STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465067	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care- Clearfield	1481 East 1450 South Clearfield, UT 84015

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 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not treat each resident with respect, dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Specifically, for 5 out of 54 sampled residents, staff were not provided education on how to attach a resident's prosthetic arm, residents complained of having incontinent episodes while waiting for staff to answer call lights, when the staff member tried to empty the ostomy bag it detached, resulting in scattered stool everywhere, and a resident was seated at a table that was at her chin height for breakfast. The first example was cited at harm. Resident identifiers: 21, 34, 63, 86, and 113.Findings included:1. Resident 63 was admitted to the facility on [DATE] with diagnoses which included other lack of coordination, weakness, blindness in right eye category 3, blindness in left eye category 3, and acquired absence of left upper limb above elbow.On 5/6/26 at 2:07 PM, resident 63 stated during a Resident Council meeting that he would like staff to be trained on how to put on his arm. Resident 63 stated that facility nurses had told him they do not know how to put on his prosthetic arm. Resident 63 stated that he was out of luck when there was no one at the facility to help him.On 5/11/26 at 10:53 AM, resident 63 asked if the surveyor could help him put his arm on. Resident 63 stated that he had asked his nurse and she never came back to help him. On 5/11/26 at 10:56 AM, an observation was made of resident 63 asking the Infection Preventionist (IP) nurse to help him put his arm on. The IP was observed to wheel resident 63 to the therapy room without attaching his arm.On 5/13/26 at 8:09 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated he was the nurse for resident 63 that day. RN 1 stated that he had only been at the facility a couple of times and did not know how to put on resident 63's prosthetic arm. RN 1 stated that he thought that the therapy department put on resident 63's arm. On 5/13/26 at 8:13 AM, an interview was conducted with CNA 8. CNA 8 stated that he did not know how to put resident 63's prosthetic arm on. CNA 8 stated that resident 63 had to go to therapy to have them assist him with his arm.On 5/13/26 at 8:58 AM, an interview was conducted with the Physical Therapist (PT). The PT stated that the facility had an on-call therapist available on the weekends that could come into the facility if there was a new admission that needed an evaluation. The PT stated that resident 63 was not able to put on his prosthetic arm and therapy had been doing it for him. The PT stated that the therapy department should probably train some CNAs on how to put on resident 63's prosthetic arm. The PT stated that resident 63 probably did not wear his prosthetic arm on the weekends because no therapy staff were available to assist him.On 5/13/26 at 9:06 AM, an interview was conducted with resident 63. Resident 63 stated that he was not able to put his prosthetic arm on by himself. Resident 63 stated that he was unable to wear his arm on the weekends because there was not any staff that could assist him with putting the prosthetic arm on. Resident 63 stated that he would like to discharge from the facility and go home, but he needed to know how to use his prosthetic arm and he could not learn when he did not wear it. On 5/13/26 at 11:03 AM, an interview was conducted with theDirector of Nursing (DON). The DON stated that resident 63 was participating in physical and occupational therapy. The DON stated (continued on next page)

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	that he thought that nursing staff and therapy staff assisted resident 63 with putting on his prosthetic arm. The DON stated that he was under the impression that therapy was in the facility on the weekends and they placed resident 63's prosthetic arm on.2. On 5/5/26 at 10:37 AM, an interview was conducted with resident 34. Resident 34 stated the call light wait times was Horrendous, and he had to wait 45 minutes for his call light to be answered. Resident 34 stated it made him feel not important when he had to wait for his call light to be answered. Resident 34 stated other residents started yelling out to get assistance and they got faster assistance. Resident 34 stated they need more staff or more people. Resident 34 stated he had a Foley Catheter since admission. Resident 34 stated he felt like he should just go home because all he did was lay here. Resident 34 stated staff did not come in and check on them every 2 hours unless he used the call light. Resident 34 stated if he was transferred to his chair, then he had to stay in it for 2 hours but that hurt his back because of herniated discs in his back because he could not sit in the chair very long. (Cross refer to F690)3. Resident 86 was admitted on [DATE] and re-admitted on [DATE] with diagnoses which included aftercare following joint replacement surgery, fracture right femur, intervertebral disc disorders, type 2 diabetes mellitus, acquired absence of right leg below knee, morbid obesity, heart failure, presence of right artificial hip joint, hypertensive heart and chronic kidney disease. On 5/5/26 at 12:55 PM, an interview was conducted with resident 86. Resident 86 stated that when he pressed the call light it sometimes took forever to be answered. Resident 86 stated that he had therapy that was often delayed because he had to wait for staff assistance to get up. Resident 86 stated that he would push the call light and staff would give him a [NAME] excuse for not assisting him when he needed it. Why do they have a call light if they don't take care of the