STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465192	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Peak Rehabilitation	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 1 out of 25 sampled residents, a resident that was dependent on cares was left unattended in the shower, sustained a head laceration that required eight staples and six stitches, and the resident sustained a pelvic fracture. Resident identifier: 118. Findings included: Resident 118 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, fracture of pubis, subluxation of right shoulder joint, localized edema, dysphagia, history of falling, moderate protein-calorie malnutrition, and essential hypertension. Resident 118's medical record was reviewed on 5/20/24. A state optional Minimum Data Set (MDS) assessment dated [DATE], documented that resident 118 required extensive assistance of two plus persons for bed mobility, transfers, and toilet use. A quarterly MDS assessment dated [DATE], documented that resident 118 had a Brief Interview for Mental Status (BIMS) score of 6. A BIMS score of 0 to 7 would indicate severe cognitive impairment. On 1/29/24 at 10:08 AM, a Skilled Nursing Note documented Resident is A&Ox2 [alert and oriented to person and place] and speaks Cantonese only. Staff to anticipate her needs. Resident had no negative behaviors observed or reported this morning. Resident took her morning medications with applesauce with no difficulty swallowing. Resident is an extensive assist x [by] 2 person for ADL's [activities of daily living], bed mobility, and transfers. Resident users her wheelchair for mobility with extensive assist x 1 person. Resident is very limited with ROM [range of motion] r/t [related to] disease process. Resident is turned and repositioned q2h [every two hours] and prn [as needed] to prevent skin breakdown. Call light within reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/2/24 at 6:45 AM, a Nursing Progress Note documented Note Text: FALL EVENT: CNA [Certified Nursing Assistant] reported to RN [Registered Nurse] that resident has fallen on the floor while attempting her morning shower. RN approached and noted blood on residents face. CNA was applying pressure on the right side of her head to stop the active bleeding. RN observed her head and noted a laceration on the right side of her forehead. Resident was unresponsive to stimuli for a minute. She came back and became agitated and calling out words in her primary language. Vitals [vital signs] immediately taken BP [blood pressure] 169/83 HR [heart rate] 86 O2 [oxygen] 90% @RA [at room air], temp [temperature] 97.4F [Fahrenheit] by CNA and nursing student. RN meanwhile called provider to report and called 911. Report was given 911 representative. Patient family or daughter was notified over the phone. First responders arrived, report given with patient info and they told RN that she will be taken to the nearest hospital which is [name of hospital redacted]. On 3/2/24, an Emergency Department (ED) physician note documented . Alzheimer's dementia who presents to the emergency department from her care facility with concern of fall resulting in head trauma with a laceration. Unclear how the patient fell , as reported she fell while showering but patient is nonambulatory and has chronic contractures of her arms and legs. She was offered admission but family has decided they would like to put her back on hospice and send her back to her care facility. They do not want any further interventions and understands she could get worsening [sic] even die from these injuries and her electrolyte abnormalities, . ASSESSMENT AND PLAN: #Pelvic fractures . Nonoperative, Weight-bear as tolerated though nonambulatory at baseline, Unable to provide benefit with PT [physical therapy] #Age Indeterminate nondisplaced rib fractures . #Chronic right shoulder subluxation . #Forehead laceration Laceration was stapled by the ED attending . On 3/3/24 at 4:46 PM, a Nursing Progress Note documented Late Entry: Note Text: Late entry for 3/3/24: [name of hospice company redacted] nurse informed this nurse that resident had a fractured pelvis. Stated that is what was on the hospital discharge papers. Nurse assessed and no s/s [signs or symptoms] of pain while turning was observed. Resident has head laceration to the left side of her head. Resident has 8 staples and 6 stitches to head laceration. Wound shows no s/s of infection. Resident was more lethargic than her baseline. Resident would respond to verbal stimulation but would go right back to sleep. Resident requires O2 to maintain sats [saturations] > [greater than] 90%. O2 running at 2 L/min [liters per minute]. Resident lungs auscultated upper and lower lobes bilaterally with decreased sounds in the bases and crackles heard in the