STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465089	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Willow Springs	85 East 2000 North Tooele, UT 84074

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review it was determined, for 1 of 14 sampled residents, that in response to allegations of abuse, neglect, exploitation, or mistreatment the facility did not have evidence that all alleged violations were thoroughly investigated. Specifically, an allegation of neglect was not thoroughly investigated to determine if neglect had occurred. Resident identifier: 6. Findings include: Resident 6 was initially admitted to the facility on [DATE] and readmitted on [DATE] with the diagnosis of polyneuropathy, chronic respiratory failure, dementia, restless leg syndrome and type 2 diabetes mellitus. Resident 6's medical records were reviewed on 7/29/24 On 7/20/24 at 6:54 AM, a nurse note stated, Resident had fall and sent to Hospital. Aide said she went to change resident in her bed, then went to get a brief, then came back and resident was on floor. Resident said she saw her dog (stuffed animal) on the floor then all the sudden was on the floor. Nurse saw Resident facedown on the floor lying flat, assessed resident and got help of multiple people to roll her over and lift her up with a sheet to her bed, assessed again, resident had a large bump on her forehead, her nose had blood on, a little blood in her mouth, She could barely move her right arm, but her right hand and fingers she could not move. She reported they felt numb . The facility abuse investigation, form 358 was submitted to the State Survey Agency (SSA) on 7/22/24 at 1:40 PM and documented an allegation of neglect. The incident details reported by the registered nurse [RN 1] stated resident 6 had been in bed getting a brief change, saw their stuffed dog on the ground and attempted to grab it and fell out of bed. It documented after the fall, resident 6 had a large bump on their forehead, blood on their nose, and blood in their mouth. Resident 6 was barely able to move their right arm and was unable to move their right hand and fingers. Resident 6 reported they felt numb. Resident 6 was transferred to a local hospital due to the injuries sustained after the fall. The form documented had sustained resident 6 had a fractured vertebrae in their neck due to the fall. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility final investigation, form 359 was submitted to the SSA on 7/26. An interview with resident 6 was not obtained due to resident 6 being in the hospital and unavailable during the investigation. The documented staff interview with Certified Nursing Assistant (CNA) 1 read as follows, I went in for last rounds around 5:20 to change [resident 6]. When I got everything ready and started to roll her, I noticed her sheet was wet. I had her roll back onto her back while I went to grab a new sheet to change it. We didn't have any sheets in the linen cart so I went to the closet to grab one and went straight back to her room. When I walked in, I saw her feet in [sic] the ground and realized she had fallen. I asked her what happened and she told me the mattress wasn't on the springs. I went to grab the nurse and other aides to help get her up in her. [RN 1] asked her what happened, and she told her that when she rolled she saw her stuffed dog on the floor and wanted to grab it. We got her vitals, all seemed fine. [RN 1] had her grab and squeeze her hands, but she was unable to do anything with her right arm, and she had a large goose egg on her forehead along with a gash on her nose. [RN 1] immediately called the on call doctor and got the okay to send her out so she called EMS (emergency medical services) to come get her. I retook her vitals and noticed she had blood in her mouth, so I checked inside and saw she had bit her lip and cut it. Before EMS arrived she told me her left thumb was going numb so I had her try to squeeze onto my hand and she could barely move it. When EMS arrived they checked her out and at first she said she didn't have any back or neck pain, but when we went to transfer her it changed. We had to transfer her with the sheet because she was in so much pain and unable to help transfer, so we got her on the stretcher