patient? Resident 86 stated that he was paying for services that he should be getting. Resident 86 stated that staff were always saying they were short staffed and they did not have enough time. Resident 86 stated that staff did not cut his fingernails so his wife had to come and do this for him. Resident 86 stated that his wife also had to help with incontinence care, cleaning feces and urine, because there was not enough staff to assist. Resident 86 stated that his wife was very upset about this and spoke with the Administration. The Administration came to speak with him and told him that they were working on fixing this but he had not seen any results yet. This is ridiculous. Resident 86 stated that he filed a grievance report with the Resident Advocate regarding these concerns. On 12/25/25, resident 86's Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 10/15, which would indicate a moderate cognitive impairment. The assessment documented that the resident was a substantial/maximal assistance with toileting, showers, bed mobility; partial/moderate assistance for upper body dressing; and dependent for lower body dressing and transfers. Resident 86's Care Plan had a focus area for alterations in Activities of Daily Living (ADL) function secondary to Right femur fracture that was initiated on 11/3/25. The interventions identified on the care plan included: 2-person assist with transfers - up to extensive assistance, assist in completing ADL tasks each day, encourage participation in Physical Therapy, and encourage use of call lights when ADL assistance is needed.The grievance log was reviewed and no documentation could be found of any complaints/concerns filed by resident 86.On 5/13/26 at 3:24, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 86 used a urinal and was incontinent of bowel. CNA 1 stated that resident 86 only required one staff for incontinence care as he was able to roll independently. CNA 1 stated that some days the facility was staffed well and others not so much. CNA 1 stated that the hallway that resident 86 resided on required more staff and was more needy. CNA 1 stated that after 6:00 PM it was crazy in the hallway. CNA 1 stated that it was difficult to complete tasks, and sometimes showers did not get completed due to low staffing. Even with a shower aide they sometimes don't get done. CNA 1 stated that incontinence care was done during rounds every 2 hours or as needed, and when it is super hectic a call light may be on for 15 minutes. CNA 1 stated that on the 300 hallway there was a resident that required 2 staff for incontinence care and it took an hour to provide so call lights were on for a longer time there. 4. Resident 113 was (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	admitted to the on 8/27/25 and readmitted on [DATE] with diagnoses which included Crohn's disease, encounter for attention to ileostomy, chronic obstructive pulmonary disease, stage 3 chronic kidney disease, and congestive heart failure. On 5/5/26 at 9:21 AM, an interview was conducted with resident 113. Resident 113 stated the agency staff were terrible. Resident 113 stated that on one occasion she requested staff assistance with her ostomy bag at 1:30 PM when the staff member tried to empty the ostomy bag it detached, resulting in scattered stool everywhere. Resident 113 stated the nurse left her room. Resident 113 stated she yelled for someone walking by and after that person searched for the nurse, they discovered that the nurse had gone home. Resident 113 stated she laid in her stool until 2:15 PM, despite the fact that her call light was activated. Resident 113 stated another occasion a staff member went to empty her ostomy and refused to follow her instructions to use a basin. Resident 113 stated the staff emptied the contents of her ostomy bag into a disposal bag, tied it, and upon lifting the bag burst stool all over the immediate area. Resident 113 stated the stool got in her mouth and the staff member started laughing. Resident 113 stated the staff were trying to put a dirty sheet on the dirty bed then handed her wipes to clean herself up. Resident 113 stated that when she requested a shower, the staff replied that it was too late for her to get one. On 5/13/26, a Daily Skilled Charting assessment documented that resident 113 required supervision or touching assistance for toilet hygiene. The assessment defined toilet hygiene as The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.Resident 113's Care Plan had a focus area for having an ostomy that was initiated on 1/19/26. The interventions initiated on the care plan included: Ostomy care every shift and as needed, monitor ostomy site every shift for signs and symptoms of infection or skin breakdown, and change ostomy site as prescribed. On 5/13/26 at 9:39 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 113 required assistance emptying her ostomy bag and the clean up involved, and that resident 113 would let CNAs know when she needed assistance. On 5/13/26 at 1:13 PM, an additional interview was conducted with resident 113. Resident 113 stated that she required assistance emptying her ostomy bag, especially when she received infusions, because the tubing hindered the process. Additionally, resident 113 stated that once a CNA had unintentionally detached the ostomy bag during the emptying process, spilling the contents onto her and the bed. Resident 113 stated that the CNA left to get a towel, but did not return, so she activated the call light. Resident 113 stated that she waited over an hour covered in stool before a different CNA assisted her. Resident 113 reported that the stool caused a burning sensation where it contacted her skin.5. On 5/5/26 at 12:46 PM, a confidential resident interview was conducted. The resident stated they had to wait an hour to have their call light answered