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	06/17/2025

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 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** Based on interview and record review, the facility did not determine that the resident's right to self-administer medication was clinically appropriate. Specifically, for 1 out of 38 sampled residents, a resident was observed to have in their possession four inhalers for self-administration of the medications. Resident identifier: 58. Findings included: Resident 58 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (a-fib), chronic obstructive pulmonary disease (COPD), and emphysema. On 6/9/25 at 2:41 PM, an interview was conducted with resident 58. Resident 58 stated that their medication Arnuity caused her heart to have a-fib and they would rather have the medication Fluticasone. Resident 58 stated that she refused the Arnuity inhaler due to side effects of heart palpitations. Resident 58 stated that the facility gave her the medication and she self administered the inhalers. Resident 58 stated that she kept the Albuterol inhaler at bedside for emergency purposes. Resident 58 stated she needed refills for the Spiriva and Fluticasone. Resident 58 obtained the Arnuity, Spiriva, Albuterol, and Fluticasone inhalers from her purse at the bedside. Resident 58's medical record was reviewed. Resident 58's physician orders revealed the following: a. On 2/3/25, an order was initiated for Albuterol Sulfate 90 micrograms (mcg), 1 puff inhale orally every 8 hours as needed for rescue inhaler. b. On 2/3/25, an order was initiated for Serevent Diskus 50 mcg disk, 1 inhalation orally two times a day for emphysema. c. On 6/9/25, an order was initiated for Fluticasone Propionate Inhalation Aerosol 44 mcg/actuation (ACT), 1 puff inhale orally two times a day for COPD. d. On 6/9/25, an order was discontinued for Arnuity Ellipta Inhalation Aerosol Powder Breath Activated 200 mcg/ACT, 1 puff inhale orally two times a day for shortness of breath rinse mouth with water after use. Do not swallow. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 58's June 2025 Medication Administration Record documented that the Arnuity medication was refused on 6/5/25 PM dose, 6/6/25 PM dose, and 6/7/25 PM dose. No documentation could be found in resident 58's medical record of a self-administration of medications assessment for the resident. On 6/12/25 at 12:50 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 58 self administered her inhalers and that she kept some inhalers at the bedside. RN 1 stated that she had in the locked medication cart resident 58's Serevent, Arnuity, and Fluticasone. RN 1 stated that resident 58 only had her Albuterol inhaler at the bedside. RN 1 stated that resident 58 struggled to breathe. RN 1 stated that the hospice team would have evaluated resident 58's ability to self administer her medications. RN 1 stated that she had watched resident 58 administer the Albuterol before. RN 1 stated that she would ask the resident if and when she had self-administered the medication. RN 1 stated that she was not aware of the facility evaluating resident 58's ability to safely administer medications. RN 1 was not aware that resident 58 had in her possession the Arnuity, Serevent, and Fluticasone. RN 1 stated that in the past they had never had a resident who self-administered medication. RN 1 stated that the purpose of the assessment was to determine if the resident was safe to self administer medications. On 6/12/25 at 1:05 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she was not aware that resident 58 was self-administering medication. The DON stated that the process for self-administration was to have the medication in a locked box in the resident room so that other residents did not have access to the medication. The DON stated that they would conduct an assessment to determine if the resident could safely self-administer medication. The DON stated that she thought the assessment was conducted upon admission and would be assessed again if the resident had a change in condition. The DON stated that even if they determined that the resident was safe they still preferred to manage the medication. The DON stated that resident 58 was admitted in September 2023 and was asked if she would like to self administer medications upon admit and the resident replied no. The DON stated that they had not conducted any other self-administration of medication assessment after admission. The DON stated that when the inhalers were provided to resident 58 at the bedside she should have been evaluated for the safety to self-administer those medications. Review of the facility policy for Self-Administration of Medication documented that the resident may only