with the help of the paramedics. Once she was moved she said her pain was pretty back in the middle of her neck and back, so they took her to the hospital to be checked out. The form had one documented staff interview for the investigation. In the section for other staff interviews, it stated, CNA reported to floor nurse and floor nurse reported to unit manager. The investigation concluded the allegation of neglect had not been verified due to the evidence collected. It should be noted, no interviews with resident 6, the nurse or the unit manager were located to indicate they had been interviewed. No documentation was located to indicate how long the cna had been gone for and the positioning of resident 6's bed. On 7/31/24 at 2:07 PM, a telephone interview was conducted with RN 1. RN 1 stated they were on shift when resident 6 fell . RN 1 stated they ran into resident 6's room once the aid had told them what happened. RN 1 stated the aid was doing a brief change on resident 6 and noticed there were no briefs in the room and left the room to find a brief. RN 1 stated resident 6 had informed them they were trying to grab their stuffed dog off the ground when they fell . RN 1 stated they found resident 6 laying on their face. RN 1 stated resident 6's mattress was at an average height for a brief change at the time of the fall. RN 1 stated the bed could have been lowered more. RN 1 stated they informed the unit manager [UM] of the fall. RN 1 stated no other staff members had asked for further details about resident 6's fall. On 8/1/24 at 9:19 AM, an interview was conducted with the UM. The UM stated resident 6's nurse informed them about the fall. The UM stated they were told resident 6 had fallen and was not able to feel their arm. The UM stated the nurse had notified the provider of the fall and sent resident 6 out to the hospital to be checked out. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 9:57 AM, an interview was conducted with both the Social Service Worker (SSW) 1 and SSW 2. SSW 2 stated they conducted investigations for residents. SSW 2 stated they started their investigation with an initial report which was the 358. SSW 2 stated during the initial investigation phase, they obtained a brief overview of what had occurred, and they made sure the resident was safe and was provided the care they needed. SSW 2 stated for the investigation portion they collected statements for the people involved in the incident which included, nurses, aids, and residents. The SSW 2 stated they also obtained statements from anyone that had contact with the person in question. The SSW 2 stated they interviewed residents with similar situations and asked them if they felt safe. The SSW 1 stated they once they obtained all their interviews and finished the information gathering, they used all that information to fill out the 359. SSW 1 stated they had been notified of resident 6's fall. SSW 1 stated they interviewed the aid and resident 6's roommate on what had happened. SSW 1 stated they interviewed other residents on the hall. The SSW 1 stated they used RN 1 progress note as their statement since it was already in the resident chart. SSW 1 stated the nurse should have fixed their progress note since it was different than what the cna had informed them. SSW 1 stated they should have talked to the nurse as part of the investigation. On 8/1/24 at 10:57 AM, an interview was conducted with CNA 1. CNA 1 stated resident 6 had been refusing their brief changes throughout the night. CNA 1 stated towards the end of their shift, resident 6 needed a brief change and they noticed that the pull up had been moved which caused resident 6 to wet her bed sheet. CNA 1 stated they had finished resident 6's brief change and had them roll on to their back while they went to find a new sheet. CNA 1 stated they had been gone for about 2 minutes. CNA 1 stated when they returned, they found resident 6 on the floor and resident 6 was unable to move their right arm. CNA 1 stated resident 6 had rolled out of bed to grab their stuff dog off the floor. CNA 1 stated the bed had been lowered but it was not in the lowest position while they stepped away. CNA 1 stated resident 6 had a tendency to do things on their own when they are not supposed to.

