| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 465116 | A. Building<br>B. Wing | 05/09/2024 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232<br><br>Based on observation, interview, and record review, the facility did not ensure that the interdisciplinary team had evaluated and determined that the resident's right to self-administer medications was clinically appropriate. Specifically, for 1 out of 28 sampled residents, medications were found at a resident's bedside and the resident had not been evaluated to self-administer their medications. Resident identifier: 43.<br><br>Findings Included:<br><br>Resident 43 was admitted to the facility on [DATE] with the following diagnoses of polyneuropathy, dementia, gastro-esophageal reflux disease without esophagitis, major depressive disorder, morbid severe obesity due to excess calories, and asthma.<br><br>On 5/6/24 at 2:12 PM, an interview was conducted with resident 43's family member. An observation was made of two medications inside of a medicine cup located on top of resident 43's bedside table. The family member stated the medications were Tums, which resident 43 took when they needed them.<br><br>Resident 43's medical record was reviewed on 5/7/24.<br><br>On 1/30/23, a self-administration of medication assessment documented resident 43 did not want to self-administer their own medication.<br><br>On 4/8/24, an annual Minimum Data Set assessment documented that resident 43 had a Brief Interview for Mental Status score of 7, which indicated a cognitive status of severe impairment.<br><br>On 5/7/24 at 1:58 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated they normally did not leave medications at the bedside and if they did, it required a physician's order. LPN 1 stated they gave residents their medications and watched them swallow the pills. LPN 1 stated they were unaware of any residents that were allowed to have pills at the bedside. LPN 1 stated resident 43 liked to take their Tums one at a time and saved the other ones for later.<br><br>On 5/7/24 at 2:13 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated residents were not allowed to have pills at the bedside until they were assessed to be safe for self-administration and then the doctors were consulted about the matter. RN 1 stated a self-administration care plan was added to the resident's plan of care. RN 1 stated a self-administration assessment was initially done when a resident was admitted to the facility.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/7/24 at 2:21 PM, an interview was conducted with the Director of Nursing (DON). The DON stated residents were not allowed to have medications at the bedside unless a self-administration assessment had been completed and there was a physician's order for medication self-administration. The DON stated the purpose of the assessment was to determine if a resident was safe to administer their own medication. The DON stated there was only one resident they were aware of that was allowed to have pills at the bedside and resident 43 was not that resident. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>50200<br><br>Based on observation, interview, and record review, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, for 3 out of 28 sampled residents, resident rooms had cracked and broken drywall, peeling paint, a door handle that sticks, and a loose toilet. Resident identifiers: 18, 24, and 37.<br><br>Findings included:<br><br>On 5/6/24 at 10:17 AM, an interview was conducted with resident 37. Resident 37 stated that he had to tape a large hole in his wall to close the hole. Resident 37 stated that the toilet in the bathroom was wobbly and moved around when he tried to use it. Resident 37 stated that the door handle in his room would get stuck and it was hard to open the door. Resident 37 stated that he had spoken with the Maintenance Director about the issues in the room, but nothing was ever fixed. Resident 37 stated that he believed the Maintenance Director did not want to fix anything in his room because the Maintenance Director did not like the resident.<br><br>On 5/6/24 at 10:20 AM, an observation was made of resident 37's room. Resident 37's room had a large hole in the wall near the bed that was taped with blue tape, paint chipped on multiple walls, the toilet was loose and moved easily from side to side, and the door handle was difficult to use.<br><br>On 5/6/24 at 10:54 AM, an observation was made of resident 24's room. Resident 24's room had paint and drywall that was chipped and peeling near the bathroom door.<br><br>On 5/6/24 at 11:43 AM, an interview was conducted with resident 18. Resident 18 stated the walls and cabinets in the room were beat up. Resident 18 stated the Formica on the door entering the room was torn off in places. Resident 18 stated that his roommate did that to the wall, the door, and the cabinet. Resident 18 stated his roommate was always in a hurry and not happy. An observation was made of resident 18's room. Resident 18's room had paint and drywall peeling from the walls near the sink and bathroom. The main door was missing pieces of Formica and the cabinets were chipped.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/8/24 at 10:26 AM, an interview was conducted with the Maintenance Director. The Maintenance Director stated that in most situations he was notified of maintenance issues through the work order lists that were hung near the lobby. The Maintenance Director stated that in some circumstances he found out about maintenance issues through audits of the resident rooms whenever he was in rooms of residents. The Maintenance Director stated that for resident 18's room, he needed to provide a cover for the nightlight that needed to be secured. The Maintenance Director stated that the call light cord needed to be secured to the wall. The Maintenance Director stated that the room required patches to the drywall, paint to the walls, and possibly a guard to the area that had been run into a lot by wheelchairs. The Maintenance Director stated that he was unsure about the time frame as to when these items would be repaired as he was still figuring out what products were required to fix them. The Maintenance Director stated that he had known about resident 37's maintenance needs for about a month and that resident 37 could be difficult to work with. The Maintenance Director stated that the hole in the wall needed to be patched and could be a quick repair. The Maintenance Director stated that the hole in the wall and the door latch would probably take about a week to repair. The Maintenance Director stated resident 37's toilet closet flange was rusted completely out and needed to be replaced. The Maintenance Director stated the toilet was secured to the ground, but did move around. The Maintenance Director stated that he was unsure of the timeframe that he would begin to work on the repairs due to the clutter in resident 37's room.