self-administer medications after the facility's interdisciplinary team had determined which medications may be self-administered safely. The policy documented that when determining if self-administration was clinically appropriate for a resident the interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration; b. The resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections; c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; d. The resident's capability to follow directions and tell time to know when medications need to be taken; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects and when to report to facility staff. f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs. g. The resident's ability to ensure that medication is stored safely and securely. The policy further documented that re-assessment for safety at a minimum should be considered when there was a significant change in the resident's status or when medication errors occurred. The policy was last revised on 04/2025.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not comprehensively assess a resident within 14 days after determining, or should have determined, that there had been a significant change in the resident's physical or mental condition. Specifically, for 1 out of 38 sampled residents, a resident that was admitted to hospice services did not have a significant change Minimum Data Set (MDS) assessment completed. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, cervical disc degeneration. On 6/9/25 at 3:34 PM, an interview was conducted with resident 1. Resident 1 stated that she had been on hospice maybe for a couple weeks. Resident 1 stated that hospice had made some changes with her medications. Resident 1's medical record was reviewed. A physician's order dated 5/8/25, documented to admit resident 1 to hospice. On 5/8/25, hospice admission paperwork was completed. On 5/9/25 at 8:00 AM, a Senior Health Support Services note documented . The family declined the orders placed on 05/08/2025 and opted for hospice care, which was initiated today, 05/09/2025. The MDS assessments were reviewed and there was no Significant Change MDS assessment in resident 1's medical record. On 6/11/25 at 11:08 AM, an interview was conducted with MDS Coordinator 1 and MDS Coordinator 2. MDS Coordinator 1 stated the main reason for a significant change MDS assessment would be the resident was going on hospice, coming off of hospice, or any significant change to the care plan. MDS Coordinator 1 stated the significant change MDS assessment should be completed within at least 14 days of the resident's significant change. MDS Coordinator 2 stated that resident 1 did not have a significant change MDS assessment completed when hospice was started.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that services provided by the facility, as outlined by the comprehensive care plan, met professional standards of quality. Specifically, for 1 out of 38 sampled residents, medications were left unattended at a resident's bedside, consumption of those medications was not supervised by the licensed nurse administering them, and administration was not verified and completed in a timely manner. Resident identifier: 49. Findings included: Resident 49 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included heart failure, end stage renal disease (ESRD), dependence on renal dialysis, chronic respiratory failure, adrenocortical insufficiency, hypotension, anemia, type II diabetes mellitus, hypertension, hyperlipidemia, mood disorder, anxiety disorder, restless legs syndrome, dysphagia, insomnia, and pain. On 6/10/25 at 8:59 AM, an interview was conducted with resident 49. A pill cup filled with medications was observed on resident 49's bedside table. Resident 49 stated that it was her morning medication. The state licensor counted 13 pills inside the cup, but was unable to determine an accurate count of the pills as they were not removed from the cup. Resident 49's June 2025 Medication Administration Record was reviewed and revealed that the following medications were documented as administered on the morning of 6/10/25, by Registered Nurse (RN) 2: a. Amlodipine Besylate Oral Tablet 2.5 milligram (mg), Give 2.5 mg by mouth one time a day for hypertension (HTN). Hold for systolic blood pressure (SBP) less than 110 or diastolic blood pressure (DBP) less than 60. b. B Complex-C-Folic Acid Oral Tablet 0.8 mg, Give 1 tablet by mouth one time a day for supplement. c. Bumetanide Oral Tablet 1 mg, Give 1 mg by mouth one time a day every Tuesday, Thursday, Saturday, Sunday for edema. d. Cholecalciferol Oral Tablet 25 microgram, Give 1 tablet by mouth one time a day for supplement. e. Escitalopram Oxalate Tablet 20 mg, Give 1 tablet by mouth one time a day for depression. f. Hydrocortisone Oral Tablet 5 mg, Give 10 mg by mouth in the morning for ESRD. g. Lokelma Oral Packet (Sodium Zirconium Cyclosilicate), Give 15 gram by mouth one time a day. h. Omeprazole Oral Capsule Delayed Release 20 mg, Give 1 capsule by mouth in the morning for gastro-esophageal reflux disease. Take on empty stomach at least 30 minutes prior to meal. i. Ascorbic Acid Oral Tablet 500 mg, Give 1 tablet by mouth two times a day for supplement. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. Clonidine Oral Tablet 0.1 mg, Give 0.1 mg by mouth two times a day for HTN Hold for SBP less than 100 or DBP less than 60. k. Eliquis Oral Tablet 5 MG (Apixaban), Give 0.5 tablet by mouth two times a day for deep vein thrombosis prophylactic. l. Senna Oral Tablet 8.6 MG (Sennosides), Give 2 tablet by mouth two times a day for constipation. m. Sodium Bicarbonate Oral Tablet 650 mg, Give 0.5 tablet by mouth two times a day for heartburn. n. Acetaminophen Oral Tablet 325 mg, Give 975 mg by mouth three times a day for pain not to exceed 3 grams from all sources in 24 hours. It should be noted that this medication was scheduled at 6:00 AM and 10:00 AM. o. Lanthanum Carbonate Oral Tablet Chewable 1000 mg, Give 1000 mg by mouth before meals for binder. It should be noted that this medication was scheduled at 7:30 AM and 11:30 AM. Resident 49's care plan revealed a focus area for at risk for complications secondary to anti-coagulant use that was initiated on 2/13/25. An intervention identified on the care plan included to administer medications as prescribed. Resident 49's care plan revealed a focus area for at risk for adverse side effects secondary to psychotropic medication use that was initiated on 2/13/25. An intervention identified on the care plan included to administer medications as prescribed. Resident 49's care plan revealed a focus area for at risk for pain that was initiated on 2/13/25. An intervention identified on the care plan included to administer medications as prescribed and monitor for side effects. On 6/12/25 at 9:57 AM, an interview was conducted with RN 1. RN 1 stated that resident 49 had quite a few morning medications and had blood pressure medications that she took on the days that she did not have dialysis. RN 1 stated that on dialysis days the night nurse would administer her medications early because she left for dialysis before 6:00 AM. RN 1 stated that Tuesday would not have been a dialysis day and resident 49 would have had more blood pressure medication scheduled in the morning. RN 1 stated that the standard practice was for the licensed nurse to stay with the resident and observe them take any medications that were administered. RN 1 stated that it was especially important to watch resident 49 take her medication because the resident dosed off and would forget to take the medications. RN 1 stated that resident 49 had blood pressure medication that was scheduled in the morning and again at midday and if she did not take them in the morning and waited she could get those medications administered too close together. RN 1 was observed to review resident 49's physician orders and stated that the Lanthanum Carbonate and Tylenol were scheduled morning and midday. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/25 at 11:28 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the licensed nurse should implement the 6 rights of medication administration and stay to watch the resident take the pills. The DON stated that medication should not be left at the resident bedside unattended. The DON stated that the nurses did not have specific education on this but that was the expectation and what was taught in nursing school. The DON stated that the potential risk of taking the Tylenol doses too close together could cause issues with the liver. The DON stated that there was a potential for toxicity and overdose with the Tylenol. The DON stated that it was difficult to determine when the medication was actually taken because it was left at the bedside unattended. On 6/12/25 at 12:16 PM, the DON stated that the Tylenol was scheduled on the flex time for administration and time ranges were 6:00 AM-10:00 AM, 10:00 AM-2:00 PM, and 6:00 PM-10:00 PM. The DON stated that it would be difficult to calculate the time the resident took the medication if it was just left at the bedside. On 6/12/25 at 2:50 PM, the DON stated that resident 49 reported that she preferred to take her morning medication after breakfast because they upset her stomach. The DON stated that she changed all of resident 49's medications to be administered at 9:00 AM. The DON confirmed that the licensed nurse left the medication at the bedside. The DON stated that the nurse should have stayed and observed the