STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the health or safety of an individual in the facility was endangered; the licensee ceases to operate the facility; the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; the transfer or discharge was appropriate because the resident's health has improved sufficiently so the resident no longer needed the services provided by the facility; or the transfer or discharge was necessary for the resident's welfare and the resident's needs cannot be met in the facility. The facility did not ensure that discharged residents' medical records included documentation of the specific resident needs that could not be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the needs. In addition, the facility did not complete a discharge summary that included a post-discharge plan of care. Specifically, for 2 out of 46 sampled residents, a resident was discharged to an ex-spouses house after the physician had documented the resident had potential decline, the hospice nurse was unaware of the discharge, and there was no new discharge summary for the resident. In addition, there was no documentation regarding why a resident was discharged , why the facility was unable to meet her needs, and why she was not readmitted to the facility after being discharged . Resident identifiers: 83 and 94. Findings included: 1. Resident 94 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included liver cell carcinoma, heart failure, and developmental disorder of scholastic skills. On 1/12/24 at 7:04 AM, a provider note stated resident 94 was recently diagnosed with liver cancer, and the oncologist told the patient he had '6-9 months to live, but closer to 6 months' according to the patient. He was admitted to hospice. He does not have a permanent place to live. He now comes to us for comfort management. On 4/11/24 at 6:15 PM, a social services note revealed resident 94's discharge plan was to continue receiving long term care at the facility and that he continues to need skilled nursing and hospice due to end of life diagnosis. On 4/28/24, an active problem titled [resident 94] current status/function requires Long Term Nursing level of care at this time was started on resident 94's care plan. The category was Discharge Plan - Long Term Care Stay. The next care conference date was 7/10/24. It should be noted that no additional information about facility discharge planning could be located in resident 94's medical record. On 5/7/24 at 10:51 AM, a provider note documented evidence of resident 94's potential decline. The (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note stated resident 94 reports experiencing frequent dizziness, describing it as a spinning sensation that goes from right to left. He states that he usually sits down to avoid falling when the dizziness occurs. Patient also mentions a significant loss of appetite, which he attributes to his liver cancer. Additionally, the patient complains of stomach discomfort and believes he may be experiencing acid reflux. It should be noted that this provider note did not include any reference to an upcoming facility discharge. On 5/8/24 at 9:14 AM, a hospice skilled nursing visit note showed further evidence of resident 94's potential decline. Patient reports he has only eaten one sausage patty in 2 days because he has no appetite and food makes him sick. He reports the right side of his abdomen has been hurting so bad it brings tears to his eyes and he rated that pain at an 8/10. That is new as of this week. He reports feeling so weak he doesn't feel safe going on walks around the building anymore like he used to. It should be noted that this hospice note did not include any reference to an upcoming facility discharge. On 5/15/24 at 9:04 AM, a hospice skilled nursing visit note documented additional evidence of resident 94's potential decline. Decline noted as evidenced by increasing pain and weakness. Patient was ambulating down the hall with a cane today. He normally doesn't use any DME [Durable Medical Equipment] to ambulate but he said he's been feeling weaker and more unsteady lately. He reports the headaches are at a 10/10 intermittently throughout the day and night. Staff report he's asking for morphine every hour as well. Nurse palpated his upper abdomen today and right side is firm and abdomen distended. Nurse observed face and eyes were mildly jaundiced today. Patient reports having more nausea and he's thrown up at least once daily for the past week. He isn't eating more than 25% of 1 meal daily now when he used to eat 100% of 3 meals. It should be noted that this was the morning that resident 94 was discharged from the facility, and that this hospice note did not include any reference to an upcoming facility discharge. On 5/15/24 at 11:21 AM, a hospice chaplain visit note revealed the first mention in resident 94's medical record that the facility initiated his discharge. [Resident 94] said he's being asked to leave the facility but doesn't know where he is going yet. I listened and gave emotional support. I spoke with hospice director and she said living arrangements are being made for him. On 5/15/24 at 3:57 PM, a document titled Transition of Care/Discharge Summary was printed. The discharge summary provided an admit date of 1/12/24, and a discharge date of 5/12/23. [Note: the discharge date for resident 94's 1/12/24 