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F 0689 Level of Harm - Minimal harm or potential for 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** 45470 Based on interview and record review it was determined, for 1 of 14 sampled residents, that the facility did not ensure that the residents received adequate supervision and assistance devices to prevent accidents. Specifically, a resident was manually lifted by two staff members, instead of using a Hoyer lift, which resulted in an assisted fall to the ground. Resident identifier: 4. Findings Include: 1. Resident 4 was initially admitted to the facility on [DATE] and again on 1/6/24 with diagnoses which included contracture of right hand, sarcoid myocarditis, severe protein-calorie malnutrition, patellofemoral disorders of left knee, neuromuscular dysfunction of bladder, depression, generalized anxiety disorder, unspecified convulsions, foot drop of right foot, muscle weakness, age-related osteoporosis, and repeated falls. Resident 4's Electronic Medical Records were reviewed. On 4/24/24 a Quarterly Review of the Minimum Data Set (MDS) documented that resident 4 scored a 15 on the BIMS (Brief Interview for Mental Status). In accordance with the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Manual (RAI) Version 3.0 Manual, a score of 15 represents cognitively intact. Resident 4's care plan was reviewed. Resident 4 had a care plan, initiated 11/3/23 and revised 6/30/24, that stated, . [Resident 4] is at risk for falls secondary to increased weakness, lower extremity pain, mobility dysfunction. The goal stated, [Resident 4] will have no untreated injuries r/t [related to] falls, through next review.] Three interventions were included in the care plan; fall 1/6/24 staff educated on safe transfer techniques to avoid falls/assisted falls, initiated 1/10/24, encourage the use of the call light, initiated 11/7/23, and keep room free of clutter and tripping hazards, initiated 11/7/23. On 7/31/24 at 1:20 PM an interview was conducted with resident 4. Resident 4 stated that she had gotten hurt one time at the facility. Resident 4 stated that when staff were transferring her using a Hoyer lift, the Hoyer lift ran out of batteries and the CNA's attempted to do a two-person transfer. Resident 4 stated that the CNA's were lifting her, and resident 4 felt and heard a pop sound in her right shoulder. Resident 4 stated that she experienced pain in her right shoulder. Resident 4 stated that she was sent to the Emergency Department to get an X-ray. Resident 4 stated that the X-ray showed that nothing appeared broken or torn, however she did use a sling for two days to ease the pain. Resident 4 stated that she requires a Hoyer lift to be transferred, and that incident was the only time that staff had attempted to transfer her without a Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document dated 1/6/24 from the Emergency Department was reviewed. The document revealed, Patient [resident 4] presents for right shoulder pain. Patient has history of spasticity fall with head injury knee dislocation and shoulder injury, currently in rehab facility they were lifting her into a chair with her arms above her head she felt a pop to her right shoulder now has pain since that time no other injuries. The document reported, X-rays negative for acute fracture likely rotator cuff injury. Will give sling to wear as needed, otherwise patient is stable for discharge declined pain meds. The facility's 358 facility reported incident document was reviewed. On 1/6/24 it was reported that around 12:00 PM staff reported to the nurse that resident 4 was assisted to the floor by two staff during an attempt to transfer the resident into a recliner. The facility's 359 investigation form was reviewed. The investigation documented that the resident did not sustain any physical or mental harm, documenting, [resident 4] states that she is doing amazing, she stated that her feet were slipping, and the aids assisted her to the floor. She states her shoulder is feeling better and is managed in regard to pain. Resident 4 showed no signs of distress/hard. The summary of interviews with the alleged perpetrator was documented as, [CNA 2]: we went to go get [resident 4] from her w/c [wheelchair] to the recliner in the day room and when lowering her, she stated that her feet were slipping and we had to assist her to the floor. When lowering her to the floor she stated that she felt a pop in her arm. Reported assist to floor and pain to nurse on shift. [CNA 1]: [Resident 4] wanted to be transferred to the recliner in the day room to watch tv, we brought the Hoyer over to the recliner and when lowering her onto the chair she stated that her feet were slipping so we assisted her to the floor, that is when she stated that she felt/heard a pop and started complaining about her