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	04/03/2025

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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview and record review it was determined, for 1 of 19 sampled residents, the facility must obtain laboratory services only when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist. In addition, the facility must promptly notify the ordering physician of laboratory results that fall outside of clinical reference ranges. Specifically, resident's urinalysis (UA) results were not obtained from the lab and reported to the ordering physician. Resident identifier: 6. Findings include: Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with generalized muscle weakness, type II diabetes, need for assistance with personal cares, and chronic kidney disease stage 3. The medical record of resident 6 was reviewed 3/31/25 through 4/3/25. A progress note dated 1/16/25 documented, .pt [patient] co [complained of] retaining urine [sic] retention, straight Cath [catheter] performed on patient and there was 255 mls [milliliters] postvoid. PT also co dysuria, urine appeared dark and had strong odor. Notified [provider] NEW orders: send sample to Lab and do UA C&S [culture and sensitivity]. A physician's order dated 1/20/25 revealed resident 6 was to be straight cathed to obtain a urine sample. The Laboratory Analysis results collected on 1/16/25, and completed on 1/20/25, were reviewed. The lab results revealed resident 6's urine was positive for protein, glucose, white blood cells and had Lactobacillus present. Progress note dated 1/29/25 revealed, Lab results for culture sent to [provider]. unable to obtain results due to presence of unknown interference substances. PT still experiencing symptoms and requested to be put on an antibiotic. Notified MD [medical doctor]. MD ordered Amoxicillin 875 mg po [by mouth] bid [twice daily] x [times] 7 days for UTI [urinary tract infection] symptoms. (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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were 9 days in between when the lab results were obtained and the provider was made aware of the results. Resident 6's Medication Administration Record (MAR) documented that Amoxicillin Oral Tablet 875 MG (milligrams). Give 875 mg by mouth two times a day for UTI for 7 Days was ordered on 1/29/25 and administered on 1/30/25. On 4/01/25 at 1:22 PM, an interview was conducted with Registered Nurse (RN) 1 who stated if a resident needed urine collected then the staff would obtain an order from the provider. RN 1 stated they would call or text the lab to come collect the sample. RN 1 stated the lab would come pick up the sample on the same day. RN 1 stated the lab would fax the results or they would call them if it is a stat order. If the results were faxed over the nurse on duty would then pass the information along in report to the other nurses. RN 1 stated the facility has an emergency kit (ekit) for antibiotics that would be used if the pharmacy could not bring the antibiotic. RN 1 stated if the antibiotic was available from the ekit the nursing staff would get it from there for the resident. RN 1 showed this surveyor the ekit and Amoxicillin 250 mg was observed to be in the ekit. On 4/02/25 at 1:58 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the nursing staff are expected to follow the provider orders, obtain the urine sample, and then notify the lab company to come collect the sample. The DON stated the lab would usually collect the sample the same day and would then send over the results when they were ready via fax. The DON stated that she had online access to the lab company and would watch for the results. The DON stated that if the on duty nurse got the results, they were expected to send those results to the provider. The DON stated she was unsure why it had taken so long for the resident to start antibiotics after an infection was found and would look into it. On 04/03/25 at 10:36 AM, a follow up interview was conducted with the DON. The DON stated the lab did not send the final result as they had in the past. The DON stated she did not look into it until the provider called and asked about the results. The DON stated she had missed it and with the process they had in place she should have checked with the lab before the provider had to call, but she had worked some night shifts that week and it it fell through the cracks. The DON stated the resident did not get started on abx until after the doctor had requested the result. The DON stated it should have and usually did happen sooner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on observation, interview, and record review, the facility did not establish an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Specifically, hand hygiene was not performed when delivering lunch trays between multiple resident rooms. Findings include: On 3/31/25 at 12:40 PM through 12:47 PM, an observation of the East Wing during lunch service was completed. An observation was made of Certified Nursing Assistant (CNA) 1 who served room [ROOM NUMBER] a food tray and placed the tray on the bedside table. CNA 1 was observed to have moved the table closer to the resident then exited room. CNA 1 then went to the meal cart without performing hand hygiene and grabbed a food tray for room [ROOM NUMBER]. CNA 1 delivered the tray, set up the meal for the resident, exited the room and hand hygiene was not completed. Certified Nursing Assistant Coordinator (CNAC) was observed to deliver a food tray to room [ROOM NUMBER] and exited the room, no hand hygiene was performed. CNAC proceeded to obtain another food tray and delivered it to room [ROOM NUMBER]. The CNAC was observed to set up the meal which included uncovering a drink and no hand hygiene was observed to have been performed. CNAC was then observed going into room [ROOM NUMBER] delivered a meal tray, exited the room and grabbed another food tray which was delivered to room [ROOM NUMBER], no hand hygiene was performed. On 3/31/25 at 12:30 PM, an observation was made of the lunch service for the 100 hallway. CNA 1 was observed to get a tray from the meal cart, no hand hygiene was observed before or after the tray was taken to room [ROOM NUMBER]. CNA 1 was then observed to take a meal tray into room [ROOM NUMBER], remove the cover and arrange items on the residents bed side table. No hand hygiene was performed on exiting of the room. CNA 1 was then observed to take a meal try into room [ROOM NUMBER], CNA 1 was observed to move the room curtain for the resident after setting up the meal tray. No hand hygiene was observed on exiting the room. CNA 1 was then observed to walk the dining room and get some covered cups filled with coffee. CNA 1 took a coffee cup to room [ROOM NUMBER] and removed the lid from the cup, no hand hygiene was observed. CNA 1 was then observed to take a tray into room [ROOM NUMBER], set up the tray, no hand hygiene was observed before entering or on exiting the room. On 4/2/25 at 12:19 PM, an observation was made of the CNAC passing meal trays in the 100 hallway, the CNAC was observed to have a cloth support wrap on her left hand that covered her palm and went up to her wrist. The CNAC was observed to take a meal tray to rooms [ROOM NUMBER] and assist with setting up the meal tray, no hand hygiene was observed before or after the interactions. On 4/3/25 at 8:30 AM, an interview was conducted with the CNAC who stated the staff should check each food tray for accuracy by lifting the lid of the meal and checking it against the food ticket. The CNAC stated each staff should use hand sanitizer each time they go in and out of a resident room, touch the meal tray or touch the residents items when setting up the meal tray. The CNAC stated that they needed to make sure they used hand sanitizer to keep the residents safe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/25 at 9:15 AM, an interview was conducted with the Director of Nursing (DON) who stated the staff should use hand hygiene before and after entering a resident's room. The DON stated when the staff pass meal trays they should use hand hygiene to keep everything clean.