resident taking the medication. The DON stated that if the resident requested to wait to take the medication with food the nurse should have taken the medication back and then they had an hour to administer them. Review of the Lippincott Nursing Procedures documented under Safe Medication Administration Practices that nurses must avoid distractions and interruptions when preparing and administering medications to promote a culture of safety and to prevent medication errors. The guidance further documented that the nurse administering the medication should adhere to the 'five rights' of medication administration: identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route. Recent literature identifies nine rights of medication administration, which in addition to the five rights includes the right documentation, the right action (or appropriate reason for prescribing the medication), the right form, and the right response. The guidance further documented under Administering scheduled medications in a timely manner that time critical medications should be administered 30 minutes before or after the regularly scheduled time. Give medications that are administered more frequently than daily but less frequently than every 4 hours (for instance, twice daily or three times per day) no more than 1 hour before or after the scheduled time. Wolters Kluwer. Lippincott Nursing Procedures. Ninth Edition. Philadelphia, PA. (2023) pp. 743-744.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 1 out of 38 sampled residents, a resident who was identified as a two-person assist for bed mobility and incontinence care sustained a fall during a one-person assist for incontinence care. Resident identifier 264. Corrective Action: On 4/8/25, resident was assessed for injury; it was determined resident needed immediate medical attention and was sent to hospital via emergency medical services (EMS). Ensure two people were in the room when moving the resident, this included rolling and Hoyer transfers. Certified Nursing Assistant (CNA) 2 was put on leave until the investigation was completed. CNA 2 was moved to a different unit. On 4/14/25, CNA 2 completed the CNA Annual Checklist and education regarding APM settings and APM two person assist. On 4/24/25, resident was in a 42 wide bed with a 42 Air Pressure Mattress (APM). A new 48 bed frame and 48 APM was purchased for the resident. Systemic Interventions: On 4/9/25, care staff were educated to place APM on static status when performing brief changes. An order was placed in the Task Administration Record for the nurse to check that the resident's air mattress was working correctly. CNA charting was added for any patient on an air mattress to perform a setting check before and after brief changes. On 4/10/25, an audit was conducted to identify which residents were on APMs. Monitoring: On 4/16/25, audits were performed to ensure staff implemented the corrective measures, specifically adjusting the setting on the APM to Static prior to performing incontinence care. Quality Assurance and Performance Improvement (QAPI): On 4/10/25, the QAPI committee reviewed the event and identified the need for further interventions for 2-person bed mobility and transfers and air mattress mode settings, including CNA charting for tasks. Determination of Compliance Date: 4/16/25. Findings included: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 264 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, body mass index 50. 0 - 59.9, and type 2 diabetes mellitus. On 4/8/25 at 3:11 PM, the facility reported to the State Agency (SA) that on 4/8/25 at 10:20 AM, resident 264 was getting a brief change by a CNA. The CNA rolled resident 264 to her right side and she fell out of bed. Resident 264 was sent to the hospital by EMS. Social services notified the Ombudsman, Police Department, and Adult Protective Services. The CNA was sent home while an investigation was conducted. Review of resident 264's medical record was completed on 6/9/25 through 6/17/25. On 4/8/25 at 11:45 AM, a Senior Health Support Services progress note revealed the following. The Physician Assistant (PA) was called to the bedside as resident 264 fell from the bed. The PA learned that the resident was being attended to at the time of her fall and rolled out of bed during cares. When arriving at the room, resident 264 was face down on the floor with visible blood pooling near her face/head. Resident 264 was unable to verbalize any location of pain and just said help me. With great effort and multiple staff members, resident 264 was log rolled to her back. Resident 264 had a large laceration on her forehead, contusion around her right eye, and reported her hand was a bit sore. Resident 264's bed was in an elevated position at the time