shoulder. Reported to the nurse to check on her post transfer. The summary of interviews with staff responsible for oversight and supervision was documented as, [RN 5] Resident also stated that she had been experiencing pain in her R [right] shoulder for about a month and that she has been working with therapy for this pain. I was on the hall assisting with other resident when the CNA's reported to me [resident 4]'s fall. I assessed resident, VS [vital signs] taken (stable), administered pain cream (biofreeze) topically, oral analgesics - (Tylenol & ibuprophen), UM [unit manager], MD [medical director] and resident family notified, Xray order placed. The allegation was not verified by the facility, who documented, The allegation was refuted by no major injury. [Resident 4] was sent out to the ED [emergency department] and returned same day with no new injury. The corrective actions taken as a result of the investigation were documented as, CNA Coordinator implemented an in-service for our CNA staff on Hoyer Trainings. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 2:06 PM an interview was conducted with CNA 2. CNA 2 stated that she was with resident 4 during the incident with the Hoyer lift. CNA 2 stated that resident 4 had always required a Hoyer lift for all transfers. CNA 2 stated that resident 4 had wanted to be transferred out of her chair into the recliner. CNA 2 stated that she and another CNA attempted to transfer resident 4 with a Hoyer lift. CNA 2 stated that they placed the Hoyer sling underneath the resident, and as they were going to lift the resident using the Hoyer lift, the lift appeared to be low on battery and did not work. CNA 2 stated that she and another CNA attempted to pick up the resident to transfer resident 4 into the recliner. CNA 2 stated that she was unaware that resident 4 had a issues with her right shoulder. CNA 2 stated that during the transfer, the resident had started to complain about shoulder pain. CNA 2 stated that she told the nurse right away, and the resident was sent out to the emergency department to get X-rays. CNA 2 stated that Hoyer lifts are supposed to be plugged in when they are not in use. CNA 2 stated that sometimes staff would forget to turn off and plug in the Hoyer lifts, which can result in low batteries. CNA 2 stated that staff did receive training on how to properly use Hoyer lifts after the incident with resident 4. On 8/1/24 at 11:55 AM an interview with the Director of Nursing (DON) was conducted. The DON stated at the incident resident 4 was a result of the Hoyer lifts running out of batteries. The DON stated that as a result of the investigation, the facility purchased a backup battery, and training on how to use a Hoyer lift was given to all CNAs. The DON stated that there have been no other incidents involving a Hoyer lift since the incident with resident 4.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38303 Based on record review and interview, it was determined the facility did not ensure that 7 of 14 sampled residents were free of significant medication errors. Specifically, one resident received another resident's medications, which resulted in a hospital admission and subsequent continuous heart monitoring. Additionally, three residents did not receive medications according to physicians' orders, one received a medication for which the resident had a known allergic reaction, and two received the incorrect medications; these errors did not result in adverse outcomes. Resident Identifiers: 3, 7, 10, 11,12,13,14. Findings include: 1. Resident 3 was an [AGE] year old female who was admitted to the facility in 7/2020 with diagnoses which included benign neoplasm of the brain. On 7/30/2024 at 11:45 AM, a review of Resident 3's medical record was conducted. An incident report, dated 2/7/2024, was reviewed and indicated that Resident 3 had received her roommate's medications during the morning medication administration. The incorrect medications administered to Resident 3 included Xanax, Eliquis, Norco, Lyrica and Zoloft. The incident report indicated facility nursing staff began vital sign checks every 15 minutes and administered three doses of Narcan and two liters of normal saline through an IV. Resident 3 was then documented to have been sent to the hospital after her vital signs started to decrease. Resident 3 was admitted to the hospital for observation and returned to the facility the following day, 2/8/2024, with a heart monitor. Resident 3 was instructed to wear the heart monitor for 14 days and follow up with a cardiologist. A review of hospital discharge notes was conducted. Resident 3 was admitted to the hospital for sinus bradycardia .[Resident 3] had multiple dips in her pulse . On 8/1/2024, an interview was conducted with the facility Director of Nursing, who acknowledged Resident 3 did not receive medications as prescribed and was admitted to the hospital after she received the incorrect medications. 