especially during shift change. The resident stated there were usually a lot of staff that called out before their shifts and they were short staffed. The resident stated he needed more empathy from the staff who cared for them. There was a strong urine odor in the room. 6. Resident 21 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with diabetic neuropathy, heart failure, weakness and convulsions. On 5/7/26 at 8:00 AM, an observation was made of resident 21. Resident 21 was placed at a table that was at chin height. CNA 3 stated It's okay, we help her. Unit Manager (UM) 1 was observed to laugh. CNA 3 was observed to lock resident 21's brakes. A care plan dated 5/2/25 revealed resident 21 had alterations in ADL function secondary to weakness and impaired mobility. An intervention was to praise all efforts at self care. On 5/7/26 at 2:38 PM, an interview was conducted with CNA 3. CNA 3 stated she was an agency CNA. CNA 3 stated resident 21 went to the dining room for meals because she had a hard time swallowing and leaned to the side in the wheelchair. CNA 3 stated she prefers to have resident 21 upright in her chair. CNA 3 stated resident 21 used one of her hands to pick up finger foods. CNA 3 stated the table was really high for resident 21 but she usually put resident 21 at the shorter tables. CNA 3 stated resident 21's feet needed to remain elevated in the wheelchair. CNA 3 stated resident 21 struggled to eat at an angle at the shorter tables. On 5/7/26 at 2:56 PM, an interview was conducted with UM 1. UM 1 stated (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resident 21 ate in the dining room and was able to feed herself but sometimes needed assistance. UM 1 was observed to laugh and stated he noticed the table was too high for resident 21. UM 1 stated there were adjustable tables in the rehab so she needed one of those to best accommodate resident 21's table height so she can feed herself. (Cross refer to F725)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for 2 of 54 sampled residents, the facility did not ensure residents were given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living (ADLs), including hygiene and dining. Specifically, a resident with visual impairment was not provided assistance with dining and another resident was not provided assistance with bathing. Resident identifiers: 4 and 38.Findings included:1. Resident 4 was admitted to the facility on [DATE] with diagnoses which included category 5 blindness to the right and left eyes, stage 5 chronic kidney disease with heart failure, and type 2 diabetes mellitus.On 5/4/26 at 12:25 PM, an observation was made in the dining room while a meal was being served. Dietary Aide (DA) 1 placed resident 4's meal tray down in front of him and walked away without assisting with set up. A female resident, who was seated next to resident 4, was observed opening up the mustard packets and squeezing the mustard onto resident 4's plate. Additionally, the female resident was observed opening up resident 4's milk carton for resident 4 to pour into his two-handled mug. On 5/4/26 at 12:29 PM, an additional observation was made of DA 1 serving resident 4's food and walking away without assisting with set up. The female resident was observed opening a packet of butter and using a fork that she had used to feed herself to mix the butter into resident 4's mashed potatoes. On 5/2/26, a Daily Skilled Charting assessment documented that resident 4 required setup or clean-up assistance for eating. Eating was defined as the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Resident 4's care plan had a focus area for being at risk for nutritional deficits related to end-stage renal disease, dialysis, diabetes mellitus, anemia, heart failure, and anxiety that was initiated on 1/18/26. Interventions initiated on the care plan included: provide assistance with meals as needed and provide diet and snacks as prescribed. Additionally, the care plan had a focus area for impaired vision secondary to diabetic retinopathy and macular edema initiated on 1/18/26. Interventions initiated on the care plan included: assist with visual appliances and provide an environment free of clutter. On 5/13/26 at 10:20 AM, an interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated that resident 4 needed assistance with getting to the dining room because he could not see well. CNA 4 stated that while all residents should have received assistance setting up their meals in the dining room, resident 4 needed help opening some items. On 5/14/26 at 9:45 AM, an interview was conducted with resident 4, who stated that his poor vision required staff to orient him to the items on his meal tray and where the items were located. Resident 4 stated that he needed staff to open containers and serve the contents due to limited strength and dexterity in his fingers. Resident 4 stated that staff typically placed his tray down and then ran off before he had time to request assistance. Resident 4 stated that the experience was frustrating, and while he did not want to be impatient, staff did not take any time to assist him. Resident 4 stated that occasionally friends, who were also residents at the facility, assisted him at mealtimes, but that he was uncomfortable relying on those friends. Resident 4 stated that if his friends were unable, he had to raise his hand and wait until staff members noticed him. Resident 4 stated that staff would eventually help him, but he had to wait a long time. On 5/14/26 at 11:47 AM, an interview was conducted with the Director of Nursing (DON), who stated that the facility expected staff to identify the plate's contents, open all containers, and provide any necessary assistance when serving resident meal trays. 