of fall, as this was her preferred bed location. EMS arrived and transported resident 264 to the hospital. On 4/9/25 at 1:20 PM, a Nurses Note documented that resident 264 had a fall on 4/8/25 at 10:10 AM. A CNA came out of resident 264's room asking for help, now. This nurse ran into the room and seen patient was lying flat on her belly with a night gown on and no brief, asking for someone to help her. When assessing resident 264 there was blood around her head. This nurse instructed a staff member to grab a phone and another staff member to go call management for help. Pressure was applied to resident 264's head laceration. Resident 264 was turned to her back for better assessment. Resident 264 had a large head laceration on her forehead and a swollen/bruised eye. The PA was there to help with the assessment of resident 264. Resident 264 was then taken by EMS to the emergency room. An intervention was placed to ensure two people were in the room when moving resident 264, this was to include rolling and Hoyer transfers. The hospital was called at 1:30 PM, stating the resident 264 would possibly be transported to another hospital due to her condition. On 4/14/25 at 8:45 AM, Senior Health Support Services progress note revealed the following. Resident 264 presented to the hospital after a fall from bed and striking her face. Resident 264 was diagnosed with a right orbital blowout fracture with a slight right eye abduction deficit. She was also found to have a type II dens fracture, 7th cervical (C7) vertebrae spinous process fracture, 7th thoracic vertebrae fracture, postseptal hematoma, and right medial maxillary wall fracture. After stabilization, she was readmitted back to the facility on 4/12/25. Although no surgical interventions were recommended, she has been prescribed a rigid cervical collar for six weeks and spinal precautions. On this admission visit resident 264 was positioned in reverse Trendelenburg due to discomfort with remaining flat, and she was adjusting her collar for increased mobility. She reports persistent double vision, which was gradually improving per ophthalmologic evaluation, as well as mild left-hand pain and ongoing right shoulder pain. There were no new complaints of chest pain or shortness of breath. Her overall status remains stable as she continues with supportive care and monitoring. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 5/8/25, the facility submitted their final investigation to the SA which revealed the following. Resident 264's fall was an unfortunate accident. The CNAs frequently changed resident 264 individually per her request and resident 264's care plan was followed for her brief change. The CNA was following resident 264's care plan regarding brief changes which listed a one person assist when she rolled out of bed and fell which fractured C7 and orbital bone. Resident 264 was interviewed and stated that Sometimes 2 CNAs assist with brief changes, and sometimes only 1 CNA assists with brief changes. Resident 264's care plan has been updated and now resident requires a two person assist with brief change. Resident also had additional bed mobility equipment and facility conducted additional training for staff. A Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed in Section G - Functional Status regarding bed mobility, for how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture. When self-performing this task, resident 264 needed extensive assistance and needed the support of two plus persons for physical assistance. On 6/17/25 at 9:41 AM, an interview was conducted with CNA 4. CNA 4 stated in order to know if a resident was a one or two person assist, she would be able to find that information in the CNA Bible which was located at the nurses' station, in the charting system, and the vitals clip board. On 6/17/25 at 11:04 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that she was the nurse for resident 264 on 4/8/25. RN 3 stated that it was just a regular day, she was sitting at the nurses' station talking with a hospice nurse when a call light went off. CNA 2 came out of resident 264's room and asked for help. RN 3 went into resident 264's room and seen she was on the floor. RN 3 called for additional back up over the radio. RN 3 stated they were able to get the bleeding stopped and resident 264 was sent out via EMS to the hospital. RN 3 stated she did not remember what type of assistance resident 264 needed for brief changes or transferring. RN 3 stated she always needed to ask the CNAs for assistance status of the residents or she would look in the CNA Bible were it was listed. On 6/17/25 at 11:05 AM, an interview was conducted with CNA 2. CNA 2 stated that resident 264 was a one-person assist for brief changes and a two-person assist