STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465191	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Meadow Rehabilitation and Nursing	2520 South Redwood Road West Valley City, UT 84119

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review, it was determined for 2 of 12 sampled residents that the facility did not ensure that the residents were free from abuse. Specifically, two residents reported that a Certified Nurse Assistant (CNA) inappropriately touched them on their genitals. Resident identifiers: 1 and 11. Findings included: 1. Resident 1 was admitted to the facility on [DATE] with diagnoses which included left knee osteoarthritis, type 2 diabetes mellitus, morbid obesity, chronic pain syndrome, and venous peripheral insufficiency. The facility investigation was reviewed 10/28/24 through 10/29/24. Form 358 was submitted to the State Survey Agency on 9/16/24 at 7:55 PM. The form indicated an incident of sexual abuse was reported by the Administrator (ADM). It indicated, [CNA 2]- CNA during her shift was helping another CNA on shift help change resident [resident 1]. [Resident 1] had been engaging in small talk with [CNA 2] and then told her that a man (CNA [CNA 3]) on night shift got 'touchy' with her and that he was trying to put his fingers inside of her vagina. [Resident 1] yelled at him to 'get the hell out of my room' before he was able to do so and he then left. Form 359, dated 9/20/24 at 4:45 PM, indicated, CNA [CNA 3] stated that he visited patient [resident 1] around 4:30 am on Thursday (9-12) to change her brief. 'She replied that she categorically refuses to change her brief, since she thought she was dry. I didn't conflict with her and left her room. I informed the CNA Coordinator -[name redacted]- that patient [resident 1] refused a brief change. [CNA Coordinator] stated that I should try again. So I asked her again and she quietly agreed. I changed her brief calmly, carefully, and quickly. She repeatedly said thank you, thank you. I then went and told [name redacted] CNA Coordinator that the change took place without any problems.' He stated: 'Perhaps I could have inadvertently touched her vagina while wiping her crotch from copious amounts of urine, but I am categorically rejecting the the [sic] allegation that I was trying to insert my fingers into her vagina.' It further indicated, Not verified-due to interviews with residents and staff, it's determined that this allegation is not verified due to Resident [resident 1] easily getting confused. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 12:17 PM, an interview was conducted with resident 1. Resident 1 stated an older man came into her room and told her he had to check her vagina to see if it is okay. Resident 1 stated he tried to get under my blanket, but that he did not get under her blanket because she told him that she thinks he better leave. Resident 1 stated the older man turned around and left. Resident 1 stated that when that happens, you just feel dazed. Resident 1 stated she felt panicked. Resident 1 stated the older man never touched her breasts or vagina because she told him no and told him to leave and he left. Resident 1 stated she never saw him again. Resident 1's medical record was reviewed 10/28/24 through 10/29/24. A Minimum Data Set (MDS) 3.0 Section C Cognitive Patterns, dated 8/16/24, indicated resident 1 had a BIMS (Brief Interview for Mental Status) Score of 8 which indicated a moderate cognitive impairment. A review of the Time Card Report for CNA 3, indicated CNA 3 clocked in on 9/12/24 at 5:42 PM, clocked out at 8:12 PM, clocked in at 8:42 PM, and clocked out on 9/13/24 at 6:03 AM. An Abuse Packet was signed as reviewed by CNA 3 on 8/21/24. A facility Abuse Neglect training, dated 9/10/24, indicated CNA 3's signature. The OIG (Office of Inspector General) LEIE (List of Excluded Individuals and Entities) database for CNA 3, dated 8/20/24 at 5:19 PM, indicated no results found. A Utah Nursing Assistant Registry for CNA 3 indicated a current license, dated 3/23/23, and indicated an expiration date of 5/31/25. On 10/28/24 at 10:35 AM, an interview was conducted with the Administrator (ADM). The