<br><br>On 5/8/24 at 10:59 AM, an interview was conducted with the Administrator (Admin). The Admin stated that he had not heard that resident 37's room needed multiple repairs. The Admin stated that there was not a specific time frame for maintenance items to be completed unless it was an emergent electrical or water issue that would jeopardize resident safety. The Admin stated that there was a work order log near the lobby where items that needed to be addressed were submitted. The Admin stated that if the repairs were related to fixing or painting walls, that this could take up to a week to be completed. The Admin stated that nothing should take over a month to be addressed and fixed by maintenance.<br><br>33215 |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47432<br><br>Based on record review and interview, the facility did not ensure that the resident assessment accurately reflected the resident's status. Specifically, for 1 out of 28 sampled residents, the facility coded a resident as having received insulin during the seven day Minimum Data Set (MDS) observation period when the resident had not received any insulin. Resident Identifier: 14.<br><br>Findings Included:<br><br>Resident 14 was admitted to the facility on [DATE] with diagnoses including infection and inflammatory reaction due to internal left knee prosthesis subsequent encounter, type 2 diabetes mellitus with hyperglycemia, and type 2 diabetes mellitus without complications.<br><br>Resident 14's medical record was reviewed from 5/6/24 through 5/9/24.<br><br>Resident 14's admission MDS assessment dated [DATE], was reviewed. The MDS assessment documented that Resident 14 received insulin on one of seven days of the seven day lookback observation period.<br><br>Resident 14's order history was reviewed. There were no orders for insulin since the admission to the facility on [DATE]. Resident 14's Medication Administration Record was reviewed. There was no documentation that Resident 14 had received any insulin since the admission to the facility on [DATE].<br><br>On 5/9/24 at 10:11 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated that the MDS assessment had been miscoded and that Resident 14 had not received any insulin during the seven day look back period. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232<br><br>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 1 out of 28 sampled residents, a resident with a respiratory illness experienced a delay in getting their illness treated timely. Resident Identifier: 43.<br><br>Findings Included:<br><br>Resident 43 was admitted to the facility on [DATE] with the following diagnoses of polyneuropathy, dementia, gastro-esophageal reflux disease without esophagitis, major depressive disorder, morbid severe obesity due to excess calories, and asthma.<br><br>On 5/6/24 at 2:12 PM, an interview was conducted with resident 43's Family Member (FM). The FM stated resident 43 had not been feeling well since Friday. The FM stated the doctor should have been made aware of resident 43's condition a lot sooner than today. The FM stated the Director of Nursing (DON) had been made aware of resident 43's condition over the weekend. The FM stated when the DON had come in to evaluate resident 43 today, they had been unaware of how bad resident 43 was doing. The FM stated over the weekend resident 43 had only been given nasal spray and Mucinex to help with their symptoms. The FM stated once the doctor had seen resident 43, they had ordered a chest x-ray, a breathing treatment, and they had put resident 43 on oxygen. The FM stated resident 43 should have been treated sooner.<br><br>Resident 43's medical record was reviewed on 5/7/24.<br><br>On 4/8/24, an annual Minimum Data Set assessment documented resident 43 had a Brief Interview for Mental Status score of 7 which indicated severe cognitive impairment.<br><br>An as needed physician order with a start date of 1/29/23, documented as followed, albuterol sulfate HFA [hydrofluoroalkane] aerosol inhaler; 90 mcg [micrograms]/actuation; amt [amount]: 2 puffs; inhalation. This was ordered for wheezing or shortness of breath.<br><br>An as needed physician order with a start date of 1/29/2023, documented as followed, fluticasone propionate [OTC] [over the counter] spray, suspension; 50 mcg/actuation; amt: 1 spray; nasal. This was ordered for nasal congestion.<br><br>Resident 43's May 2024 Medication Administration Record (MAR) was reviewed and documented that the following as needed medications were given:<br><br>a. On 5/3/24 at 4:20 PM, fluticasone nasal spray due to congestion.<br><br>b. On 5/4/24 at 7:13 AM, fluticasone nasal spray and the albuterol inhaler due to congestion.<br><br>c. On 5/5/24 at 11:23 PM, albuterol inhaler due to cough.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/4/24, A Long-Term Weekly Assessment documented that resident 43's respiratory assessment was within normal limits, on room air, and no shortness of breath was noted.<br><br>On 5/5/24 at 3:39 PM, resident 43's oxygen saturation was documented to be 89%. [Note: No documentation was located to indicate any interventions were put in place to help with resident 43's low oxygen level.]<br><br>On 5/6/24 at 10:34 AM, a nurses note documented, pt. [patient] was experiencing labored breathing with c/o [complaint of] SOB [shortness of breath]. O2 [oxygen] sats [saturations] were taken and pt. was at 80% on RA [room air]. PA [Physician Assistant], DON, UM [Unit Manager], and family notified of this change in condition. new orders for albuterol nebulizer q6h [every 6 hours] x [for] 10 days, cbc [complete blood count], cmp [complete metabolic panel], and chest XR [x-ray]. pt. is now on 3L [liters] of O2 and is maintaining > [greater than] 90%. nebulizer tx [treatment] was effective and pt. reported that they were able to breathe better.