admission was 5/15/24.] The document stated that resident 94's discharge destination was his Recreational Vehicle (RV) with home health services. The discharge goal was resident 94 would continue to get stronger with the home health services. All wet ink signatures on the discharge summary were dated on 5/15/24 at 4:45 PM. The document did not contain information about hospice services. On 5/15/24 at 5:18 PM, a nursing progress note documented [Resident 94] had discharge teaching done and all questions answered. [Resident 94] left in private vehicle with personal belongings. [Resident 94] also had 3 days supply of medications sent with him. On 5/17/24 at 9:53 AM, a hospice communication note documented Nurse was notified this morning that patient is on LOA [leave of absence] and staying at his ex-wife's home currently. On 2/5/26 at 11:45 AM, an interview was conducted with the Social Services Director (SSD). The SSD stated a welcome meeting is held upon a resident's admission to the facility, during which work on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the discharge plan begins. The SSD stated she would evaluate whether a resident needs long-term care, assisted living, or independent living, along with any concerns about returning to the community. The SSD stated that she requested a day or two of notice to set up home health or DME, arrange transport, and ensure the team had verified there were no factors that would keep the resident at the facility. The SSD stated that after arrangements had been made she would e-mail nursing so they could prepare for the day of discharge, such as sending prescriptions to the pharmacy, and confirming home health was set up. According to the SSD, resident 94 was very independent, had a terminal diagnosis, and had become threatening to staff and residents, but stated she did not know the specifics, other than he disliked his roommate and let staff know. The SSD stated resident 94 was not given a 30 day discharge notice, and she was not sure why a resident who was documented as declining would be discharged . It should be noted that following the social services note from 4/11/24, referenced prior, which indicated resident 94 was to continue receiving long-term care at the facility, five progress notes documented aggressive behaviors towards staff or residents from resident 94 on 4/27/24, 5/12/24, 5/13/24, and 5/14/24. A review of resident 94's care plan revealed no active problems or interventions related to aggressive behaviors. The provider note from 5/7/24, referenced prior, did not document any concerns regarding aggressive behaviors. A review of resident 94's medical record from 4/11/24 to 5/15/24, revealed no documentation of the hospice provider being contacted regarding behavioral concerns, no medication adjustments to manage those concerns, and no room changes during this time. On 2/9/26 at 1:49 PM, an interview was conducted with the Hospice Director. The Hospice Director stated that resident 94's hospice medical record did not have any information of a planned facility discharge prior to the hospice chaplain note on 5/15/24. On 2/12/26 at 1:05 PM, an additional interview was conducted with the SSD, who stated hospice records indicate resident 94 was discharged to his ex-wife's home. The SSD stated she did not complete the Transition of Care/Discharge Summary document and was unsure why the discharge destination was his RV. The SSD stated that resident 94's original care plan was to remain in the facility and receive long term care. The SSD stated that she was not involved in the process of discharging resident 94, and that it was not normal for her to be uninvolved. The SSD stated that if a resident leaves Against Medical Advice (AMA) the nurses educate the resident about safety risks, have the resident sign paperwork, and if possible notify the SSD so she can set up the appropriate community services. The SSD stated she was unsure if resident 94 left AMA. On 2/12/26 at 1:32 PM, an interview with Administrator (ADM) 1. ADM1 stated that she was not employed at the facility during the time of resident 94's discharge. ADM 1 stated that resident 94's ex-wife informed ADM 1 that following Resident 94's discharge from the facility, he resided at the ex-wife's home for approximately one month before moving to his sibling's home, where he subsequently passed away. On 2/12/26 at 1:51 PM, an interview was conducted with the Regional Social Work Director (RSWD), who stated that after record review she determined that resident 94 had a previous discharge on [DATE], when he was discharged to his RV with home health services. RSWD stated that staff failed to follow the discharge process for Resident 94's 5/15/24 discharge because they used the discharge summary from 5/12/23. The RSWD stated that because the discharge process was not followed the facility did not coordinate the discharge with the hospice nurse and a new discharge summary was not created to indicate an accurate location of where the resident planned to reside. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 83 was admitted to the facility on [DATE], discharged to the hospital and readmitted on [DATE] and discharged on 8/27/25 with diagnoses which included diffuse traumatic brain injury (TBI) with loss of consciousness, spastic hemiplegia, major depressive disorder, paraplegia, antisocial personality disorder and suicidal ideations. Resident 83's medical record was reviewed 2/4/26. A nursing progress note dated 8/27/25 at 1:49 PM revealed, Pt [patient] was outside of another pt's room and was using vulgar language towards other pt. Nurse removed pt from situation and discussed taking space from neighbor. Pt was visibly upset about situation but verbalized understanding. Within 2 minutes pt was back outside of neighbors door, this time with an elevated voice. Nurse removed pt from doorway and pt proceeded to kick her chair backwards towards nurse. Pt began to hit nurse with plastic gum packet in her hand. Nurse assisted pt outside to allow her some fresh air and remove her from potential triggers. Pt and nurse had a conversation outside and pt calmed down. Pt expressed her frustrations and stated she would stay away but she needed to go to the bathroom. Nurse brought pt back in building and immediately pt began using vulgar language again and calling all the staff 'fucking bitches.' Pt began to hit staff repeatedly and attempted to tip her wheelchair back. Pt threw plastic gum package at different nurse. DON [Director of Nursing] arrived and pt agreed to go talk privately with her. A Discharge summary dated [DATE] revealed that resident had physical aggression, verbal aggression, unable to manage by staff, history of suicidal ideation. There was no documentation from resident 83's physician regarding why the facility was unable to care for the resident and what interventions were tried. On 2/5/26 at 9:38 AM, an interview was conducted with the Restorative Therapy Aide (RTA). The RTA stated resident 83 was agitated and aggressive with staff. The RTA stated resident 83 was sent to the hospital because she hurt staff, threw glass dishes at staff, and punched staff. The RTA stated staff were afraid to work with resident 83. On 2/5/26 at 11:00 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that resident 83 was blue sheeted (involuntarily committed) to a local hospital because she was very aggressive and hit a Certified Nursing Assistant in the face. The ADON stated the DON and psychiatric nurse took the resident into the parking lot and worked on deescalating her but were unable to. The ADON stated the facility did not feel residents or staff were safe if resident 83 returned to the facility. On 2/5/26 at 11:45 AM, an interview was conducted with the SSD. The SSD stated prior to a resident being admitted to the facility, central intake will review all the information to determine if the resident is the right fit for the facility. The SSD stated resident 83 was blue sheeted to a local hospital because of physical aggression to staff and hurting staff. The SSD stated the mobile crisis unit was unable to deescalate resident 83.The SSD stated resident 83 was wrapping things around her neck really tightly in an attempt to commit suicide. The SSD stated resident 83 had been sent to the hospital for aggression and was readmitted to the facility but continued to have outbursts. The SSD stated police were called and the physician was involved with the discharge. The SSD stated resident 83 was not safe to readmit to the facility and it would have put staff and residents in harm's way. On 2/5/26 at 12:21 PM, an interview was conducted with ADM 1. ADM 1 stated resident 83 had a TBI (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and would get belligerent with her words. ADM 1 stated resident 83 was very aggressive to staff and made a suicide attempt when she was blue sheeted to the hospital. ADM 1 stated she had been readmitted to the facility after a hospital stay, but was blue sheeted again because she was aggressive, hitting staff, throwing things, trying to wrap things around her neck, and yelling. ADM 1 stated the facility chose not to take her back because she was a danger to herself and staff. ADM 1 was unable to provide documentation from the physician on why the resident was discharged , why the facility was unable to meet her needs, what interventions were tried, and why she was not readmitted to the facility after being discharged .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, for 3 out of 46 sampled residents, a resident experienced a change in condition after a fall, was not provided treatment for 2.5 hours, and ended up passing away. Another resident complained of hip pain after a fall and was not sent to the hospital for 10 hours. These examples will be cited at harm. In addition, a resident was not provided treatment when he was experiencing low oxygen saturation levels. Resident identifiers: 74, 86, and 90. Findings included:HARM1. Resident 90 was admitted to the facility on [DATE] with diagnoses which included, paroxysmal atrial fibrillation, difficulty in walking, and muscle weakness.The facility reported to the State Survey Agency (SSA) on 6/12/24, that resident 90 was found on the floor in her bathroom at 1:30 PM, and she stated she did not hit her head. Neurological checks were initiated and no changes or abnormal vitals were identified until 8:30 PM. Resident 90 was sent to the Emergency Department due to nausea, vomiting, and confusion where she subsequently passed away.A review of resident 90's medical record revealed the following:a. On 6/11/24 at 1:32 PM, a nursing note documented, pt. [patient] calling for help from bathroom. pt. found on floor next to soilet [sic] in soiled clothing. pt