2. Resident 38 was admitted to the facility on [DATE] with diagnoses which included displaced fracture of medial malleolus of right tibia, displaced fracture of neck of left radius, person injured in unspecified vehicle accident, encounter for other orthopedic aftercare, other lack of coordination, abnormalities of gait and mobility, and pain disorder. On 5/4/26 at 2:34 PM, an interview was conducted with resident 38. Resident 38 stated she had been at the facility since December (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2025. Resident 38 stated she has had three showers and a bed bath since she was admitted . Resident 38 stated the facility was trying to fix the resident showers and they had shower days. Resident 38 stated that she showered on Saturday and Wednesday. Resident 38 stated that staff were supposed to ask three times in the day if you needed a shower and sign a form if you refused the shower. Resident 38 stated that one night the staff asked her after 9:30 PM, and she refused to sign the form because she was sleeping. Resident 38 stated that she was not asked on Saturday, 5/2/26, if she wanted to shower. A care plan Focus initiated on 12/24/25, documented [Resident 38] has alterations in ADL function secondary to recent multiple fractures that required an ORIF [open reduction and internal fixation], increase in assistance with ADLS, increase in weakness. The interventions included, but were not limited to, assist in completing ADL tasks each day. Weight bearing as tolerated to the right lower extremity and left upper extremity no weight more than 5 pounds. The TASK: ADL documented that resident 38 received bathing on Wednesday and Saturday. The medical record and shower sheets were reviewed for April and May 2026. Resident 38 did not receive a shower as scheduled on 4/8/2026, 4/15/2026, 4/22/2026, and 5/2/2026. On 5/11/26 at 8:36 AM, an interview was conducted with Unit Manager (UM) 2. UM 2 stated that resident 38 did not require much assistance with ADLs and resident 38 was pretty independent. UM 2 stated that all residents received assistance with showers even if they were a supervision or set up. UM 2 stated that showers were charted in the medical record and were assigned to a certain day. UM 2 stated if the shower was skipped or missed the CNA could use the as needed button in the electronic charting system for a different day. UM 2 stated the shower sheets were used with every shower and the Assistant Director of Nursing would track the shower sheets and refusals in her office. On 5/11/2026 8:43 AM, an interview was conducted with CNA 5. CNA 5 stated that she would complete a shower sheet for every shower and there was a separate sheet for the refusals. CNA 5 stated that the showers would be documented in the medical record. CNA 5 stated there were shower CNAs for the 100/200 hallway, 300/400 hallway, and the rehab side of the facility. CNA 5 stated there was not enough staff to complete showers. On 5/14/26 at 1:28 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there were days that resident 38 would shower herself and resident 38 would not let the staff know. The DON stated that staff would offer resident 38 a shower and resident 38 would ask the staff to come back another time until resident 38 would completely refuse for the day. The DON stated that resident 38 required supervision to partial assistance for ADLs. The DON stated that resident 38 may have a shower in her room but there was a communal shower in that hallway. The DON stated if resident 38 attempted to access the communal shower staff would have to assist her because the communal shower was locked. The DON stated that a partial assist would consist of staff setting up everything for the resident and providing at least 25% of assistance. The DON stated that supervision would consist of staff standing by and being present. The DON stated that staff would document in the medical record if resident 38 showered herself and she was independent. The DON stated if the documentation was blank the shower either did not happen or the documentation was missed. The DON stated that Not Applicable would be marked in the electronic charting system if the resident was out of the facility. The DON stated resident 38 should sign a refusal form if she refused a shower. (Cross-refer F725)

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F 0677 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for residents who were unable to carry out activities of daily living. Specifically, for 1 out of 54 sampled residents, a resident was not provided showers as scheduled. This example will be cited at a Harm level. Resident identifier: 1.Findings included:Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included morbid obesity, other lack of coordination, weakness, and other abnormalities of gait and mobility.On 5/4/26 at 2:35 PM, a concurrent observation and interview were conducted with resident 1. Resident 1 was observed wearing a hospital gown that had stains on the front of it and hair that appeared to be greasy and uncombed. Resident 1 stated that she had not received daily showers and required assistance with showers from staff. Resident 1 stated that she had to have her head shaved by the facility nurse because her hair had become matted from the lack of washing and she could not brush her own hair. Resident 1 was upset that she had to have her head shaved because her hair used to be long and in braids. Resident 1 stated that she had not had a shower in two weeks. Resident 1 stated she had been told several times that she would get a shower, but she just sits and waits. Resident 1 stated that she had not signed any forms that declined a shower.A care plan Focus initiated on 4/8/25, documented [Resident 1] has alterations in ADL [activities of daily living] secondary to incontinence, weakness.The interventions included assisting in completing ADL tasks each day. Provide dignity