<br><br>On 5/7/24 at 4:54 AM, a nurses note documented, Resident continues to receive scheduled nebulizer treatments during the night with an occasional cough present. SOB observed with pt having to be reminded to keep oxygen 3L NC [nasal cannula] in place and HOB [head of bed] elevated multiple times. Pt has been alert and able to make needs known. Chest x-ray still waiting to be taken. Fluids encouraged and call light within reach.<br><br>On 5/7/24 at 2:02 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated resident 43 had come down with something pretty fast in the last few days. LPN 1 stated they believed resident 43 started to feel unwell on Saturday and that they were fighting a cold. LPN 1 stated something was going on with resident 43's lungs right now. LPN 1 stated they believed the physician assistant had come in yesterday. LPN 1 stated the PA had ordered labs and a chest x-ray. LPN 1 stated that resident 43 had been complaining of a stuffy nose and chest tightness for a couple of days. LPN 1 stated they had given resident 43 an inhaler over the weekend and stated resident 43 indicated the inhaler had helped their symptoms. LPN 1 stated that resident 43's vitals had remained within limits and there was nothing to indicate it was anything more than a cold.<br><br>On 5/7/24 at 2:21 PM, an interview was conducted with the DON. The DON stated there was a phone call they had received around midnight on Saturday night. The DON stated the nurse called them because they were concerned about a few residents due to cold symptoms. The DON stated they remembered the nurse mentioning a few resident names and they were unsure if resident 43's name was mentioned. The DON stated when staff called the on call person, the purpose of the phone was to help guide the nurse on the next steps they needed to take. The DON stated there were standing orders the nurses were able to use. The DON stated they were never called again so they assumed everything was fine. The DON stated when they came in on Monday, they saw resident 43 and notified the physician assistant that resident 43 sounded like crap. The DON stated the physician assistant did their assessment and put orders in place after seeing how resident 43 was doing.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/8/24 at 1:17 PM, a telephone interview was conducted with LPN 2. LPN 2 stated resident 43 had a cough on Sunday. LPN 2 stated resident 43 presented the same as any other day they had taken care of them. LPN 2 stated vitals were obtained twice a day unless they needed to get more. LPN 2 stated nurses reviewed vitals once the Certified Nursing Assistants had obtained them and if any vitals were outside of parameters the nurse personally rechecked them. LPN 2 stated a doctor's order was needed before a resident was put on oxygen since it was considered a medication. LPN 2 stated they had not been made aware of resident 43's oxygen level being at 89%. LPN 2 stated resident 43's oxygen baseline was in the 90's. LPN 2 stated if a resident was not at their baseline, then check on the resident and assess if they were feeling okay.<br><br>On 5/8/24 at 2:56 PM, a telephone interview was conducted with Registered Nurse (RN) 2. RN 2 stated resident 43 had complained of having a cold and a sore throat and told them they need to talk to the provider because they felt like they were going to die. RN 2 stated they had done an assessment on resident 43 and every thing had checked out fine. RN 2 stated they had assured resident 43 there were no signs of immediate death. RN 2 stated they told resident 43, the provider would be in on Monday to see them. RN 2 stated they had called the DON at around 11:30 PM, on Saturday night and informed the DON about their concern about a few residents having cold symptoms such as coughs and sore throats. RN 2 stated they had mentioned resident 43's name to the DON and notified the DON that they were not feeling well. RN 2 stated they were concerned about a Coronavirus Disease 2019 outbreak and needed guidance on what to do for those residents. RN 2 stated vitals were obtained about twice a day, once during the day and once at night. RN 2 stated when vitals were outside of parameters such as a low oxygen saturation, first they tried nonpharmacological interventions such as deep breathing exercises and repositioning in bed and then they rechecked the oxygen saturation. RN 2 stated if the oxygen saturations were still low, then they notified the provider. RN 2 stated resident 43's vitals were within normal limits on Saturday. RN 2 stated resident 43 had sounded nasally but their lungs and heart sounded fine.<br><br>On 5/9/24 at 7:52 AM, a follow up interview was conducted with the DON. The DON stated the nurses reviewed all the vitals once they were obtained by the certified nursing assistants. The DON stated if a vital was outside of parameters, they expected staff to check on the resident and re-take the vitals. The DON stated if a resident's oxygen was below 90%, there was a standing order in place for oxygen. The DON stated if a resident was put on oxygen then staff needed to make the physician and the DON aware and it was considered a change of condition. The DON stated looking at resident 43's oxygen saturation on Sunday afternoon, it appeared they had done nothing about resident 43's low oxygen saturation. The DON was unable to locate any documentation to indicate any interventions had been put in place to help with resident 43's low oxygen saturation. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200<br><br>Based on interview and record review, the facility did not ensure that each resident with limited range of motion (ROM) received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, for 1 out of 28 sampled residents, a resident with limited range of motion was not given restorative nursing services that was recommended by physical therapy (PT) to prevent further decrease in range of motion. Resident Identifier: 37.<br><br>Findings included:<br><br>Resident 37 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses which included, but not limited to, chronic inflammatory demyelinating polyneuritis, diabetes mellitus with hyperglycemia, difficulty walking, hypertension, chronic pain syndrome, and muscle weakness.