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	04/22/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the irregularities reported by the pharmacist to the attending physician and Medical Director (MD) were acted upon. In addition, the facility did not ensure the attending physician documented in the resident's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. Specifically, for 5 out of 20 sampled residents, pharmacy recommendations were not acted upon by the MD and the MD did not document the identified irregularity and what action was taken in the resident's medical record. Resident identifiers: 10, 18, 19, 24, and 34.Findings included:1. Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, dementia, and paranoid schizophrenia. The facility Pharmacy Consult for March 2026 was reviewed. The recommendation for the physician documented, [Name redacted], [resident 18] uses Lantus and sliding scale Humalog. She only uses her evening and bedtime Humalog. Recommend changing her sliding scale to dinner and bedtime to decrease the number of times she's tested each day. The recommendation was not documented on a separate report and sent to the attending physician or facility MD for review. The MD did not document in resident 18's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. It should be noted that if no medication change was ordered, the MD should document their rationale in the medical record. 2. Resident 24 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic venous hypertension with ulcer of left lower extremity, schizoaffective disorder, and generalized anxiety disorder. The facility Pharmacy Consult for November 2025 was reviewed. The recommendation for the physician documented, [Name redacted], [resident 24's] GFR [glomerular filtration rate] was 47 when checked last month. She has an order for milk of magnesia that is contraindicated in renal impairment. Consider discontinuing this medication to prevent toxicity. The facility Pharmacy Consult for January 2026 was reviewed. The recommendation for the physician documented, [Name redacted], [resident 24's] blood pressure has been elevated (SBP [systolic blood pressure] 130-156). She currently takes lisinopril 5mg [milligrams] daily. Recommend increasing her dose to 10mg once daily. There was a handwritten note on the January 2026 Pharmacy Consult, MAR [Medication (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Record] updated. The facility Pharmacy Consult for February 2026 was reviewed. The recommendation for the physician documented, [Name redacted], [resident 24] hasn't used her PRN [as needed] Voltaren or Tums in over a month. Recommend discontinuing these medications if they're no longer needed. The recommendations were not documented on a separate report and sent to the attending physician or facility MD for review. The MD did not document in resident 24's medical record that the identified irregularities had been reviewed and what, if any, action had been taken to address it. It should be noted that if no medication change was ordered, the MD should document their rationale in the medical record. 3. Resident 10 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, major depressive disorder, post traumatic stress disorder, personality disorder, and generalized anxiety disorder. The facility Pharmacy Consult for January 2026 was reviewed. The recommendation for the physician documented, [Name redacted], [resident 10] hasn't used his PRN lidocaine patches or albuterol in over a month. Recommend discontinuing these medications if they're no longer needed. There was a hand written note on the Pharmacy Consult, 0 DC [discontinue] per MD The recommendation was not documented on a separate report and sent to the attending physician or facility MD for review. The MD did not document in resident 10's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. It should be noted that if no medication change was ordered, the MD should document their rationale in the medical record. 4. Resident 19 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, neurocognitive disorder with Lewy bodies, type 2 diabetes mellitus, dementia, major depressive disorder, generalized anxiety disorder, conversion disorder with seizures or convulsions, and cognitive communication deficit. The facility Pharmacy Consult for December 2025 was reviewed. The recommendation for the physician documented, [Name redacted], [resident 19] hasn't used his PRN Flonase, diclofenac, loperamide, Mucinex, or ondanstron [sic] in over a month. Recommend discontinuing these medications if they're no longer needed. The recommendation was not documented on a separate report and sent to the attending physician or facility MD for review. The MD did not document in resident 19's medical record that the identified irregularity had been reviewed and what, if any, action had been taken to address it. It should be noted that if no medication change was ordered, the MD should document their rationale in the medical record. 5. Resident 34 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, active primary progressive Multiple Sclerosis, major depressive disorder, and generalized (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety disorder. The facility Pharmacy Consult for January 2026 was reviewed. The recommendation for the physician documented, [Name redacted], [resident 34] hasn't used his PRN guaifenesin since November. Recommend discontinuing this medication if it's no longer needed. The facility Pharmacy Consult for March 2026 was reviewed. The recommendation for the physician documented, [Name redacted], [resident 34] has an order for triamcinolone cream to be used as needed. Please add a schedule to this medication so the nurses know how many times they can give it. The recommendations were not documented on a separate report and sent to the attending physician or facility MD for review. The MD did not document in resident 34's medical record that the identified irregularities had been reviewed and what, if any, action had been taken to address it. It should be noted that if no medication change was ordered, the MD should document their rationale in the medical record. On 4/22/26 at 9:46 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the pharmacist would review the residents' medications monthly and would send her the Pharmacy Consult reports. The DON stated that the MD reviewed the recommendations on the Pharmacy Consult reports and would sign off on them. The DON stated that the recommendations would be implemented if approved and uploaded into the resident's medical record. The DON stated that the pharmacist was doing separate forms for recommendations. [It should be noted that no separate recommendation forms were provided by the DON.]