and respect, and encourage independence.The TASK revealed ADL documented that resident 1 received daily showers.The medical record and shower sheets were reviewed for April and May 2026. Resident 1 received showers on 4/7/26, 4/21/26, and 5/5/26. Resident 1 received a bed bath on 4/14/26 and 4/25/26.On 5/6/26 at 7:29 AM, an interview was conducted with Certified Nursing Assistant (CNA) 5. CNA 5 stated that resident 1 was to be showered daily. CNA 5 stated that CNAs received a schedule of the residents that required showers for the day. CNA 5 stated that if a resident refused a shower then staff respected that decision. CNA 5 stated that a resident was asked three times throughout the day if they wanted a shower and if they refused a shower, a shower refusal sheet was signed by the resident. CNA 5 stated that if a resident could not sign for themselves then the nurse and CNA had to sign the refusal sheet. On 5/6/26 at 7:33 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that shower refusal sheets were scanned into the resident's medical record. The ADON stated that the facility recently switched over to using shower aides for the facility and an agency CNA was performing showers for the long term care residents. The ADON stated that showers should be charted in the resident's medical record when they had been completed.On 5/13/26 at 11:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 1 was a substantial or maximum assist with showering or bathing herself. The DON stated that there had been some concerns in the facility regarding residents receiving showers as scheduled and that the facility had revamped their shower process by getting shower aides. The DON stated that if a resident refused, they were asked three times by staff and this was documented in the medical record. (Cross-refer F725)

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F 0688 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that a resident with a limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, for 1 out of 54 sampled residents, a resident's range of motion decreased with restorative nursing services after the resident was discharged from physical therapy. This was cited at a harm level. Resident identifier: 1.Findings included:Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included other abnormalities of gait and mobility, other lack of coordination, and weakness.On 5/4/26 at 11:20 AM, an interview was conducted with resident 1. Resident 1 stated that she was unable to move herself in bed and was waiting for staff to come and boost her up in bed. A care plan Focus initiated on 2/28/25, documented [Resident 1] has a decrease in mobility and functional abilities secondary to respiratory failure, morbid obesity. [Resident 1] is currently participating in the AROM [active range of motion]/Transfers restorative nursing program.The interventions included, but were not limited to, encourage participation in Restorative Program and to notify the nurse of refusals, decline in status. A review of resident 1's physical therapy discharge note dated 11/8/25 revealed that resident 1 was able to transfer independently with supervision, could ambulate 5 feet with minimum assistance, and was independent with bed mobility.A review of resident 1's Restorative Nursing Program revealed that resident 1 would perform active range of motion exercises to upper and lower body 15 minutes a day for 3-6 days a week and transfer from the bed to the wheelchair and back to bed with assistance 3-6 days a week. On 5/11/26 at 8:21 AM, an interview was conducted with the Director of Rehabilitation (DOR). The DOR stated that resident 1 was last seen for therapy in November 2025. The DOR stated that resident 1 was seen two times a week for 30 days. The DOR stated that resident 1 was discharged from therapy because she had met her therapy goals and was referred to the Restorative Nursing Program on 11/28/26. On 5/11/26 at 11:59 AM, an interview was conducted with Restorative Nursing Assistant (RNA) 1. RNA 1 stated that resident 1 was a heavy sleeper and he had a hard time waking her up to perform her active range of motion exercises and transfers. RNA 1 stated that if resident 1 was sleeping he would not perform exercises or transfers with her. RNA 1 stated that resident 1 had never refused doing her exercises and transfers but he did document that she refused or was not available when he was unable to wake her up if she was sleeping. RNA 1 stated that he would tell the RNA nurse that resident 1 felt sick or was sleeping and the nurse should be documenting the refusals and the reasons why. RNA 1 stated that he thought the last time he went in and performed exercises or transfers with resident 1 was maybe one month ago, but he could not recall. RNA 1 stated that resident 1 was unable to move herself in bed or perform transfers on her own.On 5/11/26 at 12:37 AM, a follow-up interview was conducted with resident 1. Resident 1 stated that the facility counted her showering as restorative because it was difficult for her to get up and out of bed. Resident 1 stated that when she had done physical therapy, she was able to get herself repositioned in bed and transferred to her wheelchair. On 5/13/26 at 11:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 1 typically required an extensive assist for repositioning and was dependent for transfers. The DON stated that resident 1 was placed in the RNA program after she was discharged from therapy for reaching her goals with transfers. The DON stated that based on current documentation, resident 1 needed a substantial/maximum assist for transfers and somewhere in between a partial to maximum assist with bed mobility. The DON stated that based on when resident 1 was discharged from physical therapy, resident 1 had declined in function with transfers and mobility.