<br><br>On 5/6/24 at 10:30 AM, an interview was conducted with resident 37. Resident 37 stated that he would like to do physical therapy and/or occupational therapy because he felt that he had lost mobility and range of motion in both upper and lower extremities. Resident 37 stated that he had been informed that his insurance would not cover any type of therapy services and he had not been offered any alternative therapies or exercises by the facility.<br><br>Resident 37's medical record was reviewed on 5/7/24.<br><br>A care plan initiated on 9/23/23, documented that the resident is at risk for altered ADL [activities of daily living] function. with interventions that include encourage PT/OT [occupational therapy] services as prescribed and assist with completing ADL tasks each day.<br><br>On 10/3/23, an orthopedic note documented, . will give him a prescription for physical therapy to work on range of motion and functional rehab.<br><br>On 10/3/23, a nursing note documented, Rt [resident] seen by MD [Medical Doctor]. New order given- PT right knee. F/U [follow up] 10/31/23.<br><br>On 10/11/23, a physical therapy evaluation was performed on resident 37 which recommended that resident 37 participate in the restorative nursing program for upper and lower extremity range of motion.<br><br>On 5/7/24 at 1:16 PM, an interview was conducted with the Director of Rehab (DOR). The DOR stated that he was unaware of any therapy needed for resident 37, but would check the notes to confirm this.<br><br>On 5/7/24 at 2:04 PM, an interview was conducted with the DOR. The DOR stated that resident 37 had a physical therapy evaluation on 10/11/23, and it was determined that resident 37 would benefit from the restorative nursing program and was referred to this program.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/7/24 at 2:10 PM, an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated that when she received a referral for the restorative nursing program she reviewed it and subsequently inputted the referral into the medical record if she felt the certified nursing assistants could assist the resident. The MDS Coordinator stated that she could not locate a referral for resident 37. The MDS Coordinator stated that she would talk with resident 37 regarding the restorative nursing program to see if it was something that resident 37 wanted to participate in.<br><br>On 5/8/24 at 11:07 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 37 continued to have ROM problems with his lower extremities that was present when he admitted into the facility. The DON stated that resident 37 was diagnosed with bursitis a few months ago and this had caused a worsening in ROM with his upper extremities. The DON stated that she was unsure if resident 37's lower extremity ROM had worsened since being admitted to the facility.<br><br>On 5/8/24 at 11:10 AM, an interview was conducted with the Administrator (Admin). The Admin stated that he had not heard of resident 37 wanting to participate in therapy services. The Admin stated that he had, in the past, discussed with resident 37 that the resident would have to personally pay for therapy services and resident 37 did not want to pay for these services. The Admin stated that he believed resident 37 had been receiving restorative nursing assistance and was part of the restorative nursing program. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215<br><br>Based on observation, interview, and record review, the facility did not ensure that residents maintained acceptable parameters of nutritional status unless the resident's clinical condition demonstrated that this was not possible. Specifically, for 1 out of 28 sampled residents, a resident that had a recommendation for Liquacel twice a day (BID) for wound healing and increased protein needs had the Liquacel order implemented daily and the Liquacel was unavailable for four administrations. Resident identifier: 18.<br><br>Findings included:<br><br>Resident 18 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, infection and inflammatory reaction due to internal left knee prosthesis, acute embolism and thrombosis of deep veins of lower extremity, type 2 diabetes mellitus (T2DM) without complications, muscle weakness, endocarditis, paroxysmal atrial fibrillation, and peripheral vascular disease.<br><br>Resident 18's medical record was reviewed on 5/9/24.<br><br>A care plan problem with a start date on 1/26/24, documented Category: Nutritional Status [resident 18] is at risk for nutritional deficits r/t [related to] increased energy needs for healing. The goal included, [Resident 18] will not experience any untreated weight variances through next review. The interventions included:<br><br>a. Offer supplements and double portions.<br><br>b. Dietitian/Nutritional assessment or evaluation, as needed.<br><br>c. Honor food preferences.<br><br>d. Provide assistance with meals, as needed.<br><br>e. Provide diet and snacks as prescribed.<br><br>f. Weight monitoring as prescribed.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 465116 | A. Building<br>B. Wing | 05/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rocky Mountain Care - Logan | 1480 North 400 East<br>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.

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|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 2/2/24 at 7:19 PM, a Dietary progress note documented Res [resident] admitted with surgical wound to knee and on ABX [antibiotic] for MRSA [Methicillin-resistant Staphylococcus aureus]. Hx [history] of depression. homeless, meth use, T2DM, knee infection. Admit wt [weight] of 296# [pounds] with BMI [body mass index] of 31-obese. BG [blood glucose] ~150mg/dL [milligrams per deciliter] and A1C [blood test to diagnosis diabetes] of 7.8H [high]. Res is able to make needs known no issues chewing/swallowing. He desires to eat in his own room. Skin is intact. Res with increased energy needs for healing and IBW [ideal body weight] is 208-285# ~3000kcals [kilocalorie] and ~150g [grams] protein daily. Res is eating well and has requested large portions. Res not available to speak to today. RD [Registered Dietician] to offer additonal [sic] protien [sic] food sources or offer house supplement. Will attempt again x 7 days. diet order: CCHO [consistent carbohydrate diet] with ~88% PO [by mouth]. Diet order is appropriate and with increased energy needs PO is possibly not meeting estimated energy needs. Will order supplement if res consents. Kitchen to serve double portions. Will follow per weekly wts [weights] and discuss in NAR [Nutrition at Risk] Res at moderate risk for malnutrition r/t PMH [poor medical history], poor mobility, inadquate [sic] oral intake. Supplement order pending.