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that the resident right to self-administer medications was clinically appropriate and safe. Specifically, for 1 out of 20 sampled residents, a resident was observed to have medication in their room and was not evaluated to determine if they were safe to self-administer that medication. Resident identifier: 1.Findings included:Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, personal history of pneumonia (recurrent), and pneumonitis due to inhalation of food and vomit.On 4/19/26 at 8:23 AM, an observation and interview were conducted with resident 1. A nebulizer machine and three vials of medication were observed on resident 1's night stand. Resident 1 stated the vials contained his nebulizer medication, which he administered throughout the day. Resident 1 stated that he would administer a vial after breakfast, before lunch, and before dinner. The April 2026 Medication Administration Record (MAR) was reviewed. The following medications were administered via the nebulizer machine.a. Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG [milligrams]/3ML [milliliters]) 0.083% (Albuterol Sulfate) 2.5 mg inhale orally every 4 hours as needed for SOB [shortness of breath] -Order Date12/30/2025. It should be noted that there were no administrations for April 2026.b. Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation) 0.25 mg inhale orally two times a day for SOB -Order Date12/30/2025. On 4/21/26 at 12:26 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that she did not have any residents that self administered medications and no residents had asked her if they could self administer their medications. On 4/21/26 at 12:44 PM, an interview was conducted with the Director of Nursing (DON). The DON stated they did not have any residents in the facility that self administered medications. The DON stated if a resident requested to self administer their medications there was an assessment that would be completed on admission and quarterly. The DON stated that they would provide the residents with a lock box for the medications. On 4/21/26 at 1:02 PM, an interview was conducted with resident 1. Resident 1 stated that the two vials of medicine next to his nebulizer machine were albuterol. Resident 1 stated that he also took budesonide but he took that medication immediately when the nurse brought it into his room. Resident 1 stated that they did not allow him to have the albuterol inhaler in his room but he preferred the albuterol nebulizer. Two vials of albuterol were observed next to the nebulizer machine.The facility policy Resident Self-Administration of Medication implemented on 4/11/25, was reviewed. Policy:It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.Policy Explanation and Compliance Guidelines:1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team.2. Resident's preference will be documented on the appropriate form and placed in the medical record.3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following:a. The medications appropriate and safe for self-administration;b. The resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections;c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for;d. The resident's capability to follow directions and tell time to know when medications need to be taken;e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.g. The resident's ability to ensure that medication is stored safely and securely.4. The results of the interdisciplinary team assessment are recorded on the MEDICATION (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SELF-ADMINISTRATION SAFETY SCREEN, which is an evaluation in the resident's medical record.5. Once evaluated for ability to self-administer medication orders are obtained from the medical provider to self-administer and the individual orders are updated to indicate self-administration.a. The nurse does not document on the MAR for medications that are self-administered unless the resident requires supervised self-administration.6. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur:a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective.b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy.7. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary.8. Medications stored at the bedside are reordered in the same manner as other medications.9. The nursing staff is responsible for proper rotation of bedside stock and removal of expired medications.10. When the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medications of residents permitted to self-administer are stored in the medication cart or medication room.11. Diabetic residents with attached insulin pumps for glucose control will follow the physician's orders for basal rates and/or bolus doses, blood glucose checks, and changing of infusion sets/tubing, cartridges, reservoirs, or syringes for the insulin and will notify staff of any changes in glucose readings, skin changes at the site insertion or pain at the delivery site.12. Resident may apply and self-monitor continuous glucose monitor (CGM) with physician approval if evaluated and deemed competent to do so. (See Continuous Glucose Monitors Policy)13. The care plan must reflect resident self-administration and storage arrangements for such medications and CGM devices.14. Medication errors occurring with residents who self-administer will not be counted in the facility's medication error rate.15. A re-assessment for safety at a minimum should be considered by the interdisciplinary team for the following:a. Significant change in resident's status.b. Medication errors occur.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were free of any significant medication errors. Specifically, for 1 out of 20 sampled residents, a resident taking two types of diuretics had those diuretics administered at the same time when they should have been 30 minutes apart. Resident identifier: 10.Findings included:Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, heart failure, systolic congestive heart failure, essential hypertension. A physician's order dated 4/1/26, documented metOLazone Oral Tablet 5 MG [milligrams] (Metolazone) Give 5 mg by mouth every 48 hours related to HEART FAILURE, UNSPECIFIED . *GIVE 30 MINUTES PRIOR TO BUMEX [bumetanide].A physician's order dated 4/1/26, documented Bumetanide Oral Tablet 2 MG (Bumetanide) Give 3 mg by mouth every 48 hours related to HEART FAILURE, UNSPECIFIED.The April 2026 Medication Administration Record was reviewed. The metolazone and bumetanide were administered at the same time every 48 hours.On 4/21/26 at 1:45 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that the medical record showed that the medications were given at the same time when they should have been administered 30 minutes apart per the physician's order. On 4/21/26 at 1:48 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the medications should be given 30 minutes apart. The DON stated the instructions to give the medication 30 minutes apart was in the additional directions but when staff clicked on the medication it was not populating. The DON stated she could add the instruction as a supplement to the documentation so it would prompt the nurses better.