2. Resident 7 was a [AGE] year old female who was admitted to the facility on [DATE] with diagnoses which included encephalopathy, acute kidney failure, hypertension, anxiety disorder, and pain. Resident 7 was identified as discharged from the facility on 7/30/2024. On 7/30/2024, a review of Resident 7's medical record was conducted. A review of progress notes was conducted. A progress note, dated 6/3/2024 at 2:24 PM, was reviewed and stated, New Orders per PA. Decrease oxycodone to 5 mg (milligrams) po (by mouth) Q6h (every six hours). (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A progress note, dated 6/8/2024 at 2:35 PM was reviewed and stated, The Resident received oxycodone 10 mg which was discontinued as of 6/3/2024. Current order is for 5 mg. Received 10 mg dose on 6/3/2024, 6/6/2024, 6/7/2024, 6/8/2024 at 12:30 AM, and 6/8/2024 at 9:50 AM. Notified on call nurse manager [name of employee] and [name of physician]. No new orders at this time. Asked about next dose of medication, provider okay ' d to give. A progress note, dated 6/13/2024 at 7:00 PM, was reviewed and stated, Resident discharged from facility 6/13/2024. On 7/8/2024, Resident 7 was readmitted to the facility due to an infection. A progress note, dated 7/15/2024 at 3:23 PM, was reviewed and stated, New orders per NP (Nurse Practitioner).Pantoprazole 20 mg daily Resident 7's July 2024 Medication Administration Record (MAR) was reviewed. The MAR stated Pantoprazole 40 mg daily. Start date of order: 7/15/2024. Resident 7 was documented to have received Pantoprazole 40 mg; Take one tablet once a day; Take on an empty stomach at least 30 minutes prior to lunch on 7/15, 7/16, 7/17, 7/18, 7/20, 7/21, 7/22, 7/23, 7/24, 7/25, 7/26, 7/27, 7/28 and 7/29/2024. On 8/1/2024 at 8:25 AM, a review of the telephone order for Pantoprazole was conducted. The telephone order stated, Pantoprazole 20 mg QD. An interview was conducted with RN 2, who stated that she was the one who changed the order in the eMAR and probably wrote Pantoprazole 20 mg as a mistake, because it went from Pantoprazole 40 mg twice a day to Pantoprazole 40 mg once a day. On 8/1/2024, an interview was conducted with the facility DON, who acknowledged Resident 7 did not receive her Oxycodone or Pantoprazole as prescribed. 3. Resident 11 was a [AGE] year old female who was admitted to the facility on [DATE] with diagnoses which included aftercare following joint replacement surgery, bilateral primary osteoarthritis of hip, atrial fibrillation, and muscle weakness. On 7/31/2024, a review of Resident 11's medical record was conducted. A review of progress notes was conducted. A progress note, dated 7/1/2024, was reviewed and stated, New orders: Morphine 20 mg capsules QAM, Morphine 15 mg tablets QHS . A progress note, dated 7/6/2024, was reviewed and stated, Resident had scheduled right hip replacement. A progress note, dated 7/8/2024, was reviewed and stated, New orders: Morphine 15 mg moved to QHS. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An incident report, dated 7/15/2024, was reviewed and stated, [Resident 11] approached nursing management with a potential medication error. She stated that she got the wrong medication on Saturday 7/13/2024. Morphine 15 mg instead of 20 mg. Upon investigation, it was found that the 15 mg was signed out instead of the 20 mg. [Resident 13] will be monitored x 72 hours for ASE. PA was notified. On 8/1/2024, an interview was conducted with the facility DON, who acknowledged Resident 11 did not receive her Morphine as prescribed. 4. Resident 12 was a [AGE] year old female who was admitted to the facility on [DATE] with diagnoses which included generalized skin eruption, morbid obesity, chronic respiratory failure with hypoxia, Type II diabetes mellitus, and mild persistent asthma. On 7/31/2024 at 10:05 AM, a review of Resident 12's medical record was conducted. A review of progress notes was conducted. A progress note, dated 5/13/2024 at 11:43 PM, was reviewed and stated, Med Error: short acting insulin was given in [the] long acting dose of 42 units PA [Physician's Assistant] and husband were notified right after. BS [Blood sugar] was 261 short acting dose should have been 15 units. No long after 900, the mistake was caught immediately. DON [Director of Nursing] contacted as well as PA. Resident 12 was .also order[ed] an IV of D5 if we could get one, [Resident 12] strongly refused. [PA]said to push sugar and carbs. [Resident 12] again mostly refused said she would only drink her Pepsi. snacks were left at bedside and education was given on possible outcomes. [Resident 12] also ordered her blood sugar to be taken every 15 minutes for 2 hours and then every 30 minutes for 2 hours. [Resident 12] slowly dropped to 104 by 2149, [Resident 