with transfers, which required a Hoyer lift. CNA 2 stated she had done multiple one-person assist brief changes on resident 264 and there was not an issue until the fall on 4/8/25. CNA 2 stated that it did make it easier when there were two people doing resident 264's brief changes. CNA 2 stated that she was the one that did resident 264's brief change when she rolled off the bed. CNA 2 stated that she had turned resident 264 to her side, had her all cleaned, and was just about to put the brief on when CNA 2 looked over and resident 264 was gone off the bed and onto the floor. CNA 2 stated that she really did not know what had happened, resident 264 had a shoulder that was troubling her, and she could have shifted some and that could be a reason why she rolled off the bed. On 6/17/25 at 11:18 AM, an interview was conducted with CNA 3. CNA 3 stated resident 264 could be a one or two person assist for brief changes; it would really depend on the CNA. CNA 3 stated that resident 264 trusted certain CNAs who would do a one-person brief changes. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/17/25 at 12:01 PM, an interview was conducted with MDS Coordinator 1. MDS Coordinator 1 stated the MDS assessments were done every 92 days or quarterly. If a resident was starting to have a decline, most of the time, those changes would be care planned. Every Wednesday a long-term care (LTC) meeting was conducted, in this meeting, they would start addressing concerns that had been noted on any of the residents, and which residents have MDS assessments coming up. When doing MDS assessments, they base it on CNA charting and what was learned during the LTC meetings. When reviewing a resident's functional status, they would look at how extensive the assistance had been, ask the CNAs and get their feedback, and if a resident was dependent for activities of daily living they would be assessed at extensive assistance. MDS Coordinator 1 stated, everyone had their own piece in putting in care plans and should be done when there was a need for a resident. The MDS Coordinators would update any care plan after the resident's MDS assessment was completed and would also do a final review of all the care plans. MDS Coordinator 1 stated that during resident 264's last quarterly MDS assessment she was a two-person assist, and she should have been a two-person assist with bed mobility and transfers. On 6/17/25 at 12:17 PM, an interview was conducted with Unit Manager (UM) 2. UM 2 stated that they would update the care plan within 48 hours after the LTC meeting and/or the completion of the MDS assessments. UM 2 stated that when you enter a care plan you can select which department it needed to go to, for instance when you select it to go to the CNAs the KARDEX would be updated and would alert the CNAs of the new task. UM 2 stated that she thought resident 264 was a one-person assist prior to the incident on 4/8/25. When resident 264 returned to the facility, the task list alerted the CNAs that she was now a two-person assist, so the CNAs knew what they should be doing. UM 2 stated she was not aware that the previous MDS assessment from 2/26/25, had resident 264 as being a two-person assist. On 6/17/25 at 12:25 PM, an interview with the Director of Nursing (DON). The DON stated during their investigation for the incident on 4/8/25, it was found that resident 264 was on an APM and was believed to be in alternating air pressure status. It was also discovered that all the APMs in the facility were in alternating status. Since the incident they have put in a Performance Improvement Action Plan to change the APMs status to static mode prior to any brief changes. All the CNAs have had training regarding the APM's static and alternate status settings and the settings during cares. The DON stated that resident 264 had been a one-person assistance at the time of the incident on 4/8/25, and they had changed it to a two-person assistance when returning back to the facility. The DON stated that prior to 4/8/25, they did not have resident 264 in the KARDEX or care planned for any type of assistance. The DON stated that any nurse could adjust the care plan, floor nurses, unit managers, MDS Coordinators, and management. The DON stated that CNAs would know a residents assistance status by looking in the CNA Bible or in the KARDEX. The DON expected her staff to put any ADLs or transfers that needed assistance in a care plan. The CNA team lead updated the KARDEX, as needed, related to CNA tasks. The MDS assessments could trigger a care plan. The DON stated the medical record system was a new program and she was still learning how the system worked. The DON stated that prior to the fall, resident 264 did not have an assistance status listed in the KARDEX.

