on the floor in the laundry room. Resident identifiers:15, 17, and 55.Findings included: 1. On 1/12/26 at 8:12 AM, an initial tour of the facility was conducted. It should be noted that there was no EBP signage for residents 3, 15, 17.a. Resident 15 was admitted to the hospital on [DATE] with diagnoses which included sepsis and cutaneous abscess of buttock.Resident 15's medical record was reviewed 1/12/26 through 1/14/26. A review of resident 15's physician orders revealed on 12/30/25, an order for Enhanced Barrier Precautions d/t [due to] RUE [right upper extremity] PICC [peripherally inserted central catheter] was placed.On 1/12/26 at 10:01 AM, a concurrent interview and observation was conducted with resident 15. Resident 15 was observed to have a PICC line inserted in her right upper arm. Resident 15 stated that she had been receiving intravenous (IV) antibiotics since she arrived in the facility. Resident 15 stated that staff had only worn gloves when providing cares for her. There were no gowns observed in resident 15's room and no EBP sign on the door.On 1/13/26 at 12:05 PM, an observation was made of Certified Nursing Assistants (CNA) 2 and CNA 3 weighing resident 15 with the Hoyer lift. CNA 2 and CNA 3 were observed to be wearing gloves and no gowns. b. Resident 55 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis and left third toe resection.Resident 55's medical record was reviewed 1/13/26 through 1/14/26.A review of resident 55's orders revealed on 1/12/26, an order for Enhanced Barrier Precautions due to PICC was placed.On 1/13/26 at 9:46 AM, an observation was made of resident 55 receiving IV antibiotics through the PICC line in her left upper arm. Registered Nurse (RN) 1 washed their hands and applied gloves. RN 1 did not apply a gown when handling the PICC line or attaching the Elastomeric Pump of vancomycin. RN 1 discarded gloves and exited the room without performing hand hygiene.c. Resident 17 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included left below knee amputation, and pressure ulcer of sacral stage 2.On 1/12/26 at 1:49 PM, an interview was conducted with resident 17. During the interview an observation was made that resident 17 was receiving a nasogastric (NG) tube feeding and also had an indwelling catheter with drainage bag attached to the bedside. Resident 17 stated that when staff were providing care, they would wear gloves, but they do not wear a gown.Review of resident 17's medical record was completed on 1/12/26 through 1/14/26.On 1/12/26 at 10:08 AM, a physician's order was created for EBP due to an NG tube and chronic wound to the left stump.On 1/13/26 at 11:56 AM, an observation was made of resident 17 being transported to his room by two staff members. Resident 17 stated to the staff that he wanted to lay down. Staff proceeded to close the door to resident 17's room. At 12:03 PM, the first staff member exited the room as they were doffing their gloves walking down the hallway. On the door to resident 17's room there was an EBP sign taped to the door and a three-drawer unit just inside of the room with personal protection equipment<br>(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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | (PPE), which included gowns. As the second staff member exited, he was observed to be wearing a mask as he used the sanitizer and completed hand hygiene.On 1/13/26 at 12:08 PM, an observation of resident 17's trash can inside the room. The only item in the trash was a pair of gloves. It should be noted that no other disposed PPE was in resident 17's room.On 1/13/26 at 1:00 PM, an interview was conducted with CNA 3. CNA 3 stated that the EBP signs on residents' doors meant that precautions needed to be worn. CNA 3 stated that only residents with infections needed EBP. CNA 3 stated that gowns were only worn for residents in isolation. On 1/13/26 at 2:51 PM, an interview was conducted with CNA 4. CNA 4 stated that EBP was used for residents that had urinary catheters and PICC lines. CNA 4 stated that you had to wash your hands upon entering and exiting the room of a resident who required EBP. CNA 4 stated that she kept the doors closed for residents that required EBP. On 1/14/26 at 8:06 AM, an interview was conducted with RN 1. RN 1 stated that residents that had communicable diseases had EBP. RN 1 stated that he would only wear a gown if a resident had a respiratory infection because he could get droplets on his clothes. RN 1 stated that he only wore gloves for residents that had PICC lines and gowns were not needed. On 1/14/26 at 9:16 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that EBP was for a resident that had a chronic wound, IV, PICC line, foley catheter, or NG tube. The DON stated that staff should be wearing gowns and gloves when they were spending over 15 minutes in a room with a resident. The DON stated that every resident that required EBP should have a sign on their door. The DON stated that gowns could be found in a 3-drawer bin in the residents' rooms. The DON stated that she did not know why resident 15 did not have an EBP sign on her door. 2. On 1/14/26 at 8:18 AM, an observation was made of the facility laundry room. On the clean laundry side were multiple large piles of clean laundry on tables. There was a blanket that was hanging off a table and had one side of it on the floor. There was a pillowcase and a towel on the floor. An interview was conducted with the housekeeper. The housekeeper stated that all of the items in the laundry room were clean and just needed to be folded. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure the right to self-administer medications if the interdisciplinary team had determined that this practice was clinically appropriate. Specifically, for 1 out of 26 sampled residents, it was found that the resident did not have a nursing assessment or a physician's order in place to be able to self-administer medications. Resident identifier: 2Findings included: Resident 2 was admitted to the facility on [DATE] with diagnoses which included displaced transverse fracture of shaft of right fibula, displaced fracture of lateral malleolus of left fibula, age-related osteoarthritis, and diverticulitis of large intestine.On 1/12/26 at 10:18 AM, an interview was conducted with resident 2. During the interview an observation was made of an unlabeled prescription bottle filled with white colored tablets on resident 2's bedside table. Resident 2 stated that they were her digestive enzymes that she took throughout the day.On 1/14/26 at 10:01 AM, an observation was conducted of an unlabeled medication bottle on resident 2's bedside table filled halfway with white tablets.On 1/14/26 at 11:23 AM an interview with Certified Nursing Assistant (CNA) 1 was conducted. CNA 1 stated that if she saw any medications in a resident's room, she would notify the nurse. CNA 1 stated that she was not aware of any current residents that had medications in their rooms. CNA 1 stated that if a resident were able to have medications in their room, there would be a physician's order allowing self-administration, and the CNAs would be made aware.On 1/14/26 at 1:31 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated if a resident requested to self-administer their medication the admissions nurse would be notified. LPN 1 stated that the admissions nurse would assess the resident and get a full list of their medications. LPN 1 stated once the assessment was completed the admissions nurse would contact the physician to get an order for the resident to self-administer their medications. LPN 1 stated once there was an order the resident was allowed to store medications in their room. LPN 1 stated that she was aware that resident 2 kept medication in her room. LPN 1 stated that several of the staff had talked to resident 2 about the medication she kept in her room. LPN 1 stated that resident 2's family were very vocal regarding her care, and persistent that the medications were always available.It should be noted that a review of resident 2's physician's orders was made and an order to self-administer medications was not located.On 1/14/26 at 1:55 PM, an interview with the Nurse Manager (NM) was conducted. The NM stated that he was not aware that resident 2 had medication in her room. The NM stated prior to a resident having medication kept in their room, the resident would need a nursing assessment completed and a physician's order allowing the self-administration of medication. The NM stated that he did not see any orders or anything in resident 2's medical record about her self-administering medication.On 1/14/26 at 2:24 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that for a resident to have medication kept in their room, the resident would first need a nursing assessment conducted and a physician's order for self-administration of medication. The DON stated that most times the self-administering of medication was requested at the time of admission, which the admissions nurse would complete. The DON stated that if a resident made the request later, she expected the floor nurse would conduct the assessment and request an order from the physician. The DON stated that residents should not have medications kept in their room without a physician's order. The DON stated that she was unaware of the medication that resident 2 had in her room. The DON stated that she was unable to locate a nursing assessment or a physician's order in resident 2's medical record. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, for 1 out of 26 sampled residents, the resident was not provided with multiple medications due to them being out of stock and unavailable from the pharmacy. Resident identifier: 3.Findings included: Resident 3 was admitted to the facility on [DATE] with diagnoses which included fracture of first lumbar vertebra, nondisplaced zone II fracture of sacrum, and chronic kidney disease.Review of resident 3's medical record was completed on 1/12/26 through 1/14/26.On 12/12/25, a physician's order was started for eszopiclone to be given at bedtime.Resident 3's December 2025 Medication Administration Record (MAR) revealed that the eszopiclone was not administered due to the drug being unavailable on 12/12/25, 12/13/25, 12/14/25, and 12/15/25.On 12/24/25, a physician's order was started for dronabinol to be given once a day.The MAR revealed that the dronabinol was not administered due to the drug being unavailable on 12/25/25, 12/26/25, 12/27/25, 12/28/25,12/29/25, and 12/30/25.On 1/14/26 at 1:31PM, an interview was conducted with Licensed Practice Nurse (LPN) 1. LPN 1 stated that if an ordered medication was unavailable, she would contact the pharmacy. LPN 1 stated that if the medication was critical there was an emergent pharmacy phone number to get the medication delivered as soon as possible. LPN 1 stated she would notify the Nurse Manager (NM) of the unavailable medication, since the NM was