ADM stated that resident 1 expressed some concern about CNA 3, about inappropriate touching. The ADM stated that CNA 3 was immediately suspended on 9/16/24. The ADM stated he was unable to find any concrete evidence because resident 1 was very confused about the timeline and anything specific but for safety reasons, he decided to part ways with CNA 3. The ADM stated the last day CNA 3 worked at the facility was 9/12/24 and that they had no prior complaints about CNA 3. On 10/28/24 at 10:40 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated resident 1 had a BIMS that fluctuated between an 8 to a 5 and that it depended on the day, but that she was more on the confused side. The ADON stated resident 1 had no behavioral changes after the abuse allegation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 1:03 PM, a telephone interview was conducted with CNA 2. CNA 2 stated she was working with CNA 3 and was going to help him bathe resident 1 on the day of the incident, 9/12/24. CNA 2 stated when she went into resident 1's room, she was in bed, CNA 3 was there, and resident 1 looked at her with wide eyes and resident 1 stated that she was glad that CNA 2 was there. CNA 2 stated she did not think anything of that interaction at that time. CNA 2 stated that the following week, resident 1 told her that CNA 3 had stuck his fingers in her vagina. CNA 2 stated that resident 1 told her that when CNA 2 entered the room on the day of the incident, CNA 3 had hopped off of her. CNA 2 stated she did not see CNA 3 on the resident. CNA 2 stated resident 1 was very lucid and was not confused at all and that when she would ask resident 1 questions over and over again about the incident, she would not mix it up at all. CNA 2 stated resident 1 reported the abuse a week after it happened. CNA 2 stated resident 1 told her that the Russian guy was in her room and he stuck his fingers in her and she called him a sick [expletive removed] and he stuck his fingers in her, all the way. CNA 2 stated resident 1 said in her cookie, which she referred to her vagina as her cookie. CNA 2 stated resident 1 was more confused at this current time because she might have a urinary tract infection. CNA 2 stated resident 1 told her that nobody had ever done that to her in her whole life and that she felt taken advantage of. On 10/29/24 at 10:43 AM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that resident 1 reported that she was sleeping and CNA 3 came into her room and woke her up by touching her. The CNA Coordinator stated that resident 1 reported that she felt CNA 3's hand in her brief and that he said he was just checking if she needed to be changed. The CNA Coordinator stated that resident 1 reported that she told CNA 3 that he did not have to put his hand in her vagina and that resident 1 felt CNA 3's fingers in her vagina. The CNA Coordinator stated she observed one instance when resident 1 displayed a change in behavior after the abuse allegation. The CNA Coordinator stated the day after she interviewed resident 1 about the abuse allegation, she asked resident 1 if she could check if her brief was wet, and she observed resident 1 cover her pubic region with her hands and then stated, you are not going to put your hands in my vagina. The CNA Coordinator stated that when you check a resident's brief, you just move the brief to the side or open it, but that you were never supposed to put your hand in the brief. On 10/29/24 at 2:15 PM, a telephone interview was conducted with Registered Nurse (RN) 2. RN 2 stated she was notified of the abuse allegation by CNA 2 the Monday morning following the incident that occurred the previous Wednesday night. RN 2 stated resident 1 did not notify any staff until that Monday morning. RN 2 stated that she and CNA 2 went into resident 1's room to try and get more information, but that CNA 2 had already reported everything to the CNA Coordinator. RN 2 stated that resident 1 can be confused at times but was not confused at that time and had been completely lucid and clear that day and night that she reported the abuse allegation. RN 2 stated resident 1 reported CNA 3 tried to put his finger in her