upper lobes with expiratory wheezing. Resident is sat up in bed to 30 degrees or more to help with her breathing. Resident is resting at this time with no s/s of distress. Staff to continue to monitor resident status throughout this shift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/4/24 at 5:01 PM, a Nursing Progress Note documented Note Text: Resident had a recent fall with injuries. Resident has a head laceration to the left side of her head with 8 staples and 6 stitches. Wound shows no s/s of infection. Wound was cleansed with NS [normal saline] and pat dried with gauze. This nurse spoke with [name redacted], [name of hospice company redacted], and he verified that resident does have a pelvic fracture and fractures to her 4th and 5th rib on the left side. Resident shows no grimacing or guarding during cares. Today, resident asked, through translation through her daughter, [name redacted], that she wanted to use the restroom. Staff got resident up into her wheelchair and was able to use the restroom. Resident had a medium BM [bowel movement]. V/S [vital signs] taken BP: 122/58 P [pulse]: 76 R [respirations]: 16 T [temperature]: 97.7 O2: 87% on 2 L [liters] O2 via NC [nasal cannula]. O2 was titrated up to 3 L O2. While resident was on the toilet, resident had clear, yellowish emesis. Staff got resident into bed and raised the HOB [head of bed] to >30 degrees. Resident did eventually stopped vomiting. New order received from [name of hospice company redacted] on 3/4/24: 1. Albuterol 0.63 mg [milligrams]/3 ml [milliliters] 1 vial nebulize vial q4h [every four hours] PRN for SOB [shortness of breath]; 2. suction machine use yaunker suction PRN for secretions; 3. Keep HOB up 30 degrees at all times, do not lay flat; 4. 2 person assist for any moving/transferring of patient; 5. Please premedicate before any moves or brief changes. A care plan Focus dated 3/5/24, documented [Resident 118] is risk for falls r/t hx [history] of frequent falls. The interventions initiated on 3/5/24, included: a. Anticipate and meet resident 118's needs. Encourage to wait for assistance. b. Be sure bed was in low position and locked in place. c. Be sure resident 118's call light was within reach and encourage the resident to use it for assistance as needed. Resident 118 needs prompt response to all requests for assistance. d. Educate the resident, family, and caregivers about safety reminders and what to do if a fall occurs. e. Encourage to wear well-fitting, non-skid footwear when transferring and ambulating. f. Ensure adequate lighting in room. Check night lights and call lights at bedside, bathrooms and shower rooms, ensure call light was within reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 3/5/24 at 7:49 AM, a Nursing Progress Note documented Note Text: Resident had a recent [fall] with injuries. Resident has a laceration to the right side of her head with 8 staples and 6 stitches. Wound shows no s/s of infection. Resident also sustained fractured pelvis and the 4th and 5th ribs on her left side. Nurse educated staff on careful turning and repositioning during cares. Resident is premedicated before all cares for Pain. Resident had no s/s of pain with no facial grimacing or guarding during cares. V/S taken this morning BP: 105/56 P: 67 R: 16 T: 97.6 O2: 90% on 3L O2 via NC. Resident has expiratory wheezes and crackles. Nurse suctioned her this morning per MD [Medical Director] order. Lungs auscultated upper and lower lobes bilaterally with decreased sounds in the bases and crackles heard in the upper lobes. Resident is sat up to 30 degrees or more per MD order. Nurse observed right sided weakness. She is having a hard time getting her right arm up to her walker when she's using the restroom to help balance herself. Staff to stay with her while she's on the toilet. Resident is alert to self and is unable to appropriately communicate her needs r/t language barrier. Staff to anticipate needs and use her picture board to help convey her needs. Resident is more lethargic and did not wake during V/S this morning. Resident is turned and repositioned q2h and PRN to prevent skin breakdown. Staff to continue to monitor resident throughout this shift to ensure comfort and safety. Push pad call light is within reach. On 3/5/24 at 4:57 PM, a Nursing Progress Note documented Note Text : CNA informed nurse that resident wasn't responding to verbal or physical stimuli. Nurse went in and found resident not breathing and pale. Nurse auscultated heart for five minutes and heard no sounds. Time of death 1625 [4:25 PM] on 3/5/24. Family was present while nurse was listening to her heart. [Name redacted] from [name of hospice company redacted] was notified. On 5/21/24 at 12:15 PM, an interview was conducted with CNA 2. CNA 2 stated on the day in