STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465166	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspen Ridge West Transitional Rehab	5323 South Murray Boulevard Murray, UT 84123

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 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** 43212 Based on observation, interview, and record review it was determined, for 1 of 21 sampled residents, that the facility did not ensure that the resident right to self-administer medications was clinically appropriate and safe. Specifically, residents were observed to have medications on the bedside table and were not evaluated to determine if they were safe to self-administer medications. Resident identifiers: 20 and 27. Findings included: 1. Resident 20 was admitted to the facility on [DATE] with diagnoses which included wedge compression fracture of first, second, and third lumbar vertebra, fusion of spine, metabolic encephalopathy and cardiac arrhythmia. Resident 20's medical records were reviewed from 8/19/24 through 8/21/24. On 8/21/24 at 8:10 AM, an observation was made during morning medication pass for resident 20. Resident 20 stated, If I take any more pills, I will throw up. Registered Nurse (RN) 1 placed the medication cup with two large white pills and a medication cup with 10 milliliters (ml) of magic mouthwash on resident 20's bedside table. RN 1 stated to resident 20 to take them when she was able to, RN 1 then left resident 20's room. On 8/21/24 at 8:12 AM, an interview with RN 1 was conducted. RN 1 stated that she had left the medications at resident 20's bedside due to the resident stating, that if she took any more pills she would throw up. RN 1 identified the medications in the medication cup as omeprazole-sodium bicarbonate 20-1.1 (milligrams) mg and potassium chloride capsule 10 (milliequivalent) mEq. RN 1 stated she was not sure if resident 20 had any orders that allowed her to self-administer medications. RN 1 stated when a resident was not ready for their medications, she would leave them on the bedside table. RN 1 stated she would then follow up with the resident to make sure the medications were taken. 2. Resident 27 was admitted to the facility initially on 7/22/24, and readmitted on [DATE] with diagnoses that included presence of urogenital implants, long term use of anticoagulants, pretension of urine, pressure ulcer, acute respiratory failure with hypoxia, cardiac arrhythmia, Parkinson's disease, and pneumonia. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 9:30 AM, an interview was attempted with resident 27. Resident 27 appeared to be confused and was not answering questions appropriately. Resident 27 was observed to have a nasal cannula in place and was receiving oxygen and a significant tremor in both hands was observed. On 8/20/24 at 9:36 AM, an observation was made of resident 27, who was laying on her bed. It was observed that resident 27 had a small cup with several medications on the bedside table next to her bed. Resident 27 did not answer when asked if she administered her own medications or if she knew what medications were in the cup. Resident 27's medical records were reviewed between 8/19/24 and 8/21/24. An MDS (Minimum Data Set) admission assessment dated [DATE] revealed that resident 27 had a BIMS (Brief interview for Mental Status) assessment score of 6, suggesting significant cognitive impairment. On 8/17/24 at 10:13 AM, A nursing progress note revealed, .Mental Status: Alert & [and]cooperative; Oriented to: Person, Place, Time and Situation .Additional notes: Alert and oriented x [times] 3 .Takes medication whole with water. On 8/19/24 at 11:00 AM, a nursing progress note revealed, .Mental Status: Alert & cooperative; Oriented to: Person, place, time and situation .Additional notes: Alert and oriented x 3 .Takes medications whole with water. Needs help getting medications to mouth because of essential tremors in both hands. It should be noted that no Self Administration Assessment was located in resident 27's medical record. On 8/21/24 at 9:33 AM, an interview was conducted with RN 1 who stated resident 27 was alert and oriented x 4 today, but that resident 27 was confused at times. RN 1 stated that she had to feed resident 27 her pills because she was always shaking and had trouble taking the pills herself. RN 1 stated sometimes resident 27 would forget that she had medications remaining in her cup and would not take them. RN 1 stated that she provided resident 27's medications during meals and that resident 27 did not have difficulty swallowing. RN 1 stated the concerns with resident 27 taking medications on her own were forgetting to take the medicaitons, or spilling the medicaitons due to her tremors. On 8/21/24 at 7:58 AM, an observation was made of RN 1 walking into resident 27's room with a cup of medications. RN 1 stated to resident 27 upon entering the room, Here are your meds. RN 1 was then observed to walk out of resident 27's room prior to the resident taking the medications. On 8/21/24 at 8:12 AM, an observation was made as RN 1 walked into resident 27's room and stated, Did you take all of your pills? RN 1 was then observed to walk out of resident 27's room with an empty medication cup and threw it away in medication cart trash can. On 8/21/24 at 10:24 AM, an interview with RN 2 was conducted. RN 2 stated that he would not leave medication at the bedside and that nursing staff were not allowed to leave medications at the bedside. RN 2 stated that medication should not be left at the bedside because another resident could take the medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at 10:48 AM, an interview with Director of Nursing (DON) was conducted. The DON stated if a resident refused medication, and if she could identify the medications, she would label the cup and lock the medications up. The DON stated if there were a lot of medications, she would waste them and repull them when the resident was ready to take them. The DON stated she would not leave any medications at the bedside for the resident to take when they were ready. The DON stated that a few residents could have eyedrops in their room which needed to be locked up. The DON stated prior to allowing a resident to have any medications left in their room the nursing staff would do a self-medication assessment. 47431