cookie. RN 2 stated she asked resident 1 specifically if CNA 3 put his finger inside her and resident 1 responded that CNA 3 put it right close to it, on the side of it. RN 2 stated that resident 1 reported that she threw CNA 3 out of her room and that she never wanted that man in her room again. On 10/29/24 at 3:25 PM, a follow-up interview was conducted with the ADM. The ADM stated this incident was reported to the police but they did not come in or follow up with them about it. The ADM stated that resident 1 told him that CNA 3 had attempted to put his fingers in her vagina and that nobody told him that CNA 3 actually put his finger in her vagina. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 11 was admitted to the facility on [DATE] with diagnoses which included pulmonary embolism, weakness, difficulty in walking, and encephalopathy. On 10/29/24 at 9:31 AM, an interview was conducted with resident 11. Resident 11 stated CNA 3 touched her inappropriately and that she did not remember the exact date but that it was shortly before he was suspended. Resident 11 stated CNA 3 was changing her brief and needed to replace the sheet and CNA 3 told her he had to go get a clean sheet and that he left her laying on her side with her buttocks exposed and patted her on the buttocks before he walked away. Resident 11 stated CNA 3 left her bare and patted her on her bare bottom like a baby. Resident 11 stated it made her feel violated and that it did not feel right and that it made her feel like she did not want to be touched. Resident 11 stated she did not report that incident to staff at that time. An undated document was provided as part of the facility abuse allegation investigation, it indicated, Resident/room #/staff member [resident 11] -105 B - What interaction have you had in the past with this staff member? - when changing me, his hand brushed across my breast. Possibly intentionally. -didn't think it was intentional so I didn't tell any [illegible hand writing] - patted on backside and stomach briefly when being changed - just weird. A few weeks ago. On 10/29/24 at 9:50 AM, the ADM provided a document that included his interpretation of his hand writing of the interview with resident 11, it indicated, Resident [Resident 11] Statement: When CNA [CNA 3] was changing me, his hand brushed across my breast. I didn't think it was intentional so I didn't tell anyone. I was patted on the backside and stomach briefly when being changed. It just seemed weird. Resident 11's medical record was reviewed 10/28/24 through 10/29/24. A MDS 3.0 Section C Cognitive Patterns, dated 9/28/24, indicated resident 11 had a BIMS score of 15 which indicated an intact cognition. On 10/28/24 at 1:03 PM, a telephone interview was conducted with CNA 2. CNA 2 stated that she was aware that resident 11 reported that she was spanked on her buttocks by CNA 3. On 10/29/24 at 8:49 AM, an interview was conducted with the ADM. The ADM stated there was never an okay time to tap anyone on the buttocks. The ADM stated that this incident was reported to staff by resident 11 during the abuse investigation from resident 1. The ADM stated resident 11's abuse allegation was not reported to the State Survey Agency. The ADM stated that when an abuse allegation was reported that the facility would get as much information as possible from residents, staff, and witnesses and then that would be followed by a five-day, thorough investigation. The ADM stated abuse allegations needed to be reported to authorities, like the local police department and ombudsman so they are aware of the situation. The ADM stated that any allegation of abuse needed to be reported within 24 hours. On 10/29/24 at 10:43 AM, an interview was conducted with the CNA Coordinator. The CNA Coordinator stated that she was aware of the incident where resident 11 reported being hit on the buttocks by CNA 3. The CNA Coordinator stated that there was never a time that it would be okay to hit or tap a resident on the buttocks. On 10/29/24 at 10:45 AM, a follow-up interview was conducted with the ADM. The ADM stated that a date was never discovered for when resident 11 was smacked on the buttocks.