immediately assisted back onto toilet, changed into clean clothing, neuros [neurologicals] started, and vitals. vitals and neuros are baseline for pt. pt. denies hitting head and no signs of injury present. pt. has a current UTI [urinary tract infection], poor lighting in bathroom, and no grippy socks were on. maintenance informed of the poor lighting, grippy socks placed, call light clipped to pt. with education to use that when needing to transfer, and pt. placed back into chair.b. On 6/11/24, neuro checks began at 1:15 PM. At 8:00 PM, the neuro sheet documented resident 90's blood pressure as 171/80 and heart rate was 106. At an unknown time the neuro sheet documented resident 90's level of consciousness as lethargic-slow to respond to verbal stimuli, hand grasps as weakness, and speech as slurred. c. On 6/12/24 at 1:40 AM, a nursing note documented, At 2030 [8:30 PM] pt started c/o [complaining of] HA [headache] and reported that she did hit her head at the time of the fall-bp [blood pressure] 123/59. 2100 [9:00 PM] neuros again checked 145/77. She was c/o nausea, vomiting, and was not following simple cues. 2130 [9:30 PM] BP assessed again 171/80. pthad [sic] left sided weakness for grip strength. Nurse contacted PA [physician assistant] and he reported that since her focal point has deficits et [and] that she has weakness, that needed [sic] to send her out. Called pt son et reported finding et he reported to send to ER [emergency room] for CT [computed tomography] Scan. EMTS [emergency medical technicians] called and pt was sent out at 2230 [10:30 PM] .A review of resident 90's Facility Reported Investigation interviews revealed the following:a. Registered Nurse (RN) 4's interview documented, I first saw [resident 90] for her 1900 [7:00 PM] neuro check. All checks and vitals were WNL [within normal limits]. At about 2000 [8:00 PM] the CNA [Certified Nursing Assistant] notified me she was complaining of a headache. I notified [name redacted] the wing nurse of the headache concerned [sic] due to her fall earlier in the day. [Name redacted] stated that she got in report that [resident 90] did not hit her head when she fell earlier in the day. I prepared her 2000 meds [medications] adding Tylenol for the headache. I then administered her meds and did the 2000 nuero [sic] checks. They were all WNL, but her blood pressure was starting to elevate. She conversed with me appropriately. I spent several minutes with her at the time administering her breathing treatment. I asked the CNAs to get her an ice pack to see if it helped her headache. At about 2100 [9:00 PM] the CNA notified me that [resident 90] had vomited. I immediately went in and assessed her. Her LOC [level of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0684 Level of Harm - Actual harm Residents Affected - Few	consciousness] had changed concerningly although she would still respond to me. She would not open her eyes. She followed commands to grip my hands. Right hand was strong, no grip at all with the left. I immediately notified [name redacted] the wing nurse and she started the notification process of all appropriate parties. I instructed the CNAs to clean [resident 90] up. She vomited once more right before the EMTs arrived.b. RN 5's interview documented, As I was receiving report for shift change, I was informed that pt [resident 90] had taken a fall earlier in the day and was on neuros. I asked many questions to see where they fell, if head was hit and behavior change from normal. Med nurse and swing aides gave answers, fell in bathroom and hit head and was recently complaining of headache. Once report was finished, I entered the room to immediately check on pt. Pt name was called many times and arm stimulation was used before pt responded. Pt kept saying yes to all questions and requests regardless of questions or tasks asked. Pt was unable to open eyes or respond as normal. Med nurse was notified who informed me to notify and give all information to the charge nurse. Charge nurse was notified and call Non-emergency line and requested transportation for pt. Med nurse called on radio that pt was throwing up and needs immediately [sic] attention. Swing aide and I rushed to the room to assist pt. As assisting EMTs arrived and took over. Charge nurse, swing aide and I stayed in room to assist and comfort roommate. EMT's stated BP was out of range and no response of puplies [sic]. Pt was assisted on stretcher and EMTs transported to hospital.A review of resident 90's hospital CT scan records revealed, Head CT: This examination is abnormal. There is a very large holohemispheric right cerebral convexity subdural hematoma, most pronounced along the right frontal lobe and subinsular cortex. This subdural hematoma measures 3.2 cm [centimeters] in maximum thickness. There is an additional right parafalcine subdural hematoma measuring up to 16mm [millimeters] in thickness-posteriorly. There is effacement on the right lateral ventricle. There is a leftward shift of the septum by approximately 21 mm. There is developing moderate right and left uncal and subfalcine herniation. [It should be noted that resident 90 was on anticoagulant medication and her International Normalized Ratio level was 3.5 on 6/11/24 at 10:51 PM.]On 2/5/26 at 10:58 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she expected staff to reach out to the Director of Nursing or herself