12] felt slightly shaky so [RN] checked again and [Resident 12] was 118 will continue to monitor closely, snacks were given this time around as well as more soda per her request. A progress note, dated 5/14/2024, was reviewed and stated, Continuing to monitor [Resident 12] after med error with no further complications related to insulin .Glucose reading continues to be baseline for resident. Resident 12's medication orders were reviewed and were as follows: Insulin lispro 100 unit/ml insulin pen. Per sliding scale, subcutaneous. Before meals and at bedtime, if blood sugar is 131 to 180, give 6 units. If blood sugar is 181 to 240, give 13 units. If blood sugar is 241 to 300, give 15 units. If blood sugar is 351 to 400, give 21 units. If blood sugar is greater than 400, give 23 units. If blood sugar is greater than 400, call MD. The order was started on 11/24/2023 and ended on 7/2/2024. On 7/31/2024 at 12:40 PM, the investigation was requested. On 7/31/2024 at 2:10 PM, the facility investigation was provided and stated, 5/14/2024-Patient [Resident 12] was administered short acting insulin instead of long acting insulin. While investigating the root cause, it was discovered that one the medication cart in the drawer that short acting insulin was being store[d] in the same container as long acting insulin . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 8/1/2024, an interview was conducted with the facility DON, who acknowledged Resident 12 did not receive her Insulin as prescribed. 5. Resident 13 was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses which included quadriplegia, major depressive disorder, suicidal ideations and borderline personality disorder. Resident 13 was identified as discharged from the facility on 5/28/2024. On 7/31/2024 at 10:35 AM, a review of Resident 13's medical record was conducted. A review of progress notes was conducted. A progress note, dated 1/17/2024, was reviewed and stated, [Resident 13] was given a different patient's medication. [Resident 13] was notified at 1200 PM, PA (Physician ' s Assistant) notified at 12:00 PM. PA ordered blood sugar checks Q30 (every 30) mins (minutes) for three hours. There was no change in patient condition. At 11:10 AM, a review of incident reports was conducted. An incident report, dated 1/17/2024 at 1:43 PM, was reviewed and stated, Resident [13] was given other residents (sic) medications. Under Interventions, the incident report stated, PA ordered blood sugar checks Q30 minutes for three hours. On 7/31/2024 at 12:40 PM, the investigation was requested. At 2:10 PM, the investigation was provided and stated, [Resident 13] was given the wrong patients medication on 1/17/2024. DON [Director of Nursing] interviewed RN [name of employee] that had the medication error. [Nurse] stated that when she went in the patients (sic) room she asked if the patient was [the name of Resident 13 ' s roommate] and the patient stated yes. RN administered oral medications in the cup and insulin SQ to the patient (sic) abdomen. After the nurse administered the medications and left the patients (sic) room, the nurse looked at the eMAR [electronic Medication Administration Record] and realized that she had given the wrong medication. [Nurse] then informed the patient and the patient stated he does not even take insulin . A medication error reporting form, dated 1/17/2024, was reviewed and stated Incorrect meds that were given: .[C]arbidopa-levodopa 25-100 mg (milligrams), insulin lispro 12 units, methocarbamol 500 mg . On 8/1/2024, an interview was conducted with the facility DON, who acknowledged Resident 13 did not receive his medications as prescribed, which included receiving the incorrect medications. 6. Resident 14 was a [AGE] year old female who was admitted to the facility on [DATE] with diagnoses which included polyneuropathy, Type II diabetes mellitus, hypertension, osteoarthritis, and chronic kidney disease. Resident 14 was noted as discharged from the facility on 5/9/2024. On 7/30/2024, a review of Resident 14 ' s medical record was conducted. A review of medication error incident reports was conducted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465089	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Willow Springs	85 East 2000 North Tooele, UT 84074