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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. 48709 Based on interview and record review, it was determined for 1 of 12 sampled residents, that the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 24 hours if the events that cause the allegation did not involve abuse and did not result in serious bodily injury to the State Survey Agency (SSA). Specifically, a sexual abuse allegation was reported to the SSA. Resident identifier: 11. Findings included: An untitled and undated document was provided as part of a facility abuse allegation investigation, it indicated, Resident/room #/staff member [resident 11] -105 B - What interaction have you had in the past with this staff member? - when changing me, his hand brushed across my breast. Possibly intentionally. -didn't think it was intentional so I didn't tell any [illegible hand writing] - patted on backside and stomach briefly when being changed - just weird. A few weeks ago. On 10/29/24 at 9:50 AM, the ADM provided a document that included his interpretation of his hand writing of the interview with resident 11, it indicated, Resident [Resident 11] Statement: When CNA [CNA 3] was changing me, his hand brushed across my breast. I didn't think it was intentional so I didn't tell anyone. I was patted on the backside and stomach briefly when being changed. It just seemed weird. It should be noted that the untitled and undated document was attached to Form 359 regarding another resident's allegation of abuse. The form was dated 9/20/24 at 4:45 PM. On 10/29/24 at 8:49 AM, an interview was conducted with the Administrator (ADM). The ADM stated that this incident was reported by resident 11 during another abuse investigation, so it was all done as one investigation and that it was not reported as a separate abuse investigation. The ADM stated that when an abuse allegation was reported that the facility would get as much information as possible from residents, staff, and witnesses and then that would be followed by a five-day, thorough investigation. The ADM stated abuse allegations needed to be reported to authorities, like the local police department and ombudsman so they were aware of the situation. The ADM stated that any allegation of abuse needed to be reported within 24 hours. The ADM confirmed this allegation was not reported.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 48709 Based on interview and record review, it was determined for 1 of 12 sampled residents, that in response to allegations of abuse, neglect, exploitation, or mistreatment the facility failed to have evidence that all alleged violations were thoroughly investigated. Specifically, there was an allegation of abuse that was not thoroughly investigated. Resident identifier: 11. Findings included: An untitled and undated document was provided as part of a facility abuse allegation investigation, it indicated, Resident/room #/staff member [resident 11] -105 B - What interaction have you had in the past with this staff member? - when changing me, his hand brushed across my breast. Possibly intentionally. -didn't think it was intentional so I didn't tell any [illegible hand writing] - patted on backside and stomach briefly when being changed - just weird. A few weeks ago. On 10/29/24 at 9:50 AM, the Administrator (ADM) provided a document that included his interpretation of his hand writing of the interview with resident 11, it indicated, Resident [Resident 11] Statement: When CNA [Certified Nurse Assistant] [CNA 3] was changing me, his hand brushed across my breast. I didn't think it was intentional so I didn't tell anyone. I was patted on the backside and stomach briefly when being changed. It just seemed weird. It should be noted that the untitled and undated document was attached to Form 359 regarding another resident's allegation of abuse. The form was dated 9/20/24 at 4:45 PM. On 10/29/24 at 8:49 AM, an interview was conducted with the Administrator (ADM). The ADM stated that this incident was reported to staff by resident 11 during another abuse investigation, so it was all done as one investigation and that it was not reported or investigated as a separate abuse investigation. The ADM stated that when an abuse allegation was reported that the facility would get as much information as possible from residents, staff, and witnesses and then that would be followed by a five-day, thorough investigation. The ADM stated abuse allegations needed to be reported to authorities, like the local police department and ombudsman so they are aware of the situation. On 10/29/24 at 10:45 AM, a follow-up interview was conducted with the ADM. The ADM stated that a date was never discovered for when resident 11 was tapped on the buttocks by CNA 3.