about any changes in condition that residents may have. The ADON stated that the medical provider made the decisions on when to send a resident to the hospital. On 2/6/26 at 5:02 PM, the facility provided additional information regarding resident 90. It should be noted that the additional information did not include why there was a 2.5 hour delay in sending resident 90 to the hospital once she began experiencing a change in condition. Resident 90 passed away on 6/12/24 at 1:48 AM. 2. Resident 86 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinsonism, muscle weakness, difficulty walking and sepsis. The facility reported to the SSA that resident 86 was found on the floor on 6/8/25, complaining of pain and an x-ray confirmed there was a fracture. A nursing progress note revealed resident 86 had a fall on 6/5/25. Resident 86 was moved closer to the nurses station. A nursing progress note from Licensed Practical Nurse (LPN) 1 dated 6/8/25 at 9:26 AM, revealed, Pt had fall this morning at approximatly [sic] 0645 [6:45 AM]. Pt found lying flat on ground next to bed and stated she had L [left] hip pain. Pt assessed no new bruising or redness noted at the time of fall. Pt unable to tell nurse where she was trying to go or what she needed. Pt at baseline. Nuro [sic] and vital check started. Pain medication administered and family Management and MD [medical doctor] notfified [sic]. Order placed for L hip xray. On 6/8/25 at 9:37 AM, a nursing progress note revealed Pt bed placed at lowest position, replaced personal socks with non slip socks, personal items and call light placed in reach. On 6/8/25 at 10:55 AM, a nursing progress note revealed, Pt stated the cna hit her while nurse and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0684 Level of Harm - Actual harm Residents Affected - Few	cna were moving her up in bed. Pt was not hit by CNA the movement in bed using the draw sheet made her uncomfortable. On 6/8/25 at 7:04 AM, oxycodone 5 milligrams was administered with a pain level of 5. On 6/8/25 at 1:06 PM, oxycodone 5 milligrams was administered for left hip pain. The medication was documented as being ineffective with pain relief. On 6/8/25 at 4:59 PM, a nursing progress note revealed Pt discharged to [local] hospital via ambulance, due to left femoral neck fracture at 6/8/2025 1650 (4:50 PM). MD, family and unit manager notified. Copy of POLST [physician order for life sustaining treatment] Emergent discharge and Quality imaging results sent with ambulance staff. Pt or family unable to sign paperwork copy to be faxed to hospital. Nurse to Nurse report Hospital ER called and updated on PT info condition, baseline, vitals and arival [sic] with left femoral neck fracture. On 6/8/25 at 9:06 PM, a nursing progress note revealed 6/8 Unwitnessed Fall: Patient was found lying supine on the floor adjacent to her bed following an unwitnessed fall. She reported pain localized primarily to the left hip but was unable to confirm any head impact. A comprehensive head-to-toe assessment revealed no visible bruises, lacerations, or hematomas on the head. Neurological examination indicated pupils equal, round, and reactive to light, with bilateral hand-grip strength consistent with her baseline. Examination of the left hip showed mild erythema without evidence of bruising, swelling, or deformity. No additional abnormalities were noted on supporting extremities. Vital signs were within normal limits. The patient received her prescribed analgesic in conjunction with her scheduled morning medications. The attending physician, nursing management, and the patient's daughter . were promptly notified. A STAT [immediately] X-ray of the left hip was ordered per their direction. At the time of the fall, the patient was not wearing non-slip socks; her personal socks were immediately replaced with non-slip footwear. The orthopedic boot had been removed for comfort while resting and had not yet been reapplied. The room was free of clutter, with personal items and the call light within reach, and the bed was in its lowest position. The patient had been assisted with toileting less than 30 minutes prior to the incident. Post-fall, the patient was educated on the importance of using her orthopedic boot for ankle support and instructed to use the call light for assistance before mobilizing. Fall-risk assessment and care plan will be reviewed and updated to reflect this event. Resident 86 was readmitted to the facility with hospice services and passed away on 6/15/25. On 2/4/26 at 12:13 PM, an interview was conducted with Administrator (ADM) 1. ADM 1 stated she started on 6/16/25, and was unable to find additional information for resident 86's fall and change in condition. On 2/11/26 at 1:18 AM, a phone interview was conducted with LPN 1. LPN 1 stated after a fall he completed an initial assessment which included evaluating for a major injury and then neuro checks and vital signs were done for 72 hours. LPN 1 stated if a resident was on blood thinner, then a CT scan would be needed. LPN 1 stated resident 86 sustained a fall and complained of more pain in her hip and an x-ray was ordered. LPN 1 stated initially resident 86 complained of pain but not a significant amount of pain. LPN 1 stated he could not remember if the x-ray was ordered stat and if it was done at the facility or the hospital. LPN 1 stated he did not know why resident 86 was not