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 0760 Level of Harm - Actual harm Residents Affected - Few	A medication error incident report, dated 4/7/2024, was reviewed and stated, At approximately 2440 (sic) [Resident 14] called needing [an] allergy pill for body itching [Resident 14] states she has this skin disease that makes her skin itch. [Resident 14] was given her 0100 schedule oxycodone and benadryl. As I was documenting I then realized she was allergic to Benadryl [and] went back to [the] room to assess [Resident 14] asked what reaction does she get when taking Benadryl. [Resident 14] verbally stated it enhances symptoms makes her skin itch more. At 0140 [Resident 14] started to [complain of] tongue swelling and feeling like her throat was tight. Notified [name of physician] at 0145 he verbally stated she ' s probably having a panic attack and was advised to hydroxyzine 25 mg and listen for [NAME] if symptoms get worse call him back. At 0150 pt was given hydroxyzine and within 5 mins pt stated she felt a lot better . A review of progress notes was conducted. A progress note, dated 4/7/2024, was reviewed and stated, At approximately 2440 (sic) [Resident 14] called needing [an] allergy pill for body itching [Resident 14] states she has this skin disease that makes her skin itch. [Resident 14] was given her 0100 schedule oxycodone and benadryl. As I was documenting I then realized she was allergic to Benadryl [and] went back to [the] room to assess [Resident 14] asked what reaction does she get when taking Benadryl. [Resident 14] verbally stated it enhances symptoms makes her skin itch more. At 0140 [Resident 14] started to [complain of] tongue swelling and feeling like her throat was tight. Notified [name of physician] at 0145 he verbally stated she ' s probably having a panic attack and was advised to hydroxyzine 25 mg and listen for [NAME] if symptoms get worse call him back. At 0150 pt was given hydroxyzine and within 5 mins pt stated she felt a lot better . A progress note, dated 4/9/2024 was reviewed and stated, I called and spoke to [name], [Resident 14 ' s] daughter and POA regarding the medication error .I explained that Benadryl is a standing order, and the nurse gave her one because [Resident 14] asked for an allergy pill, without looking at [Resident 14 ' s] allergies . On 7/31/2024 at 12:40 PM, the investigation report was requested. At 2:58 PM, the investigation report was provided and was observed to be the medication error incident report, dated 4/7/2024, that was previously reviewed. On 8/1/2024 at 9:05 AM, a review of Resident 14 ' s April 2024 MAR was conducted. Benadryl was not documented to have been administered to Resident 14 on 4/7/2024. Additionally, Benadryl was not observed as one of Resident 14 ' s medication orders. At 9:28 AM, the standing order/telephone order for Benadryl was requested from UM 1. At 12:00 PM, an interview was conducted with the facility Director of Nursing (DON), who stated standing orders, like the Benadryl for Resident 14, are signed off by the physician upon admission. The facility DON further stated that If the nurse administers a standing order medication, she is supposed to verify allergies. Obviously, this nurse did not do that. Once the nurse verifies the allergies, it is her responsibility to enter the medication into the MAR and document that it was administered. (continued on next page)

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	465089	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Willow Springs	85 East 2000 North Tooele, UT 84074

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F 0760 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with the facility DON, regarding Resident 14 ' s MAR. The facility DON acknowledged the MAR did not include an order for Benadryl or documentation that the medication was administered to Resident 14. 19354 7. Resident 10 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease with dyskinesia, type 2 diabetes mellitus, anemia epilepsy and hypertension. Resident 10's medical record was reviewed on 7/31/2024. The admission medication orders were reviewed. An order to administer Primidone (a medication used to prevent seizures) 50 mg (milligrams) 1/2 tablet at bedtime was ordered. The contracted pharmacist documented on 5/14/2024 that patient 10's medications were reviewed. The pharmacist did not identify that Primidone 250 mg was being administered instead of the ordered 25 mg. A facility registered nurse (RN) documented in a progress note, dated 7/15/2024, Nurse reported to UM (unit Manager) that primidone tabs sent from pharmacy are 250mg and not the 25mg tabs that were ordered and resident has received 4 nights worth at this dose. Pharmacy was notified of the error, PA (physician's assistant) notified . The Director of Nursing (DON) was interviewed on 7/31/2024 at 1:08 PM, related to the Primidone medication error. The DON was asked if the nursing staff verified the medications delivered were in accordance with the physician's orders. The DON stated that the nurse's were not verifying the medication dosage with the physician's orders. The DON was asked if education and training for the nurses was provided. The DON stated that there was ongoing administration educations, but a formal education or training had not been provided to the licensed nurses and the medication technician involved in administering the incorrect dosage.