the one that puts in the physician's orders. LPN 1 also stated that she would leave a note for the physician regarding the unavailable medication. LPN 1 stated that the physician was usually here the next day and the NM would follow-up with the pharmacy.On 1/14/26 at 1:55 PM, an interview was conducted with the NM. The NM stated that if a medication was unavailable, he would call the pharmacy regarding the availability. The NM stated that if the medication was on backorder from the pharmacy, he would reach out to the resident's family to see if they have any of the medication on hand until they were able to receive it from the pharmacy. The NM stated that if that still did not fix the issue, he would contact the physician regarding the unavailable medication and get an updated order or possible substitution. The NM stated that he was not made aware that resident 3 had unavailable medications. The NM stated the floor nurses usually made him aware the next day when a medication was not in stock. The NM stated that possibly the pharmacy did not receive the signed physician's order due to the medications being controlled substances and could not be filled.On 1/14/26 at 2:24 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that when medication was unavailable, she expected the floor nurse to contact the pharmacy regarding the issue and to inform the physician. The DON stated that even if the medication was a controlled substance there were physicians on call that could submit a signed order. The DON stated that a resident's medication should not be unavailable for any period of time, especially more than a day or longer. The DON stated that she expected the nurses to contact the physician and inform them of the unavailable medication and get an updated order for a possible substitution. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on interview and record review, the facility did not ensure that residents were offered the pneumococcal immunization and that the medical records included documentation that the resident either received the immunization or did not due to medical contraindications or refusal. Specifically, for 2 out of 5 sampled residents, there was no documentation of declination of the pneumococcal immunization. Resident identifiers: 15 and 55.Findings included:1. Resident 15's medical record was reviewed 1/12/26 through 1/14/26. A form labeled PNA [pneumonia], FLU [Influenza] COVID [Coronavirus Disease 2019], RSV [respiratory syncytial virus] Immunizations, Medication Consent was located in resident 15's medical record. The form was signed by resident 15 and dated 12/30/25. The form contained checkboxes to mark resident 15 as up-to-date on the recommended pneumococcal immunization. A Utah Statewide Immunization Information System (USIIS) immunization record was located in resident 15's medical record. The USIIS record documented that resident 15 had not received any pneumococcal immunizations. Resident 15's medical record did not indicate that she was offered or declined these immunizations.2. Resident 55's medical record was reviewed 1/13/26 through 1/14/26.A form labeled PNA, FLU COVID, RSV Immunizations, Medication Consent was located in resident 55's medical record. The form was signed by resident 55 and dated 1/12/26. The form contained checkboxes to mark resident 55 as up-to-date on the recommended pneumococcal immunization. A USIIS immunization record was located in resident 55's medical record. The USIIS record documented that resident 55 had received PCV-13 (Pneumococcal Conjugate Vaccine-Variant 13) on 8/7/17, and PPSV 23 (Pneumococcal Polysaccharide Vaccine 23) on 10/13/97 and 1/1/06. The USIIS record indicated that resident 55 was due to receive a pneumococcal immunization. It should be noted that according to the Centers for Disease Control (CDC) Pneumococcal Vaccine timing that resident 55 required an immunization of PCV 20 or PCV 21. Resident 55's medical record did not indicate that she was offered or declined these immunizations. On 1/14/26 at 8:55 AM, an interview was conducted with the Nurse Manager (NM). The NM stated that he had access to the USIIS system and would pull an immunization log on new admissions. The NM stated that if the USIIS log indicated that a resident was not current on an immunization then he would notify the Director of Nursing (DON) and have the immunization ordered. The NM stated that the admitting nurse went over all the immunizations upon admission with new residents. The NM stated that when a USIIS report indicated that a resident was not up-to-date on immunizations then he would go and talk with the resident and ask them if they wanted the immunization. The NM stated that if a resident declined to have an immunization then he would document this in a progress note. On 1/14/26 at 9:25 AM, an interview was conducted with the DON. The DON stated that the admission nurse was new in her position and was the one who discussed immunizations with new residents. The DON stated that if a resident stated they were current on their immunizations then the nurse would just check the box that they were up-to-date. The DON stated that the admission nurse did not have access to USIIS and did not have a way to verify if a resident was current on immunizations. The DON stated that the admission nurse should have verified if residents were current on immunizations and if they were not, then administer the vaccine or have the resident sign a declination form. |