sent to the emergency room for 10 hours after complaining of pain to the hip, but it was probably because he did not have a physician's order to send resident 86 to the hospital. LPN 1 stated he wanted to see if the resident's pain could be controlled at the facility. LPN 1 stated resident 86 had severe pain only with movement like rolling in bed or moving. LPN 1 stated he remembered her being in pain but did not remember any concerns of a CNA hitting her when repositioning her in bed. POTENTIAL FOR HARM 3. Resident 74 was admitted to the facility on [DATE] with diagnoses which included muscular dystrophy, obstructive sleep apnea, and dysphagia. The facility reported to the SSA on 12/28/25, that a nurse was not attending to resident 74 when his oxygen saturations (sats) were at 35% and a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0684 Level of Harm - Actual harm Residents Affected - Few	heart rate in the 100s. Resident 74 appeared gray-blue in color with an ashen appearance. A nurse reported to administration that resident 74's nurse had neglected him by not treating the low sats. A CNA had told the nurse that earlier in the evening resident 74's sats were in the 40s and 50s. After resident 74 did a cough assist and was placed on oxygen, his sats improved to 93%. Resident 74's medical record was reviewed 2/4/26 through 2/12/26. Resident 74's sats from 10/2/25 through 11/30/25, were above 90% on room air. A physician's order dated 10/27/25, and discontinued on 12/21/25, revealed to offer cough assist treatment every shift for airway management. On 12/1/25 at 6:17 AM, resident 74's sats were 80%. At 10:38 AM, a secured conversation via text message between facility staff and the provider revealed that the provider would like the facility to obtain a chest x-ray and a laboratory value for the resident. There was no documentation of treatment provided for low sats until 4 hours later. The next sats documented were on 12/5/25. A physician's order dated 10/2/24, revealed Bilevel Positive Airway Pressure (BIPAP) to be applied every night when sleeping but to hold from 12/1/25 through 12/28/25. It should be noted that there was no documentation located to indicate why the BIPAP order was to be held during this time frame. On 12/2/25 at 8:35 AM, the x-ray results revealed possible bronchitis and continue to offer cough assist. A nursing progress note dated 12/3/25 at 2:03 AM, revealed Alert Charting- Resident on alert charting related to a Change of Condition Hypoxia. every shift for change of condition for 3 Days Document in progress note how the resident is doing post their change of condition for 72 hours after no hypoxia concerns this shift. A physician's order dated 12/3/25, revealed cough assist treatment. Cough assist present on home setting. Registered Nurse (RN) to hold mask in place for patient to complete 4 coughs. The frequency was every shift for airway management. A secure conversation via text message between a nurse and physician on 12/4/25 at 5:36 PM, revealed resident 74 had called the nurses station 10 times. The nurse talked to resident 74 about that behavior and not getting consistent and solid sleep and that would affect his health in a negative way. The nurse asked resident 74 about a medication for sleep aide and resident 74 was agreeable. The physician ordered melatonin 3 milligrams (mg) every night. It should be noted there were no sats documented that night. On 12/6/25 at 3:21 AM, sats were 88% and at 5:37 AM, sats were 76%. There were no follow up sats. On 12/7/25 at 4:00 AM, sats were 86%, at 5:00 AM sats were 86%, at 6:34 AM sats were 75%, and at 3:54 PM sats were 90% on room air. Resident 74 refused cough assist and told the nurse it was as needed according to the orders-administration note. On 12/10/25 at 5:00 AM, sats were 85%. There were no follow up sats. On 12/17/25 at 5:38 AM, sats were 85%. There were no follow up sats. On 12/19/25 at 5:51 AM, sats were 65% and at 6:16 AM, sats were 65%. There were no follow up sats. On 12/26/25 at 5:52 AM, sats were 51%. There were no follow up sats. Cough assist was done at 12:58 PM. There was no follow up documentation after resident 74 had sats at 51%. On 12/27/25 at 5:40 AM, sats were 48%, at 6:26 AM, sats were 94%. On 12/28/25 at 4:32 AM, a nursing progress note revealed, resident has not slept for any length of time that would be considered restful despite being given a dose of melatonin at HS [hours of sleep]; has been highly [sic] using his phone to call for assistance in repositioning in bed only to call again within minutes to be repositioned again; offered oral pain med multiple times this shift with resident declining offered med; has also been noted to be randomly talking in jibberish [sic] as if there is someone present in the room that in reality is not there; will continue to monitor sleep and behaviors On 12/28/25 at 5:00 AM, sats were 47% and at 5:59 AM sats were 93%. Cough assist treatment was completed at 1:35 AM. On 12/28/25 at 7:32 AM, a secure conversation via text message between facility staff and a medical provider revealed resident 74 was requiring 4 liters of oxygen after being found at 47% oxygen sats on room air. Resident 74 was very pale and cyanotic in lips, according to the message. A nurses note (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0684 Level of Harm - Actual harm Residents Affected - Few	dated 