question it was resident 118's shower day. CNA 2 stated he put resident 118 in the shower chair and pushed resident 118 into the shower room. CNA 2 stated the shower room was in the resident's bathroom. CNA 2 stated the towels and gloves were in the chair in resident 118's room. CNA 2 state he grabbed the towels and gloves that were in the chair and when he came back to the shower room resident 118 was on the floor. CNA 2 stated there should have been two people for the transfer of resident 118 to the shower Chair. CNA 2 stated when he put resident 118 in bed he could do that by himself even though resident 118 was heavy. CNA 2 stated that CNA 3 had helped him transfer resident 118 to the shower chair and then CNA 3 left to go back to her section. CNA 3 stated that resident 118 only needed one person for the shower. On 5/21/24 at 2:51 PM, an interview was conducted with CNA 3. CNA 3 stated that she had helped CNA 2 transfer resident 118 from the bed to the chair but she did not help CNA 2 transfer resident 118 to the shower chair the night of the incident. CNA 3 stated that CNA 2 was tall and a big guy and he probably transferred resident 118 himself. CNA 3 stated that she had heard resident 118 scream but resident 118 was already on the floor when she had arrived at resident 118's room. CNA 3 stated that resident 118 was not able to sit in a chair by herself and that resident 118 would lean over. CNA 3 stated that the shower chair was a bench with holes and it did not have sides. CNA 3 stated resident 118 was a two person assist for transfers, resident 118 could not walk, and resident 118 was total dependent with cares. CNA 3 stated that resident 118 was a one person assist for showers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/21/24 at 3:01 PM, an interview was conducted with the PT Director. The PT Director stated that resident 118 was never able to ambulate while resident 118 was a resident at the facility. The PT Director stated that resident 118's right ankle had limited ROM and the left ankle was more so limited. The PT Director stated that resident 118's right hand had limited ROM. The PT Director stated that resident 118 was able to sit in a chair unassisted. The PT Director stated if the shower chair had a back rest he would think that resident 118 would have been able to sit up. The PT Director stated that resident 118 would sit in the bedside chair for extended periods. On 5/21/24 at 3:13 PM, an interview was conducted with Medication Technician (MT) 3. MT 3 stated she was not working the night that resident 118 fell . MT 3 stated the day that resident 118 was getting her shower the staff were not using the shower chair that should have been used. An observation was conducted with MT 3 of a similar shower chair that was used when resident 118 fell . The shower chair was observed to be a bench with holes and the bench had a back rest attached. An observation was conducted with MT 3 of a similar shower chair that resident 118 should of been using. The shower chair was observed to look like a bedside commode with arm rest but according to MT 3 the one resident 118 used was smaller. MT 3 stated that resident 118 did not lean when sitting in a chair and was more ridged. MT 3 stated that resident 118 was dependent on all cares. MT 3 stated that resident 118 was not able to hold onto the arm rests of the shower chair and the arm rests were more for security. MT 3 stated that resident 118 had limited ROM in her hands but would hold onto a walker from a sitting position in the wheelchair. MT 3 stated resident 118 would not be able to grasp the walker to get up and walk. On 5/21/24 at 3:30 PM, an interview was conducted with RN 2. RN 2 stated it was early morning and she had just started her shift. RN 2 stated that she liked to do rounds to look in on the residents to see how they were doing and resident 118 was sleeping. RN 2 stated the CNA went to shower resident 118 and it happened so fast. RN 2 stated that resident 118 was bleeding from the head and she had applied pressure to the area. RN 2 stated that resident 118 usually required one person for showers. RN 2 stated that resident 118 was very low maintenance. RN 2 stated that resident 118 spoke Cantonese and the family was very involved. RN 2 stated that during the day resident 118 would sit in her chair and would have a walker in front of her. RN 2 stated that having the walker in front of resident 118 was a mental thing and resident 118 had her bags on the walker. RN 2 stated that resident 118 could not pull herself up or walk. RN 2 stated it was an unfortunate event. On 5/22/24 at 12:49 PM, an interview was conducted with the Director of Nursing (DON). The DON stated they had continued education with the staff regarding gathering supplies before going