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	06/17/2025

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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not file in the resident's clinical record the laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, for 1 out of 38 sampled residents, the resident did not have laboratory results filed in their medical record. Resident identifier: 18. Findings included: Resident 18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included bilateral primary osteoarthritis of knee, type 1 diabetes mellitus with diabetic polyneuropathy, anxiety disorder, mood disorder due to known physiological condition with depressive features. Review of resident 18's medical record was completed on 6/9/25 through 6/17/25. On 4/25/25 at 10:44 AM, a Nurses Note revealed per physician's assistant orders: vaginal culture for yeast, trichomonas (trich) vaginalis, and sexually transmitted disease (STD). Diagnoses: vaginal discharge. On 4/25/25, a completed Physician's Order for yeast, trich, and STD one time only for vaginal discharge. It should be noted that no laboratory results could be located in the medical record. On 6/12/25 at 3:02 PM, an interview was conducted with Unit Manager (UM) 1. UM 1 stated she could not find the lab result from 4/25/25, in the resident's electronic medical record (EMR). UM 3 stated that the lab results from 4/25/25, were from an outside facility and Medical Records had to request the results and upload them to resident 18's EMR.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain records on each resident that were complete and accurately documented. Specifically, for 1 out of 38 sampled residents, a resident that received a narcotic did not have the narcotic signed out as administered. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, cervical disc degeneration, bilateral primary osteoarthritis of knee, and chronic pain syndrome. On 6/9/25 at 3:34 PM, an interview was conducted with resident 1. Resident 1 stated that she was in pain and needed something. Resident 1 was observed to close her eyes and grimace. Resident 1 activated her call light and told Certified Nursing Assistant (CNA) 1 that she needed something for pain. CNA 1 stated that she would tell the nurse. Resident 1 stated that she had oxycodone four times a day and she could have another pain medication every hour. Resident 1 stated that her whole left side was painful. Resident 1's medical record was reviewed. A physician's order dated 5/9/25, documented Morphine Sulfate Solution 10 MG [milligrams]/5ML [milliliters] Give 0.25 ml by mouth every 1 hours as needed for Pain . The June 2025 Medication Administration Record (MAR) was reviewed. Resident 1 had not received Morphine on 6/9/25. The Narcotic Record Book was reviewed. Resident 1 received Morphine on 6/1/25 at 1:00 PM, 6/2/25 at 12:00 PM, 6/3/25 at 8:00 AM and 1:00 PM, 6/5/25 at 11:00 PM, 6/6/25 at 11:00 PM, 6/7/25 at 11:00 PM, 6/8/25 at 1:00 PM, 6/9/25 at 8:00 AM and 5:50 PM, and 6/10/25 at 8:00 AM and 1:00 PM. It should be noted that the listed entries of Morphine were not signed out as administered to resident 1 on the MAR. On 6/11/25 at 9:05 AM, an interview was conducted with CNA 1. CNA 1 stated if a resident complained of pain she tried to stay on top of it and told the nurse. CNA 1 stated that she was pretty sure she told the nurse on Monday about resident 1's pain. On 6/11/25 at 9:07 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that resident 1 received pain medications on Monday. LPN 1 stated resident 1 received oxycodone every six hours and morphine every hour if she needed it. LPN 1 looked at the narcotic record book and stated that resident 1 received Morphine at 5:50 PM on 6/9/25. On 6/11/25 at 9:41 AM, a follow-up interview was conducted with LPN 1. LPN 1 clarified that resident 1's Morphine was not signed out on the MAR as being administered. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 12:02 PM, an interview was conducted with Unit Manager (UM) 1. UM 1 clarified there was no additional information and resident 1's Morphine was not signed out as administered on the MAR. UM 1 stated that staff should sign the medication out in the Narcotic Record Book, administer the medication to the resident, and click the box on the MAR that the medication was administered to the resident.