12/28/25 at 5:31 PM, revealed, . Family looking for Bi pap and will bring it in if they find it. On 12/28/25, resident 74 was started on Amoxicillin-Pot Clavulante tablet 875-125 MG every 12 hours until 1/5/26, for bacterial infection/pneumonia. On 12/30/25, a physician's note revealed resident 74 had aspiration pneumonia. On 2/4/26 at 9:22 AM, an interview was conducted with resident 74. Resident 74 stated he used oxygen and staff monitored his oxygen levels. Resident 74 was observed to have oxygen being administered via a nasal cannula. On 2/9/26 at 1:48 PM, a phone interview was conducted with CNA 9. CNA 9 stated sats were checked every morning at 5:00 AM, for residents. CNA 9 stated resident 74 refused oxygen when he was first admitted to the facility. CNA 9 stated resident 74 was normally in the 70s and 80s for sats during the night. CNA 9 stated one night resident 74 was hot and cold, calling for help every 15 minutes throughout the 8 hour shift. CNA 9 stated he was calling to get adjusted like blanket on, blanket off, and then he said it was hard for him to breathe. CNA 9 stated resident 74's oxygen was in the 40s so she sat down with him and discussed using respiratory therapy to help him get his oxygen up. CNA 9 stated resident 74 was blue in the face and pale, so CNA 9 told him that he would die if he did not use oxygen. CNA 9 stated the resident agreed to oxygen that night. CNA 9 stated when she noticed resident 74 turning blue she was in the middle of helping the resident use the urinal, so she finished helping him and then took the garbage in his room out. CNA 9 stated she then informed the nurse that his sats were low and he was blue. CNA 9 stated she was told by the nurse to get an oxygen concentrator, so she did and his sats increased to above 90%. On 2/4/26 at 1:53 PM, an interview was conducted with RN 6. RN 6 stated sats were taken daily between 3:00 PM and 5:00 PM, by the CNA's. RN 6 stated it was not standard to have sats checked during the night shift. RN 6 stated if a resident had low sats, it was standard to provide oxygen and then recheck saturations. RN 6 stated resident 74 dropped in sats and another nurse and CNA were checking on him. RN 6 stated resident 74 had pneumonia. RN 6 stated that the monitor to check sats did not work on all of resident 74's fingers. RN 6 stated resident 74 did not wear oxygen until after he was diagnosed with pneumonia. RN 6 stated a CNA reported that the resident's sats were at 47% sats oxygen was started. RN 6 stated if a resident's oxygen saturations were below 80% she would provide oxygen and report it to the DON, physician, and family. On 2/4/26 at 9:28 AM, an interview was conducted with the ADM and Director of Nursing (DON). The DON stated she received a phone call from a nurse on 12/28/25 that resident 74 was having oxygen issues and his nurse did not act fast enough. The DON stated there was an investigation started. The ADM stated she was unable to determine if there was neglect. The ADM stated she did not look at previous oxygen levels.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident received care consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable. Specifically, for 1 out of 46 sampled residents, a resident was admitted to the facility with surgical wounds and Moisture Associated Skin Damage (MASD) and was discharged with a stage 4 pressure ulcer. This example will be cited at a harm level. Resident identifier: 89. Findings included: Resident 89 was admitted to the facility on [DATE] and discharged on 7/24/24 with diagnoses which included infection and inflammatory reaction due to internal left knee prosthesis, Methicillin resistant Staphylococcus aureus infection, and osteomyelitis. A form titled Clinical admission Documentation dated 3/28/24, revealed resident 89's skin was clean/dry/intact with surgical wounds. The wounds were breakdown on proximal posterior left lower extremity r/t [related to] brace, breakdown on coccyx r/t MASD. It should be noted there was no other information regarding the wounds above. There were no measurements or descriptions of the wounds. A physician's order dated 3/28/24 until 5/3/24, revealed that resident 89 had a knee immobilizer and the frequency was twice daily. There was no information on what was to be done with the knee immobilizer twice daily. It was signed off by a nurse twice daily on the Medication Administration Record. A nurses note dated 3/28/24, revealed Pt [patient] has some breakdown r/t friction from leg brace, pillowcase barrier applied. Pt also has MASD on coccyx, barrier cream applied. Pt has 2 wound vac's to LLE [left lower extremity] r/t surgical wounds and infection. Care plans initiated on 3/29/24, revealed resident 89 had skin impairment of surgical wound to left hip/upper thigh. Another care plan revealed [Resident 89] will have no unaddressed alteration to skin integrity, through next review. A Braden Scale for Predicting Pressure Sore Risk dated 3/29/24, revealed resident 89 was at high risk for developing pressure sores. A physician's order dated 3/29/24 until 7/24/24, revealed barrier cream to buttocks/peri-area as needed and apply with each incontinent episode until discharge. There were no signatures on the Treatment Administration Record that the treatment was done. Care plans further revealed on 4/11/24, resident 89 had skin impairment to the sacrum. A nursing