into the shower and using the call light to ask for assistance. The DON stated that she would have not thought that resident 118 could not be left alone. The DON stated that resident 118 would sit on the edge of the bed. The DON stated that resident 118 did not have to have the walker to sit on the edge of the bed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on interview and record review, the facility did not ensure each resident's drug regime was free from unnecessary drugs. Specifically, for 1 out of 25 sampled residents, staff were not monitoring a resident's blood pressure as instructed in a physician's order. Resident identifier: 33. Findings Included: Resident 33 was admitted to the facility on [DATE] with diagnoses which included end state heart failure, depression, hypertensive heart and chronic kidney disease, encounter for palliative care, chronic combined systolic and diastolic heart failure, anxiety disorder, paroxysmal atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease, hyperlipidemia, essential hypertension, and gastro-esophageal reflux disease. Resident 33's medical record was reviewed on 5/23/24. Resident 33 had a physician's order that stated, amLODIPine Besylate Oral Tablet 10 MG [milligrams] (Amlodipine Besylate). The order stated, Give 10 mg by mouth one time a day related to ESSENTIAL (PRIMARY) HYPERTENSION. The order instructed to Hold if SBP [systolic blood pressure] < [less than] 110 or DBP [diastolic blood pressure] <60. Call physician if SBP > [greater than] 180. The Start Date was 12/2/23 at 8:00 AM. Resident 33's Medication Administration Record (MAR) was reviewed. a. The March 2024 MAR documented that resident 33 received Amlodipine from 3/1/24 to 3/12/24, and 3/14/24 to 3/31/24. Resident 33 did not receive Amlodipine on 3/13/24, due to the resident not being at the facility that day. b. The April 2024 MAR documented that resident 33 received Amlodipine from 4/1/24 to 4/29/24, and Amlodipine was refused by resident 33 on 4/30/24. c. The May 2024 MAR documented that resident 33 received Amlodipine each day from 5/1/23 to 5/23/23. Resident 33's blood pressure (BP) values were reviewed and the following were documented. The BP values were recorded in millimeters of mercury. a. On 3/22/24, 100/52 b. On 3/23/24, 110/57 c. On 3/24/24, 102/66 d. On 3/24/24, 99/69 e. On 3/26/24, 112/69 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. On 4/13/24, 102/58 g. On 5/19/24, 109/59 h. On 5/23/24, 130/70 On 5/22/24 at 8:08 AM, an interview with Licensed Practical Nurse (LPN) 1 was conducted. LPN 1 stated that if he were to documented a resident's vital signs prior to administering a blood pressure medication he would document the vital signs in the medical record under the vital signs tab. LPN 1 further stated that he may document the vital signs on the MAR also. LPN 1 stated he was not sure where the Certified Nursing Assistant's (CNA's) documented the vitals signs that they had collected. On 5/22/24 at 8:25 AM, an interview with Medication Technician (MT) 2 was conducted. MT 2 stated that if the nurse needed vital signs for a resident assessment then the nurse would document the vital signs. MT 2 stated that the other vital signs collected by the CNA's would have been documented by the CNA under the vital signs section of the resident's medical record. On 5/23/24 at 8:36 AM, an interview with MT 1 was conducted. MT 1 stated that typically when a resident had an order with specific parameters, the vital signs could be directly added to the MAR when medications were administered. MT 1 stated that resident 33's current vital signs were typically documented in resident 33's medical record, and she would refer to the most recent vital signs prior to administering the Amlodipine. MT 1 stated that resident 33's most recent blood pressure was documented on 5/19/24. MT 1 stated that she would take resident 33's blood pressure today prior to administering the Amlodipine because resident 33 did not have a more current blood pressure reading. MT 1 stated that resident 33's blood pressure would get documented in the vitals section of the medical record because there was not a place to add the blood pressure values to the MAR. On 5/23/24 at 9:00 AM, an interview with CNA 1 was conducted. CNA 1 stated that a nurse would instruct the CNA's as to which resident's needed vital signs taken. CNA 1 stated that sometimes the CNA's would chart the vital signs, and sometimes the CNA's would write down the vital signs and give the information to the nurse. CNA 1 stated that she had not yet taken resident 33's blood pressure today. On 5/23/24 at 9:06 AM, an interview with Registered Nurse (RN) 1 was conducted. RN 1 stated that nurses would normally create a sheet that included which residents needed their vital