<br><br>On 2/23/24 at 6:51 AM, a Physicians Assistant (PA) progress note documented . Patient also states he wonders if he is getting enough protein. He states supplementation has been considered, but he feels he is 'nearly 300 pounds' and may not be getting enough protein. Appreciate dietary recommendations for appropriate protein intake.<br><br>On 4/4/24 at 7:35 AM, a Dietary progress note documented Monthly High Risk Nutritional Assessment Pertinent Diagnosis: T2DM, chronic wound Current wt/BMI: 282# / 30 Admit wt: 292# UBW [usual body weight]: ~290# Wt trends: wt trending down slightly but no significant wt changes x 4 months . Supplement/MVI [multi vitamin]: MVI Allergies: none Medication with nutritional implications: metformin, vitamin C Pertinent labs: BG ~110mg/dL Skin integrity: diabetic ulcer UST [unstageable] on heel . Estimated energy needs: 3182-3818 kcals // 165g protein // 3818 ml [milliliters] fluid Intervention/discussion: Res with wt trending down slightly and very elevated kcal/protein needs. Res has been eating well and wound is stable but current energy needs are likely not met for wound healing. Will recommend medpass 1.7 60ml TID [three times a day] or liquacel 30ml BID per res desire. Will contiue [sic] to monitor via monthly weights.<br><br>On 4/4/24 at 3:47 PM, a Dietary progress note documented Spoke w [with] pt [patient] about increasing protein consumption. Pt is pleased with cottage cheese and Greek yogurt and would like to continue. Dietitian asked Dietary Director to ask pt about med pass or liquacel for additional protein supplement. Dietary Director gave pt samples of both and pt decided he wanted liquacel. Dietary Director informed pt he would get it 2x a day. Pt seemed pleased with outcome and would also like the in house milkshakes on occasion. Dietitian/nursing to follow up on orders.<br><br>On 4/12/24 at 7:35 AM, a PA progress note documented . Patient expressed to me several frustrations today. He is worried about numbness/tingling in this pinky fingers and part of ring fingers bilaterally. He is worried this is peripheral neuropathy and it indicates his diabetes is not under control. He is concerned about his diet, that it is not 'diabetic' and he is not getting enough protein. He understands he can't have it exactly like he had it at home, but seems very anxious about his upcoming surgery and having the best outcome. He feels frustrated that it feels to him when he has an issue, it is fixed for 'a few days, then it goes back to the way it was.' He does feel like he is concerned we can't 'meet his needs' here, and is thinking he wants to go to another facility. He states his upcoming surgery is scheduled on 5/20 [24].<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/17/24 at 8:31 AM, a Nursing progress note documented New order per NAR [Nutrition At Risk]. Liquacel 30 mL daily for supplement. [Note: The recommendation per the Dietary progress note dated 4/4/24 at 7:35 AM, was Liquacel 30 ml BID.]<br><br>On 5/7/24 at 8:55 AM, a Dietary progress note documented NAR meeting; wound status Pertinent Diagnosis: T2DM, chronic wound Current wt/BMI: 282# / 30 Admit wt: 292# UBW: ~290# Wt trends: -6.8% x 3 months (not significant) . Pertinent labs: BG ~125mg/dL Skin integrity: multiple diabetic ulcers to LE [lower extremity] x4; chronic . Estimated energy needs: 3182-3818 kcals // 165g protein // 3818 ml fluid<br>Intervention/discussion: liquacel started BID to provide ~30g protein daily. PO is ~88% with cottage cheese and greek yogurt offered daily for additional protein as well. Res has refused Liquacel a few times. Will speak with res on 5/9/24 to update diet/supplement preferences. Current PO and supplement is likely meeting estimated energy needs. Will continue to follow per monthly weights.<br><br>The April and May 2024 Medication Administration Record were reviewed. The following physician's order dated 4/18/24, documented Liquacel (amino acids-protein hydrolys) liquid; 16-100 gram-kcal/30 mL; Amount to Administer: 30 mL; oral once a day. The following were documented regarding the Liquacel.<br><br>a. On 4/25/24 at 6:00 AM to 10:00 AM, Not Administered: Drug/Item Unavailable.<br><br>b. On 5/5/24 at 6:00 AM to 10:00 AM, Not Administered: Drug/Item Unavailable.<br><br>c. On 5/6/24 at 6:00 AM to 10:00 AM, Not Administered: Drug/Item Unavailable Comment: pharmacy notified.<br><br>d. On 5/7/24 at 6:00 AM to 10:00 AM, Not Administered: Drug/Item Unavailable.<br><br>On 5/9/24 at 11:09 AM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated when there were five or six pills left for the resident she would first double check that there were not some already stocked at the facility. RN 4 stated she would then pull the tab on the medication card and add it to the refill order form and fax the form to the pharmacy. RN 4 stated if there was not a tab on the medication card she would make a note and call the pharmacy for the refill. RN 4 stated that sometimes it was hard to get certain medications from the pharmacy timely but it was usually an insurance issue. RN 4 stated the pharmacy was usually good at delivering. RN 4 stated there was a different pharmacy for hospice residents and they were really good. RN 4 stated the Liquacel was ordered with the over the counter (OTC) medications, Central Supply ordered the Liquacel, and the Liquacel was stored in the medication room. RN 4 stated that the Transportation staff member ordered the Liquacel. RN 4 stated when the staff were low on the Liquacel she would fill out a form and add the item to the list for Central Supply to order. RN 4 stated if the staff were out of the Liquacel and they needed it, Central Supply would just go and grab it. An observation was conducted of the medication room with RN 4. There was no Liquacel observed in the medication room. Liquacel was observed on the list to be ordered.