note dated 4/12/24, revealed that resident 89 had wound care rounds completed for surgical wounds and the patient was wearing a brace to his left lower extremity. A physician's order dated 4/12/24, revealed treatment to his Gluteal cleft cleanse wound and apply medihoney to wound bed and secure with dressing three times a week. A daily skilled charting dated 4/14/24, revealed resident 89 had a surgical wound with no other skin issues documented. A care plan dated 4/22/24, revealed left inner thigh skin impairment and over the counter powder was ordered to be applied. A physician's order dated 4/29/24, revealed the left great toe was to be cleansed and skin prep applied twice daily. A physician's order dated 4/30/25, revealed for the Sacrum to remove the old dressing. Cleanse wound with wound cleanser or normal saline. Apply medihoney to wound bed. Secure with cover dressing. Complete 3 times weekly and as needed if soiled or dislodged. There was no documentation regarding the wound. A care plan dated 5/2/24, revealed resident 89 had actual skin impairment to his left great toe and left posterior calf. A nurses note dated 5/2/24, revealed the wound care provider documented a new wound to the left posterior calf noted by an aide post shower this morning. There was also a great toe wound noted. There were no wound measurements or description of the wound. Physician orders for wound treatment to the left posterior calf started on 5/4/24, until discharge. A nurse's note dated 5/13/24, revealed a wound to the left posterior calf. The area was still black and the surrounding skin was pink and intact. A nurse's note dated 5/18/24, revealed wound to left toe cleaned and wound was showing improvement. It (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465116	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Logan	1480 North 400 East Logan, UT 84341

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 0686 Level of Harm - Actual harm Residents Affected - Few	should be noted that no objective data was documented to show the wound improvement. A nurse's note dated 5/19/24, revealed a wound was cleansed, betadine applied, left open to air. It should be noted that the note was not specific to which wound. A nurses note dated 5/20/24, revealed hip surgery was canceled due to a wound on the back of leg. A nurse's note dated 5/22/24, revealed a wound to the left great toe was open to air. A nursing note dated 5/26/24, revealed Wound to calf is open with yellow slough on top, moderate yellow drainage et [and] foul ordor [sic]. Surrounding tissue is intack [sic] et pink. A daily skilled charting dated 6/11/24 revealed resident 89 had other for skin integrity. There was no other information. The first weekly skin assessment was dated 6/19/24, new onset left calf skin impairment. A physician's note dated 6/23/24, revealed stage 4 ulcer of left shin. It should be noted that prior documentation had the wound located on the calf and not the shin. The documentation made it unable to determine if two wounds were located with one the left calf and one on the left shin. Weekly skin assessments dated 6/26/24, 7/3/24, and 7/12/24, revealed skin was pink, dry, warm, intact. The locations listed on the assessments were left calf and ankle posterior. A nurse note dated 6/27/24, revealed that resident 89 had surgical site on left anterior thigh reopen and left posterior calf was progressing well. A physician's note dated 7/1/24, and 7/4/24, revealed resident 89 had a stage 4 ulcer of left shin which was managed by wound care. A physician's note dated 7/11/24, revealed resident 89 had a Stage 4 ulcer on Left hip treated with calcium alginate dressings. It should be noted this was another skin breakdown area. It should be noted that this was the first documentation of a stage 4 PU on the left hip. Prior documentation described the left anterior thigh as a surgical site only. A physician's note dated 7/21/24, revealed resident 89 was seen for wound debridement. The treatment plan revealed a pressure ulcer of right hip stage 4. There were no wound treatments for the right or left hip in the Medication Administration Record. A physician's note dated 7/23/24, revealed . He [resident 89] has been receiving wound care for a Stage 4 pressure ulcer on the posterior left lower leg. It should be noted that resident 89 was admitted with breakdown on proximal posterior left lower extremity r/t brace and breakdown on coccyx. Resident 89 further developed wounds and there was no documentation of interventions used to prevent skin breakdown. Resident 89 was admitted with a knee immobilizer and developed a stage 4 pressure ulcer on his calf that the immobilizer was on. Additionally, resident 89's left hip surgical site degraded and was classified as a stage 4 pressure ulcer and there were no interventions to prevent further skin breakdown. Resident 89 developed skin breakdown to his toe and there were no interventions to prevent the skin breakdown. In addition, there was no documentation of when resident 89 developed skin breakdown to his sacrum area. On 2/11/26 at 3:10 PM, the Administrator was asked for additional information regarding what the facility was doing to prevent skin breakdown. The Administrator stated she did not have documentation beyond what was in the resident's medical record. The Administrator was unable to provide additional information.