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	465067	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care- Clearfield	1481 East 1450 South Clearfield, UT 84015

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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 0725 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, for 7 out of 54 sampled residents, multiple residents complained of staffing shortages, long call light response times, and delays in assistance with Activities of Daily Living (ADLs). Additionally, resident council notes documented late medication administration. Resident identifiers: 1, 7, 9, 13, 31, 73, 86, 110, 113, 127, 129, and 156.Findings included:1. On 5/5/26 at 12:55 PM, an interview was conducted with resident 86. Resident 86 stated that when he pressed the call light it sometimes took forever to be answered. Resident 86 stated that he had therapy that was often delayed because he had to wait for staff assistance to get up. Resident 86 stated that he would push the call light and staff would give him a [NAME] excuse for not assisting him when he needed it. Why do they have a call light if they don't take care of the patient? Resident 86 stated that he was paying for services that he should be getting. Resident 86 stated that staff were always saying they were short staffed and they did not have enough time. Resident 86 stated that staff did not cut his fingernails so his wife had to come and do this for him. Resident 86 stated that his wife also had to help with incontinence care, cleaning feces and urine, because there was not enough staff to assist. Resident 86 stated that his wife was very upset about this and spoke with the Administration. The Administration came to speak with him and told him that they were working on fixing this but he had not seen any results yet. This is ridiculous. Resident 86 stated that he filed a grievance report with the Resident Advocate regarding these concerns.Resident 86 was admitted on [DATE] and re-admitted on [DATE] with diagnoses which included aftercare following joint replacement surgery, fracture right femur, intervertebral disc disorders, type 2 diabetes mellitus, acquired absence of right leg below knee, morbid obesity, heart failure, presence of right artificial hip joint, hypertensive heart and chronic kidney disease. On 12/25/25, resident 86's Minimum Data Set (MDS) Assessment documented that the resident was a substantial/maximal assistance with toileting, showers, bed mobility; partial/moderate assistance for upper body dressing; and dependent for lower body dressing and transfers. Resident 86's Care Plan had a focus area for alterations in Activities of Daily Living (ADL) function secondary to Right femur fracture that was initiated on 11/3/25. The interventions identified on the care plan included: 2-person assist with transfers - up to extensive assistance, assist in completing ADL tasks each day, encourage participation in Physical Therapy, and encourage use of call lights when ADL assistance is needed.The grievance log was reviewed and no documentation could be found of any complaints/concerns filed by resident 86.On 5/13/26 at 3:24, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 86 used a urinal and was incontinent of bowel. CNA 1 stated that resident 86 only required one staff for incontinence care as he was able to roll independently. CNA 1 stated that some days the facility was staffed well and others not so much. CNA 1 stated that the hallway that resident 86 resided on required more staff and was more needy. CNA 1 stated that after 6:00 PM it was crazy in the hallway. CNA 1 stated that it was difficult to complete tasks, and sometimes showers did not get completed due to low staffing. Even with a shower aide they sometimes don't get done. CNA 1 stated that incontinence care was done during rounds every 2 hours or as needed, and when it is super hectic a call light may be on for 15 minutes. CNA 1 stated that on the 300 hallway there was a resident that required 2 staff for incontinence care and it took an hour to provide so call lights were on for a longer time there. 2. On 5/4/26 at 12:40 PM, an observation was made of the Minimum Data Set (MDS) Coordinator in the dining room serving drinks to residents when resident 110's family member asked for a food item. The MDS Coordinator (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	stated she did not usually help with dining as much as she was that day and she did not know if she could get the food item.3. On 5/4/26 at 10:39 AM, an interview was conducted with resident 9. Resident 9 stated that staff sometimes took a long time to respond to call lights, and while she had some great nurses and CNAs, there was not enough staff to ensure quick responses. Resident 9 stated that she waited for over an hour for assistance with a brief change the previous night after activating the call light due to a bowel movement, because her CNA was assisting another resident with complex medical needs to prepare for bed.4. On 5/4/26 at 11:20 AM, an interview was conducted with resident 1. Resident 1 stated that she required assistance from staff and had waited over 2 hours for staff to come in and assist her. Resident 1 stated that she was waiting for staff to come in and boost her up in bed and had been waiting for approximately 10 minutes. On 5/4/26 at 11:35 AM, an observation was made of two CNAs entering resident 1's room to reposition her in bed. 5. On 5/4/26 at 11:39 AM, an interview was conducted with resident 31. Resident 31 stated that call light response times are horrendous. Resident 31 stated that the facility was always short -staffed on the weekends. Resident 31 stated that he had waited over one hour for staff to come and get him off of the toilet. Resident 31 stated the CNAs do not work together and if someone was busy and other lights turned on other CNAs just say it was not their hall and they don't respond.6. On 5/5/26 at 8:23 AM, an interview was conducted with resident 156. Resident 156 stated that his call light was not answered all the time and he sometimes had to wait over 20 minutes for staff to come into his room. 7.On 5/5/26 at 8:45 AM, an interview was conducted with resident 129. Resident 129 stated that call lights took about 60 minutes for staff to respond to. Resident 129 stated that CNAs come in and turn off the call light and say they will be back and they never come back. 8. On 5/5/26 at 9:09 AM, an interview was conducted with resident 13. Resident 13 stated that she was unable to walk and was non-weight bearing. Resident 13 stated that there were times that she really had to pee and had to wait a long time for staff to respond to her call light. Resident 13 stated that she had some incontinent episodes waiting for staff to respond. 