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/9/24 at 11:22 AM, an interview was conducted with the Transportation Director (TD). The TD stated that she was the staff member that ordered OTC medications and she had just started working central supply. The TD stated there was a paper in the medication room where staff could write down the OTC medications that were out. The TD stated that every Friday she would review the list and the list would be sent out on Monday by noon. The TD stated she would keep the past order and ask the Director of Nursing (DON) if there were any extra supplies that needed to be ordered. The TD stated she would also ask the Certified Nursing Assistants and the nurses if she was missing anything that needed to be ordered or if she needed to order more of something. The TD further stated if the staff saw her in the hallway they could inform her of items they needed and she would write it on the list. The TD stated the Liquacel was something that she ordered OTC but she had not had to order the Liquacel as of yet. The TD stated if she had problems getting items she would call the representative with the supply company and see if they could get the item sooner or a replacement. The TD stated the items ordered on Monday would be at the facility on Tuesday. The TD stated that sometimes there was a delay on some items. The TD stated the supply company would let her know if items were delayed and sometimes the representative would get the item to her as soon as possible and would overnight items if needed.<br><br>On 5/9/24 at 12:57 PM, an interview was conducted with the Registered Dietician (RD) and the Dietary Director (DD). The RD stated that resident 18 was started on the Liquacel for wound healing. The RD stated she wanted to make sure resident 18 was getting adequate protein for wound healing. The DD stated that the Liquacel was ordered through a supply company as an OTC product. The RD clarified that the Liquacel order should have been BID. The RD stated she would go through the NAR meeting notes, she would list the dietary recommendations for the team, and then she would email the recommendations to the team. The RD stated that the DON, Unit Manager, DD, and the Administrator attended the NAR meetings. The RD stated that after the NAR meeting on 4/4/24, the DD spoke with resident 18 regarding the supplement. The RD stated that her recommendation for the supplement on 4/4/24, was an order pending because she gave resident 18 the choice of Med Pass or Liquacel.<br><br>On 5/9/24 at 1:10 PM, an interview was conducted with the DON. The DON stated that in order to refill a medication the staff were to pull the tag off the medication card and put it on the refill list, check to ensure the medication was not somewhere in the facility, and fax the refill list to the pharmacy. The DON stated if the medication was out the facility had an emergency medication system. The DON stated if the medication needed was not in the emergency medication system the staff were to call the pharmacy to see when the medication would be delivered. The DON stated that she had access to the orders and she could see if the medication was actually delivered. The DON stated that Liquacel was OTC and Central Supply ordered the Liquacel. The DON stated if the staff were running low the staff would write it on the list and Central Supply ordered weekly. The DON stated that Liquacel came in a case of eight bottles. The DON stated that dietary recommendations were passed on verbally in the NAR meeting and discussed with the PA. The DON stated that the Unit Manager would input the orders.<br><br>On 5/9/24 at approximately 1:10 PM, a follow up interview was conducted with RN 4. RN 4 stated that resident 18 was taking the Liquacel and then two days in a row resident 18 had refused the Liquacel because of diarrhea. RN 4 stated the facility did not have Liquacel on Monday, but she gave resident 18 Metamucil instead. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215<br><br>Based on observation, interview, and record review, the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, for 1 out of 28 sampled residents, a resident was not administered their supplement for wound healing and increased protein needs as ordered by the physician due to the supplement not being available. Resident Identifier: 18.<br><br>Findings included:<br><br>Resident 18 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, infection and inflammatory reaction due to internal left knee prosthesis, acute embolism and thrombosis of deep veins of lower extremity, type 2 diabetes mellitus without complications, muscle weakness, endocarditis, paroxysmal atrial fibrillation, and peripheral vascular disease.<br><br>Resident 18's medical record was reviewed on 5/9/24.<br><br>On 4/4/24 at 7:35 AM, a Dietary progress note documented . Will recommend medpass 1.7 60ml [milliliters] TID [three times a day] or liquacel 30ml BID [two times a day] per res [resident] desire. Will contiue [sic] to monitor via monthly weights.<br><br>On 4/4/24 at 3:47 PM, a Dietary progress note documented Spoke w [with] pt [patient] about increasing protein consumption. Pt is pleased with cottage cheese and Greek yogurt and would like to continue. Dietitian asked Dietary Director to ask pt about med pass or liquacel for additional protein supplement. Dietary Director gave pt samples of both and pt decided he wanted liquacel. Dietary Director informed pt he would get it 2x [times] a day. Pt seemed pleased with outcome and would also like the in house milkshakes on occasion. Dietitian/nursing to follow up on orders.<br><br>On 4/17/24 at 8:31 AM, a Nursing progress note documented New order per NAR [Nutrition At Risk]. Liquacel 30 mL daily for supplement. [Note: The recommendation per the Dietary progress note dated 4/4/24 at 7:35 AM, was Liquacel 30 ml BID.]<br><br>The April and May 2024 Medication Administration Record were reviewed. The following order dated 4/18/24, documented Liquacel (amino acids-protein hydrolys) liquid; 16-100 gram-kcal [kilocalorie] /30 mL; Amount to Administer: 30 mL; oral once a day. The following were documented regarding the Liquacel.<br><br>a. On 4/25/24 at 6:00 AM to 10:00 AM, Not Administered: Drug/Item Unavailable.<br><br>b. On 5/5/24 at 6:00 AM to 10:00 AM, Not Administered: Drug/Item Unavailable.<br><br>c. On 5/6/24 at 6:00 AM to 10:00 AM, Not Administered: Drug/Item Unavailable Comment: pharmacy notified.<br><br>d. On 5/7/24 at 6:00 AM to 10:00 AM, Not Administered: Drug/Item Unavailable.<br><br>(continued on next page) |