signs taken. RN 1 stated that if a resident had a medication that had specific parameters, the nurse or MT administering the medication was responsible for ensuring that the vital signs were recently done or checking the vital signs themselves prior to administering the medication. RN 1 stated that resident 33 had her blood pressure checked every morning. RN 1 stated that whomever checked resident 33's blood pressure would document the vital signs into resident 33's medical record. On 5/23/24 at 10:25 AM, an interview with the Director of Nursing (DON) was conducted. The DON stated that checking a resident's blood pressure was not always required for long term residents who were on a stable blood pressure medication. The DON stated that resident 33's order was changed in December of 2023 and the requirement to check the resident's blood pressure was supposed to be removed. The DON stated that the verbiage that instructed staff to check resident 33's blood pressure was left on the order, and that it was a mistake and should have been taken off.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on interview and record review, the facility did not ensure that residents did not receive psychotropic drugs pursuant to an as needed (PRN) order unless the PRN order for psychotropic drugs were limited to 14 days. If the attending physician or prescribing practitioner believed that it was appropriate for the PRN order to be extended beyond 14 days, they should document their rationale in the resident's medical record and indicate the duration for the PRN order. In addition, residents who have not used psychotropic drugs were not given these drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record. Specifically, for 2 out of 25 sampled residents, residents had PRN orders for Trazodone that were not limited to 14 days, and the physician or prescribing practitioner had not evaluated the residents for the appropriateness of the medication. In addition, a resident with an order for an antipsychotic medication did not have an appropriate indication for use. Resident identifiers: 28 and 44. Findings included: 1. Resident 44 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, encounter for orthopedic aftercare following surgical amputation, acquired absence of right foot, acute osteomyelitis right ankle and foot, dehiscence of amputation stump, type 2 diabetes mellitus, traumatic subdural hemorrhage with loss of consciousness, abrasion left great toe, dementia severe with agitation, essential hypertension, and normal pressure hydrocephalus. Resident 44's medical record was reviewed on 5/21/24. On 4/18/24, a physician's order documented traZODone HCl [hydrochloride] Oral Tablet 50 MG [milligrams] (Trazodone HCl) Give 25 mg by mouth every 4 hours as needed for agitation. The physician's order had an indefinite end date and was discontinued on 5/21/24. [Note: The physician's order was not limited to 14 days and the physician did not document their rationale in the resident's medical record for extending the Trazodone.] On 5/21/24, a physician's order documented traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 25 mg by mouth every 4 hours as needed for sleep pattern disturbance with depressive symptoms. The April and May 2024 Medication Administration Record (MAR) were reviewed. Resident 44 did not have any requested administrations of Trazodone in April 2024. Resident 44 had requested Trazodone on one occasion in May 2024 on 5/7/24. On 5/21/24 at 8:18 AM, a Nursing Progress Note documented Note Text: Resident is on psychotropic medications without appropriate diagnoses: Aripiprazole, Trazodone. Notified provider to address for appropriateness/continuation of medications. Resident does have sleep pattern disturbance, Dementia with occasional behaviors, and Moca [Montreal Cognitive Assessment] of 3. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 28 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affection right dominant side, functional quadriplegia, type 2 diabetes mellitus with foot ulcer and autonomic neuropathy, chronic kidney disease stage 3, esophageal varices without bleeding, atrial fibrillation, and chronic pain. Resident 28's medical record was reviewed on 5/22/24. The hospital discharge orders dated 5/2/24, included a prescription details for quetiapine fumarate. The prescription included to dispense five tablets with no refills. On 5/2/24, a physician's order documented QUEtiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 6.25 mg by mouth at bedtime for delusions. Resident 28 had no documented behaviors of delusions and resident 28 did not have an appropriate indication for use. On 5/2/24, a physician's order documented traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 50 mg by mouth every 