9. On 5/5/26 at 12:46 PM, a confidential interview was conducted with a resident. The resident stated there were not enough staff and they had to wait for an hour for assistance. The resident stated they were unable to feel when they had a bowel movement and had to wait for long periods of time in a dirty brief. The resident stated there were a lot of CNAs that called out sick so the facility was short staffed a lot. 10. On 5/5/26 at 10:37 AM, an interview was conducted with resident 34. Resident 34 stated he was on the rehab side of the building and the call light wait time on the long term side was Horrendous. Resident 34 stated it made him feel not important. Resident 34 stated residents started to yell out for assistance because call lights were not answered. Resident 34 stated staff did not check on him throughout the shift. Resident 34 stated staff have been kind of mean in the long term care side by telling him if he got in his wheelchair he had to be up for longer than 2 hours. Resident 34 stated he could not stay up for 2 hours in his chair because of back pain caused by his herniated discs. 11. On 5/4/26 at 3:335 PM, an interview was conducted with resident 73. Resident 73 stated his hall needed at least another CNA for each shift. Resident 73 stated he had to wait up to an hour and a half for his call light to be answered. Resident 73 stated there were a lot of staff that called in sick and there should be 4 CNA's for his hallway but sometimes there are only 2. Resident 73 stated that he sometimes was not repositioned for over 12 hours because there were not enough staff. Resident 73 stated weekends and Mondays they were short staffed. Resident 73 stated sometimes he had to sit in a dirty brief for a long time because other residents need more assistance. Resident 73 stated staff worked their butts off. 12. On 5/4/26 at 2:53 PM, an interview was conducted with resident 110's family member. The family member stated there were not enough staff for 2 staff members to transfer residents who required a hoyer lift. The family member stated resident 110 had waited up to an hour for his call light to be answered. The family member stated resident 110 liked to get back in bed about 2:30 PM but that was the hardest time to get 2 staff members to transfer him with the hoyer lift. The family member stated she had been the second person assisting with the hoyer lift because there were not enough staff. 13. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 5/5/26 at 9:21 AM, an interview was conducted with resident 113. Resident 113 stated the agency staff were terrible. Resident 113 stated a nurse came and argued with her about taking medications one time and she refused. Resident 113 stated the nurse came back and said the resident was right. Resident 113 stated staff did not know how to empty her colostomy bag and there had been a few incidents when the bag exploded. Resident 113 stated she had to wait for 45 minutes in her bowel movement when her bag exploded. Resident 113 stated the staff do not look professional and smelled. 14. On 5/4/26 at 3:14 PM, an interview was conducted with resident 127. Resident 127 stated agency staff were not as diligent as facility staff. Resident 127 stated he had waited 30 to 60 minutes and had fallen out of bed waiting for staff. Resident 127 stated he felt frustrated and stated Don't I matter? 15. On 5/4/26 at 10:39 AM, an interview was conducted with resident 7. Resident 7 stated she just did not use her call light because the staff were very busy. On 5/13/26 at 9:43 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that staffing was based on the facility census and resident acuity. The ADON stated that the 300/400 currently had multiple residents that required Hoyer lifts and call light wait times were very long and residents had to wait for staff to be available. The ADON stated that there was primarily just agency staff on the 300/400 hallway and there had been resident complaints about staff sitting at the nurse's station and not answering call lights. The ADON stated that she was trying to identify why there were so many staffing issues in the 300/400 hall and that this was a work in progress. The ADON stated that weekend staffing was difficult because it was mainly just agency staff that were working in the facility. The ADON stated that she thought most of the CNAs were good, but some had some bad habits that she would like to get fixed.16. Resident Council notes were reviewed for April 2025. There were concerns that Certified Nursing Assistants (CNAs) were at the desk talking when call lights were on. Resident Council notes were reviewed for May 2025. There were concerns that medications were being delivered late to residents.Resident Council notes were reviewed for June 2025. There were concerns that agency staff were delivering medications late. Resident Council notes were reviewed for July 2025. There were concerns that agency staff were administering medications late. Newer CNAs were using their cell phones while providing care to residents.Resident Council notes were reviewed for August 2025. There were concerns about additional staff in the dining room to offer additional assistance to residents. CNAs assigned to other halls are not willing to assist each other.Resident Council notes were reviewed for September 2025. There were concerns that showers were offered late, extended call light times, and the need for shower aides.Resident Council notes were reviewed for October 2025. There were concerns with inconsistent nurses, CNAs not rounding and rushing through cares, and call light times. Resident Council notes were reviewed for November 2025. There were concerns with inconsistent medication routines, the need for improvement with follow-up and availability from staff, and shower aides.Resident Council notes were reviewed for January 2026. There were concerns with nighttime staffing.Resident Council notes were reviewed for February 2026. There were concerns that CNAs did not help covering halls not in their section.Resident Council notes were reviewed for March 2026. There were concerns that CNA availability in the dining room was causing late meals and CNAs were complaining about their jobs in front of residents.Resident Council notes were reviewed for April 2026. There were concerns with call lights being turned off without addressing the needs of residents.(Cross refer to F550, F676, F677, F684, F688)