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| | 465116 | A. Building<br>B. Wing | 05/09/2024 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/9/24 at 11:09 AM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated when there were five or six pills left for the resident she would first double check that there were not some already stocked at the facility. RN 4 stated she would then pull the tab on the medication card, add it to the refill order form, and fax the form to the pharmacy. RN 4 stated if there was not a tab on the medication card she would make a note and call the pharmacy for the refill. RN 4 stated that sometimes it was hard to get certain medications from the pharmacy timely but it was usually an insurance issue. RN 4 stated the pharmacy was usually good at delivering. RN 4 stated there was a different pharmacy for hospice residents and they were really good. RN 4 stated the Liquacel was ordered with the over the counter (OTC) medications, Central Supply ordered the Liquacel, and the Liquacel was stored in the medication room. RN 4 stated that the Transportation staff member ordered the Liquacel. RN 4 stated when the staff were low on the Liquacel she would fill out a form and add the item to the list for Central Supply to order. RN 4 stated if the staff were out of the Liquacel and they needed it, Central Supply would just go and grab it. An observation was conducted of the medication room with RN 4. There was no Liquacel observed in the medication room. Liquacel was observed on the list to be ordered.<br><br>On 5/9/24 at 11:22 AM, an interview was conducted with the Transportation Director (TD). The TD stated that she was the staff member that ordered OTC medications and she had just started working central supply. The TD stated there was a paper in the medication room where staff could write down the OTC medications that were out. The TD stated that every Friday she would review the list and the list would be sent out on Monday by noon. The TD stated she would keep the past order and ask the Director of Nursing (DON) if there were any extra supplies that needed to be ordered. The TD stated she would also ask the Certified Nursing Assistants and the nurses if she was missing anything that needed to be ordered or if she needed to order more of something. The TD further stated if the staff saw her in the hallway they could inform her of items they needed and she would write it on the list. The TD stated the Liquacel was something that she ordered OTC but she had not had to order the Liquacel as of yet. The TD stated if she had problems getting items she would call the representative with the supply company to see if they could get the item sooner or a replacement. The TD stated the items ordered on Monday would be at the facility on Tuesday. The TD stated that sometimes there was a delay on some items. The TD stated the supply company would let her know if items were delayed and sometimes the representative would get the item to her as soon as possible and would overnight items if needed.<br><br>On 5/9/24 at 12:57 PM, an interview was conducted with the Registered Dietician (RD) and the Dietary Director (DD). The RD stated that resident 18 was started on the Liquacel for wound healing. The RD stated she wanted to make sure resident 18 was getting adequate protein for wound healing. The DD stated that the Liquacel was ordered through a supply company as an OTC product. The RD clarified that the Liquacel order should have been BID. The RD stated she would go through the NAR meeting notes, she would list the dietary recommendations for the team, and then she would email the recommendations to the team. The RD stated that the DON, Unit Manager, DD, and the Administrator attended the NAR meetings. The RD stated that after the NAR meeting on 4/4/24, the DD spoke with resident 18 regarding the supplement. The RD stated that her recommendation for the supplement on 4/4/24, was an order pending because she gave resident 18 the choice of Med Pass or Liquacel.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/9/24 at 1:10 PM, an interview was conducted with the DON. The DON stated that in order to refill a medication the staff were to pull the tag off the medication card and put it on the refill list, check to ensure the medication was not somewhere in the facility, and fax the refill list to the pharmacy. The DON stated if the medication was out the facility had an emergency medication system. The DON stated if the medication needed was not in the emergency medication system the staff were to call the pharmacy to see when the medication would be delivered. The DON stated that she had access to the orders and she could see if the medication was actually delivered. The DON stated that Liquacel was OTC and Central Supply ordered the Liquacel. The DON stated if the staff were running low the staff would write it on the list and Central Supply ordered weekly. The DON stated that Liquacel came in a case of eight bottles. The DON stated that dietary recommendations were passed on verbally in the NAR meeting and discussed with the Physicians Assistant. The DON stated that the Unit Manager would input the orders.<br><br>On 5/9/24 at approximately 1:10 PM, a follow up interview was conducted with RN 4. RN 4 stated that resident 18 was taking the Liquacel and then two days in a row resident 18 had refused the Liquacel because of diarrhea. RN 4 stated the facility did not have Liquacel on Monday, but she gave resident 18 Metamucil instead. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215<br><br>Based on interview and record review, the facility did not ensure that the pharmacist reported irregularities to the attending physician, the facility's Medical Director (MD), and the Director of Nursing (DON) were acted upon. Specifically, for 1 out of 28 sampled residents, a pharmacy recommendation to discontinue a statin medication that may cause myopathy and rhabdomyolysis if administered concomitantly with daptomycin was not acted upon timely when the physician agreed to the recommendation. Resident identifier: 18.<br><br>Findings included:<br><br>Resident 18 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, infection and inflammatory reaction due to internal left knee prosthesis, acute embolism and thrombosis of deep veins of lower extremity, type 2 diabetes mellitus without complications, muscle weakness, endocarditis, paroxysmal atrial fibrillation, and peripheral vascular disease.<br><br>Resident 18's medical record was reviewed on 5/9/24.