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and 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 1 out of 20 sampled residents, staff did not wear personal protective equipment (PPE) during wound care for a resident that should have been on Enhanced Barrier Precautions (EBP). Resident identifier: 34.Findings included:Resident 34 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, unspecified open wound of lower back and pelvis without penetration into retroperitoneum.A physician's order dated 4/8/26, documented SKIN TX [treatment] to chronic pilonidal ulcer: cleanse, pack with collagen sheet, cover with bordered dressing. every day shift.Resident 34 was observed to not have EBP signage outside his door or PPE available for use.On 4/20/26 at 10:30 AM, an observation and interview were conducted with Registered Nurse (RN) 1. RN 1 was observed to perform hand hygiene prior to entering resident 34's room and then donned gloves. Resident 34 stated the old bandage was removed because he had a bowel movement. RN 1 confirmed that the area was open a little bit. RN 1 cleaned the area with wound cleaner, doffed gloves, and performed hand hygiene. RN 1 donned gloves and packed the wound with a collagen sheet and applied a border dressing. RN 1 doffed gloves and performed hand hygiene. After wound care was completed, RN 1 stated that EBP precautions would be used for any open wound and anything that was leaking. RN 1 stated she would take precautions to prevent infection. RN 1 stated the facility was good with EBP and she did not think resident 34 needed EBP because of the stage of his wound and they were healing. RN 1 stated she had used EBP with another resident earlier because of the duration of contact with that resident. On 4/22/26 at 9:49 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that EBP should be implemented for any resident with a catheter, feeding tube, peripherally inserted central catheter (PICC) line, open wounds, and a history of multidrug-resistant organisms (MDRO). The DON stated if a resident was on EBP staff should have worn PPE, including a gown and gloves, for any high contact activity, such as a brief change and wound care. The DON stated that resident 34 had EBP in place for a very long time and last week she was told that not all wounds required EBP, only certain wounds. The DON stated that she was told all wounds with a dressing required EBP. The facility policy Enhanced Barrier Precautions implemented on 4/11/25, was reviewed. Policy:It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.2. Initiation of Enhanced Barrier Precautions:a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by CDC [Centers for Disease Control and Prevention] but may be considered epidemiologically important.b. An order for enhanced barrier precautions will be obtained for residents with any of the following:i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.)ii. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply.3. Implementation of Enhanced Barrier Precautions:a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care).b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.c. Ensure access to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alcohol-based hand rub in every resident room (ideally both inside and outside of the room).d. Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room.e. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education.f. Provide education to residents and visitors.g. Do not restrict room placement or out-of-room activities due to enhanced barrier precautions.h. See Table 1 for implementing contact versus enhanced barrier precautions for more information.4. High-contact resident care activities include:a. Dressingb. Bathingc. Transferringd. Providing hygienee. Changing linensf. Changing briefs or assisting with toiletingg. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline cathetersh. Wound care: any skin opening requiring a dressing .10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.

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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** Based on interview and record review, the facility did not ensure that residents were offered the influenza vaccine and that the medical record included documentation that the resident either received the vaccine or did not due to medical contraindications or refusal. Specifically, for 1 out of 5 sampled residents, there was no documentation of declination of the influenza vaccine. Resident identifier: 19.Findings included: Resident 19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, but were not limited to, neurocognitive disorder with Lewy bodies.A review of resident 19's immunizations in the medical record documented the last influenza vaccine was completed on 10/25/24. There was no documentation for the current 2025/2026 influenza season.On 4/22/26 at 11:09 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated they did not have the requested documentation for resident 19. The RNC stated they had a spreadsheet that resident 19 refused but no declination form was completed. The RNC stated on admission the immunization consent forms were in the admission paperwork. The RNC stated that every September and October they would offer the Covid, influenza, and pneumococcal vaccines to the residents. The RNC stated they would audit those residents who were ready and would do an immunization clinic.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were offered the Coronavirus disease 2019 (COVID-19) vaccines. Specifically, for 1 out of 5 sampled residents, no documentation was located to demonstrate how the resident accepted or refused the COVID-19 vaccination. Resident identifiers: 19. Findings included:Resident 19 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which include, but were not limited to, neurocognitive disorder with Lewy bodies.A review of resident 19's immunization in the medical record revealed no documentation for the current 2025/2026 COVID-19 season.On 4/22/26 at 11:09 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated they did not have the requested documentation for resident 19. The RNC stated they had a spreadsheet that resident 19 refused but no declination form was completed. The RNC stated on admission the immunization consent forms were in the admission paperwork. The RNC stated that every September and October they would offer the Covid, influenza, and pneumococcal vaccines to the residents. The RNC stated they would audit those residents who were ready and would do an immunization clinic.