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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** Based on observation, interview, and record review, for 3 of 54 sampled residents, the facility did not 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, Enhanced Barrier Precautions (EBP) were not implemented for a resident receiving wound care, and an observation was made of cross-contamination between residents during meals. Additionally, a resident's tube feeding formula was not capped when disconnected from the resident. Resident identifier: 2, 4, and 8. Finding Included:1. Resident 2 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included neutropenia due to infection, cellulitis of right lower limb, cellulitis of left axilla, unspecified open wound right lower leg, and non-pressure chronic ulcer of other part of right foot with fat layer exposed. On 5/4/26 at 8:50 AM, an observation was made of resident 2's room. There was no EBP signage on the door and no Personal Protective Equipment (PPE) available for use. On 5/4/26 at 3:04 PM, an interview was conducted with resident 2. Resident 2 stated that her right leg had cellulitis and required daily bandage changes. Resident 2 stated that she wore briefs because she was not able to make it to the bathroom. Resident 2 stated that nursing staff do not come in and change her briefs and that she had to do that herself. On 5/5/26 at 8:10 AM, an observation was made of resident 2's room. There was no Enhanced Barrier Precaution signage on the door and no Personal Protective Equipment (PPE) available for use. On 5/5/26 at 3:15 PM, an observation was made of resident 2's room. There was no Enhanced Barrier Precaution signage on the door and no PPE available for use. On 5/6/26 at 7:54 AM, an observation was made of resident 2's room. There was an Enhanced Barrier Precautions sign and PPE was available for use. A review of resident 2's physician orders revealed an order on 3/8/26 for Enhanced Barrier Precautions- Related to wound care. On 5/6/26 at 11:11 AM, an interview was conducted with Certified Nursing Assistant (CNA) 9. CNA 9 stated that she was the CNA for resident 2 and that she did not know that resident 2 was on Enhanced Barrier Precautions and did not know why she would need them. CNA 9 stated that she believed that resident 2 was continent. On 5/6/26 at 1:07 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that resident 2's Enhanced Barrier Precautions were lifted 2 weeks ago. LPN 2 stated that staff only needed Enhanced Barrier Precautions if a resident had COVID, catheters, or wounds. LPN 2 stated that resident 2 did have a wound on her leg and that might possibly be why she was on Enhanced Barrier Precautions. On 5/11/26 10:33 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated a resident was placed on Enhanced Barrier Precautions upon if they had an increased infection risk, such as a wound or an invasive line, including a PICC line, a catheter, or an open system dialysis port. The IP stated that Enhanced Barrier Precautions signs and instructions were posted on the outside the resident's door and PPE would be placed in an over the door storage hanger or in a chest of drawers right next to the resident's door. The IP stated that infection control protocols require staff to wear PPE if they are going to provide intimate contact with a resident on Enhanced Barrier Precautions. On 5/13/26 at 11:03 AM, an interview was conducted with the Director of Nursing. The DON stated that resident 2 was on Enhanced Barrier Precautions related to chronic wounds. The DON stated that resident 2 had an order for Enhanced Barrier Precautions. The DON stated that the infection nurse was overseeing the infection control program and should have posted signage and provided PPE. 2. Resident 4 was admitted to the on 1/16/26 with diagnoses which included category 5 blindness to the right and left eyes, stage 5 chronic kidney disease with heart failure, and type 2 diabetes mellitus. On 5/4/26 at 12:29 PM, an observation was made in the dining room while a meal was being served. After resident 4's tray had been served a female resident, seated next to resident 4, was observed opening a packet of butter and using a fork that she had used to feed herself to mix the butter into resident 4's mashed potatoes. On 5/14/26 at (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:48 AM, an interview was conducted with the DON. The DON also stated that infection control protocols require staff to perform hand hygiene between assisting each resident during meal time and to provide any assistance a resident might need during meals. 3. Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic respiratory failure, dysphagia following cerebral infarction, gastrointestinal hemorrhage, and tracheostomy status. On 2/25/26, the following orders were started: a. Enteral Feed Order every shift Glucerna 1.2 at 63 ml/hr [milliliters per hour] and water flushes at 30 ml/hr x 20 hours (off at 1300 [1:00 PM], on at 1700 [5:00 PM]) via pump. b. Enteral Feed Order in the afternoon ***Disconnect tube feeding c. Enteral Feed Order in the evening ***Reconnect tube feeding On 5/4/26 at 10:32 AM, an observation was made of resident 8 with her tube feeding disconnected and the feeding bag, which still contained formula, uncapped. On 5/6/26 at 3:45 PM, an observation was made of resident 8 with her tube feeding disconnected and the feeding bag, which still contained formula, uncapped. On 5/6/26 at 3:47 PM, an interview was conducted with Registered Nurse (RN) 9. RN 9 stated that he would resume resident 8's tube feeding during his final rounds using the same formula in the feeding bag. RN 9 stated that once a feeding was complete he flushed the tubing with water, disconnected it from resident 8's gastrostomy tube, and then clipped the feeding bag tube to the pump. RN 9 stated that they did not normally cap the feeding bag tube after it was unhooked from a resident. RN 9 stated that the feeding bag and tubing would be changed every 24 hours during the night shift. On 5/7/26 at 2:22 PM, an observation was made of resident 8 with her tube feeding disconnected and the feeding bag, which still contained formula, uncapped. On 5/14/26 at 11:43 AM an interview was conducted with the DON. The DON stated that infection control protocols require staff to cap and hang disconnected feeding bag tubing on the pump.