<br><br>A pharmacy Consultation Report dated 3/14/24, recommended to consider discontinuing atorvastatin calcium during daptomycin therapy. The recommendation was accepted and signed by the Physician Assistant (PA) on 3/15/24.<br><br>A physician's order dated 1/27/24, documented atorvastatin tablet; 40 mg [milligrams]; Amount to Administer: 40 mg; oral at Bedtime. The physician's order was open ended.<br><br>A physician's order dated 2/29/24, documented daptomycin recon [reconstitution] soln [solution]; 500 mg; Amount to Administer: 1gram; intravenous Once A Day. The physician's order was discontinued on 4/2/24.<br><br>On 3/15/24 at 6:51 AM, a PA progress note documented . 3/15/2024 Pharmacy recommendations were to hold the atorvastatin while patient was on daptomycin. Discussed this with the patient, and it will be held.<br><br>On 4/4/24 at 12:55 PM, a Nursing progress note documented Atorvastatin 40 mg hold d/c'd [discontinued] d/t [due to] Abx [antibiotic] daptomycin completed on 4/2/24 per PA.<br><br>The March and April 2024 Medication Administration Record (MAR) were reviewed. The atorvastatin was administered daily in March 2024, concomitantly with the daptomycin. The atorvastatin was held on 4/2/24 and 4/3/24, according to the April 2024 MAR.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 5/8/24 at 12:52 PM, an interview was conducted with the DON. The DON stated the pharmacist reviewed the resident's monthly and would get the reports to her within 24 hours after the psychotropic meeting. The DON stated the reports always came on a Friday. The DON stated that the following Monday the MD would review the pharmacist recommendations. The DON stated if the recommendation was discussed in the psychotropic meeting she already had the order and could sign it off. The DON stated that the other stuff not discussed would go to the PA and he would look over the recommendations and sometimes the PA would hand them off to the MD. The DON stated that depending on the resident's insurance the recommendations may go to the Nurse Practitioner. The DON stated that after the recommendations were signed she would get them back usually within 24 hours. The DON stated that within 24 to 48 hours she would get the orders updated and noted. The DON stated that she was on vacation right after psychotropic meeting in March 2024, and that probably contributed to the recommendation not being implemented. The DON stated that the PA probably gave the recommendations back to her knowing that she managed those and she was on a 10 day vacation until 3/25/24. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465116 | A. Building<br>B. Wing | 05/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Rocky Mountain Care - Logan | 1480 North 400 East<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>50200<br><br>Based on observation, interview, and record review, the facility did not ensure that medication error rates were not five percent or greater. Observations of 25 medication opportunities on 5/8/24, revealed four medication errors which resulted in a 16% medication error rate. Specifically, for 4 out of 28 sampled residents, medications that were supposed to be taken at least 30 minutes before meals were given to the residents after they had consumed a meal. Resident identifiers: 23, 33, 51, and 69.<br><br>Findings included:<br><br>1. On 5/8/24 at 8:36 AM, an observation was made of Registered Nurse (RN) 3 during morning medication administration on the north west hallway. RN 3 was observed to give pantoprazole 40 milligrams (mg) to resident 23 after he had eaten breakfast.<br><br>On 5/8/24 at 8:38 AM, an interview was conducted with RN 3. RN 3 stated that resident 23 preferred to take his medications after breakfast. RN 3 stated that she did not know if resident 23's preference for taking medications after meals was known by others or written in the medical record. RN 3 stated that she knew resident 23's medication preference because she had been his nurse before. RN 3 stated that the doctor's order was to take the pantoprazole on an empty stomach at least 30 minutes before meals.<br><br>2. On 5/8/24 at 8:40 AM, an observation was made of RN 3 during morning medication administration on the north west hallway. RN 3 was observed to give gabapentin 600 mg to resident 51 after she had eaten breakfast. The medication directions stated to give before meals and at bedtime.<br><br>On 5/8/24 at 8:41 AM, an interview was conducted with RN 3. RN 3 stated that resident 51 was often times hard to find in the morning. RN 3 stated that the order for gabapentin was to be given before meals and at bedtime. RN 3 stated that she tried to give the gabapentin before breakfast, but could not locate the resident in the mornings a lot of the time and gave the medication to resident 51 when she located her even if the resident had eaten a meal.<br><br>3. On 5/8/24 at 8:50 AM, an observation was made of RN 3 during morning medication administration on the north west hallway. RN 3 was observed to give metoclopramide 5 mg to resident 33 after the resident had eaten breakfast.<br><br>On 5/8/24 at 8:53 AM, an interview was conducted with RN. RN 3 stated that the order for the metoclopramide was that it should be given before meals. RN 3 stated that she should have given metoclopramide before resident 33 ate breakfast.<br><br>4. On 5/8/24 at 9:08 AM, an observation was made of RN 3 during morning medication administration on the south east hallway. RN 3 was observed to give omeprazole 20 mg to resident 69 after the resident had eaten breakfast.<br><br>On 5/8/24 at 9:10 AM, an interview was conducted with RN 3. RN 3 stated that all medications that have orders to be given before meals must be given to residents before they eat.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 5/8/24 at 11:03 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that there was nothing charted in the medical record that showed a resident's preferred schedule regarding medications and when the resident received them. The DON stated that all nurses need to follow what the doctor's orders were for giving medications. The DON stated that medications that were supposed to be taken before meals, need to be given to residents before meals. The DON stated if medications that need to be given prior to meals were routinely given after residents have eaten a meal, then the doctor's orders need to be updated to reflect this. |