24 hours as needed for sleep. The physician's order had an indefinite end date and was discontinued on 5/21/24. [Note: The physician's order was not limited to 14 days and the physician did not document their rationale in the resident's medical record for extending the Trazodone.] On 5/21/24, a physician's order documented traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 50 mg by mouth every 24 hours as needed for sleep pattern disturbance related to INSOMNIA, . The May 2024 MAR was reviewed. Resident 28 did not have any requested administrations of Trazodone in May 2024. On 5/22/24 at 12:52 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The DON stated that psychotropics were reviewed on admission and the goal was to have a 14 day stop on PRN psychotropics and a review of the medications. The DON stated the psychotropic meeting was held once a month and the Medical Director attended. The DON stated that gradual dose reductions were in place for residents. The DON stated that she preferred not to use many psychotropics but some residents required them. The DON stated the psychotropic meeting would have been held today and the residents in question would have been reviewed. The ADON stated if the resident was not using the PRN medication then it would have been discontinued.

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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** 33215 Based on interview and record review, the facility did not obtain laboratory (lab) services only when ordered by a physician; physician assistant; nurse practitioner (NP) or clinical nurse specialist. Specifically, for 1 out of 25 sampled residents, a resident had additional labs completed without a physician's order after the resident had completed their antibiotic therapy. Resident identifier: 44. Findings included: Resident 44 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, encounter for orthopedic aftercare following surgical amputation, acquired absence of right foot, acute osteomyelitis right ankle and foot, dehiscence of amputation stump, type 2 diabetes mellitus, traumatic subdural hemorrhage with loss of consciousness, abrasion left great toe, dementia severe with agitation, essential hypertension, and normal pressure hydrocephalus. Resident 44's medical record was reviewed on 5/21/24. On 4/5/24, the hospital Discharge Orders documented . Discharge Antimicrobial Recommendation: Patient will need: Cefuroxime 500 mg [milligrams] PO [by mouth] twice daily for 2 weeks. Second antibiotic: Doxycycline 100 mg PO twice daily for 2 weeks. Stop Date: 4/26/24 While receiving antibiotics recommend the following labs near planned stop date of therapy (SNF [Skilled Nursing Facility], please draw) CBC [complete blood count] w/diff [with differential] CMP [comprehensive metabolic panel] ESR [erythrocyte sedimentation rate] CRP [c-reactive protein] . A physician's order dated 4/18/24, documented Cefuroxime Axetil Oral Tablet 500 MG (Cefuroxime Axetil) Give 500 mg by mouth two times a day for infection until 04/26/2024 23:59 [11:59 PM]. A physician's order dated 4/18/24, documented Doxycycline Hyclate Oral Tablet 100 MG (Doxycycline Hyclate) Give 100 mg by mouth two times a day for infection until 04/26/2024 23:59. A physician's order dated 4/19/24, documented CBC with Diff, CMP, ESR, CRP fax to [doctors name redacted] when results received on 4/24/2024 one time only for 4 Days. The physician's order had a start date of 4/23/24. On 4/29/24 at 9:06 AM, a Nursing Progress Note documented Late Entry: Note Text: NP reviewed recent lab work from 04.29.2024, NNO [no new orders]. CBC W/ [with] Auto Diff [differential], CMP, ESR, [NAME], Sed [sedimentation] Rate, CRP. A lab result dated 5/8/24, documented that a CBC, CMP, and a CRP test were collected. On 5/10/24 at 9:26 AM, a Nursing Progress Note documented Note Text: NP reviewed recent CMP CRP CBC results from 05.08.2024, NNO. A lab result dated 5/16/24, documented that a CBC, CMP, CRP, and an ESR were collected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465192	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Peak Rehabilitation	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)
F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No documentation could be located or provided to indicate a physician's order was written for the labs collected on 5/8/24 and 5/16/24. On 5/22/24 at 12:47 PM, an interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The DON stated that the order from the hospital was to complete the labs weekly. The ADON stated that the antibiotic was stopped on 4/26/24. The ADON stated that resident 44 saw the infectious disease doctor on 5/14/24. The DON stated that they continued the lab orders until resident 44 saw the infectious disease doctor.