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on interview and record review, the facility did not ensure that 3 of 12 sampled residents were free of significant medication errors. Specifically, three residents were not administered insulin at the correct time per the physician orders. Resident identifiers: 2, 4, and 10. Findings include: The facility's posted insulin administration times are: 7:00 AM, 11:30 AM, and 4:30 PM. Resident Council Notes dated 5/14/24 revealed the following. Not getting meds in a timely manner . Resident Council Notes dated 6/12/24 revealed the following. Meds still not on time Resident Council Notes dated 7/9/24 revealed the following. Meds being passed too late at [sic.] night Resident Council Notes dated 8/27/24 revealed the following. Meds not given when asked. 1. Resident 2 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included Type 1 diabetes mellitus, acute kidney failure, sepsis, encephalopathy, type 2 diabetes mellitus with foot ulcer, and depression. Review of Resident 2's records was completed 10/28/24 through 10/29/24. A quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 2 had a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. A physician's order for Resident 2 revealed the following: Insulin Glargine Subcutaneous Solution 100 UNIT/milliliter (ML), subcutaneously one time a day related to type 2 diabetes mellitus at AM pass. A physician's order for Resident 2 revealed the following: Humalog Injection Solution 100 UNIT/ML injected subcutaneously before meals and at bedtime for DM (diabetes mellitus). A review of Resident 2's Medication Administration Record (MAR) for May 2024 revealed the following: On 5/6/24 Insulin Glargine Subcutaneous Solution was administered at 8:37AM, which was 37 minutes overdue. On 5/6/24 Humalog Injection Solution was administered at 8:36 AM, which was 36 minutes overdue. On 5/7/24 Insulin Glargine Subcutaneous Solution was administered at 8:50 AM, which was 50 minutes overdue. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/24 Insulin Humalog Injection Solution was administered at 10:36 AM, which was 1 hour and 36 minutes overdue. On 5/15/24 Insulin Humalog Injection Solution was administered at 9:30 PM, which was 1 hour and 30 minutes overdue. On 5/16/24 Insulin Humalog Injection Solution was administered at 9:23 PM, which was 1 hour and 23 minutes overdue. On 5/19/24 Insulin Glargine Subcutaneous Solution was administered at 11:26 AM, which was 2 hours and 26 minutes overdue. On 5/20/24 Insulin Humalog Injection Solution was administered at 1:18 PM, which was 1 hour and 18 minutes overdue. On 5/20/24 Insulin Humalog Injection Solution was administered at 12:23 AM, which was 1 hour and 23 minutes overdue. On 5/24/24 Insulin Glargine Subcutaneous Solution was administered at 10:41AM, which was 1 hour and 41 minutes overdue. On 5/26/24 Insulin Humalog Injection Solution was administered at 10:53 PM, which was 1 hour and 53 minutes overdue. 2. Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] then discharged on [DATE] with diagnoses which included type 2 diabetes mellitus with diabetic neuropathy, Crohn's disease, post-traumatic stress disorder, schizoaffective disorder, and major depressive disorder. Review of Resident 4's records was completed 10/28/24 through 10/29/24. A quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 4 had a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderately impaired cognition. A physician's order for Resident 4 revealed the following: Humalog Injection Solution 100 UNIT/ML injected subcutaneously before meals related to type 2 diabetes mellitus with diabetic neuropathy. Specific times being, 7:00 AM, 11:30 AM, and 4:30 PM. A physician's order for Resident 4 revealed the following: Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneously at bedtime with time ranges of 7:00 PM through 9:00 PM. A review of Resident 4's Medication Administration Record (MAR) for May 2024 revealed the following: On 5/3/24 Insulin Humalog Injection Solution was administered at 9:01 PM, which was 1 hour and 1 minute overdue. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/6/24 Lantus Subcutaneous Solution was administered at 10:10 PM, which was 1 hour and 10 minutes overdue. On 5/8/24 Insulin Humalog Injection Solution was administered at 9:36 AM, which was 1 hour and 36 minutes overdue. On 5/8/24 Lantus Subcutaneous Solution was administered at 8:51 PM, which was 51 minutes overdue. On 5/9/24 Insulin Humalog Injection Solution was administered at 10:41 PM, which was 1 hour and 41 minutes overdue. On 5/26/24 Insulin Humalog Injection Solution was administered at 8:44 AM, which was 44 minutes overdue. 3. Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included acute osteomyelitis, left ankle and foot; type 2 diabetes mellitus with foot ulcer; infection of amputation stump; depression; and anxiety. Review of Resident 10's records was completed 10/28/24 through 10/29/24. A quarterly Minimum Data Set (MDS) dated [DATE] revealed that resident 10 had a Brief Interview of Mental Status (BIMS) score of 14 which indicated intact cognition. A physician's order for Resident 10 revealed the following: Humalog Injection Solution 100 UNIT/ML injected subcutaneously before meals and at bedtime related to type 2 diabetes mellitus with diabetic neuropathy. Specific times being, 7:00 AM, 11:30 AM, 4:30 PM, and 8:00 PM. A physician's order for Resident 10 revealed the following: Lantus Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) Inject 25 units subcutaneously at bedtime with time ranges of 7:00 PM through 9:00 PM. On 10/3/24 Lantus Subcutaneous Solution was administered at 11:18 PM, which was 3 hours and 18 minutes overdue. On 10/3/24 Insulin Humalog Injection Solution was administered at 11:18 AM, which was 3 hours and 18 minutes overdue. On 10/4/24 Lantus Subcutaneous Solution was administered at 10:00 PM, which was 2 hours and 1 minute overdue. On 10/4/24 Insulin Humalog Injection Solution was administered at 9:58 PM, which was 1 hour and 58 minutes overdue. On 10/5/24 Lantus Subcutaneous Solution was administered at 10:41 PM, which was 2 hours and 41 minutes overdue. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/5/24 Insulin Humalog Injection Solution was administered at 10:45 PM, which was 2 hours and 45 minutes overdue. On 10/6/24 Lantus Subcutaneous Solution was administered at 11:14 PM, which was 3 hours and 14 minutes overdue. On 10/6/24 Insulin Humalog Injection Solution was administered at 11:27 PM, which was 3 hours and 27 minutes overdue. On 10/10/24 Lantus Subcutaneous Solution was administered at 11:48 PM, which was 3 hours and 48 minutes overdue. On 10/10/24 Insulin Humalog Injection Solution was administered at 11:48 PM, which was 3 hours and 48 minutes overdue. On 10/11/24 Lantus Subcutaneous Solution was administered at 10:51 PM, which was 2 hours and 51 minutes overdue. On 10/11/24 Insulin Humalog Injection Solution was administered at 11:04 PM, which was 3 hours and 4 minutes overdue. On 10/12/24 Lantus Subcutaneous Solution was administered at 11:08 PM, which was 3 hours and 8 minutes overdue. On 10/13/24 Insulin Humalog Injection Solution was administered at 9:21 PM, which was 1 hour and 21 minutes overdue. On 10/13/24 Lantus Subcutaneous Solution was administered at 9:24 PM, which was 1 hour and 24 minutes overdue. On 10/18/24 Insulin Humalog Injection Solution was administered at 10:00 PM, which was 1 hour overdue. On 10/17/24 Lantus Subcutaneous Solution was administered at 11:32 PM, which was 3 hours and 32 minutes overdue. On 10/20/24 Lantus Subcutaneous Solution was administered at 11:02 PM, which was 3 hours and 2 minutes overdue. On 10/20/24 Insulin Humalog Injection Solution was administered at 11:49 PM, which was 49 minutes overdue. On 10/24/24 Lantus Subcutaneous Solution was administered at 11:34 AM, which was 3 hours and 34 minutes overdue. On 10/25/24 Lantus Subcutaneous Solution was administered at 12:07 AM, which was 4 hours and 7 minutes overdue. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465191	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Meadow Rehabilitation and Nursing	2520 South Redwood Road West Valley City, UT 84119

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/24 Insulin Humalog Injection Solution was administered at 12:07, which was 4 hours and 7 minutes overdue. On 10/26/24 Insulin Humalog Injection Solution was administered at 9:54 PM, which was 54 minutes overdue. On 10/27/24 Insulin Humalog Injection Solution was administered at 11:43 PM, which was 2 hours and 43 minutes overdue. On 10/29/24 at 8:30 AM, an interview was conducted with the Assistant Director of Nursing (ADON). ADON stated the medication administration times were: 6:00 AM-9:00 AM, 11:00 AM-1:00 PM, 3:00 PM-5:00 PM, and 7:00 AM-9:00 AM. ADON stated that the insulin scheduled times for the morning was at 7:00 AM, with an administration time window of 6:00 AM-8:00 AM. Mid-day insulin scheduled time was 11:30 AM, with an administration time window of 10:30 AM-12:30 PM. Evening insulin scheduled time was 4:30 PM, with an administration time window of 3:30 PM-5:30 PM. ADON stated that there could be implications, depending on the medication. ADON stated that she makes sure that she does everything in her power to not be late. ADON stated that she likes to administer insulin as close to mealtimes as possible and that she would postpone other medication to get all scheduled insulin orders administered on time. ADON stated that the risk of not giving insulin at the ordered time could cause blood sugars to spike or drop too low, which created additional concerns. Per the National Library of Medicine regarding Nursing Rights of Medication Administration indicated the following: 'Right time' - administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level. A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability or other chemical mechanisms . https://www.ncbi.nlm.nih.gov/books/NBK560654/