

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2025
NAME OF PROVIDER OR SUPPLIER  Meadow Peak Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  6084 South Summit Vista Boulevard Taylorsville, UT 84129	

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)
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>An abbreviated complaint survey was conducted on July 9, 2025. Based on interview, observation, and record review, it was determined that for 1 of 5 sampled residents, that the facility failed to provide the services consistent with the resident's needs and choices. Specifically, a resident was not offered a shower for 15 days. Resident identifier: 1. An abbreviated complaint survey was conducted on July 9, 2025. Based on interview, observation, and record review, it was determined that for 1 of 5 sampled residents, that the facility failed to provide the services consistent with the resident's needs and choices. Specifically, a resident was not offered a shower for 15 days. Resident identifier: 1. Findings IncludeThe surveyor reviewed Resident 1's medical records, and the following entries were observed: Resident 1's care plan, initiated May 30, 2025, indicated that Resident 1 had an Activities of Daily Living self-care performance deficit related to her diagnoses. The intervention listed that Resident 1 was able to bathe with a one-person staff assist. Resident 1's Minimum Data Set assessment, dated June 11, 2025, indicated that Resident 1 required substantial/maximal assistance for showering or bathing. Resident 1's shower log revealed that Resident 1 was given a shower on June 13, 2025. It should be noted that this was the first shower given to Resident 1 in 15 days. On July 15, 2025, the survey interviewed the Director of Nursing (DON). The DON stated that all residents are offered showers twice a week. The DON stated that residents can refuse showers or request more showers, and the facility staff would accommodate the residents' needs. The DON stated that staff were instructed to document shower refusals. The DON stated that Resident 1 had refused showers and staff failed to document the refusals. The DON stated that Resident 1 had been given showers that were not documented.</p>

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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