STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465125	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Cottage on Vine	835 East Vine Street Murray, UT 84107

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident consistent with the resident's rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Specifically, for 1 out of 11 sampled residents, a resident who had psychological needs and multiple falls did not have a care plan for mental health or falls developed. Resident identifiers: 10. Findings include: Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included suicide attempt, fall on same level, morbid obesity, obstructive sleep apnea, suicidal ideations, difficulty walking, dissociative identity disorder, need for assistance with personal care, hypothyroidism, type II diabetes mellitus, hypertension, atrial fibrillation, bipolar disorder, post traumatic stress disorder, chronic kidney disease stage 3 and panic disorder. Resident 10's medical record was reviewed on 5/14/24. Psychological needs: A complaint form was submitted to the State Agency on 5/3/24 regarding resident 10. The complaint indicated that resident 10 had a history of self-injurious behaviors and inflicted another wound with an unknown implement. No protocol for self-harm or suicidal ideation was put into place; the only new order was for bactracin to the wound. Review of resident 10's progress notes revealed that on 5/4/24, At approximately 1630 [4:30 PM], [resident 10] took this RN [registered nurse] to the side and stated that another personality of hers had initiated self-harm behaviors, inflicting an incision of approximately half an inch on the front of her right thigh. The incision was very clean and straight, as if made by a razor blade. The other RN on duty made a search, with [resident 10's] consent, of her room and purse. No implements capable of inflicting such a wound were found. On-call provider and administrator notified; close monitoring ordered as well as bacitracin ointment to prevent infection of wound. Staff will monitor closely. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 10's care plan was reviewed. The focus adjustment to placement was dated 3/12/24 and indicated that the resident was at risk for adjustment/psychological well-being issues secondary to recent need for skilled nursing . With an approach which indicated 1:1 with social services to discuss any psychosocial concerns; LCSW (licensed clinical social worker) consult, PRN (as needed) N/A - Not Applicable. Review of the care plan revealed that it had not been updated since it's initial entry of 3/12/24. A review of the New Admission Checklist dated 3/5/24 revealed that the section for Psychotropic care plan was marked as completed but no care plan was found in the medical record. Falls: Progress notes documented resident 10 had a fall on the following dates: a. 3/21/24 b. 3/27/24 c. 3/28/24 d. 4/2/24 e. 4/3/24 f. 4/10/24 g. 5/6/24 h. 5/7/24 No fall care plan was located in resident 10's medical record. On 5/14/24 at 1:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 10 did not have a care plan for her specific behaviors or falls, ideally those should have been care planned. The DON stated the staff have a checklist of what they are supposed to follow after a resident falls but stated there was not one specific place where the staff could find the information of what had been done previously to help the resident avoid falls. The DON stated she was aware of resident 10's behaviors and psychological issues and that her medications were being managed but her behaviors were not being managed, especially for someone who was self harming. The DON stated in order for the staff to know their residents the CNA's are expected to use their report sheet and look at the CNA brain book to find the information about resident cares and behaviors. And the nurses can get the information from report and through the progress notes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22992 Based on record review and interview, the facility did not ensure that 1 of 11 sample residents had a care plan that was revised by the interdisciplinary team. Specifically, a resident had repeated behaviors that were not care planned, including interventions that should be taken by staff to prevent behaviors. Resident identifiers: 1 and 3. Findings include: Resident 1 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included substance use disorder, schizoaffective disorder, anxiety, and a traumatic brain injury. Resident 3 was admitted on [DATE] with diagnoses that included dementia and encephalopathy. Resident 1's and resident 3's medical records were reviewed on 5/14/24. Resident 1's quarterly Minimum Data Set (MDS) assessment documented that resident 1 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. Resident 3's quarterly MDS assessment documented that resident 3 had a BIMS score of 4, which indicated severe cognitive impairment. Review of resident 1's progress notes revealed that on 1/9/24 Nurse witnessed [resident 1], going into [resident 3's] room. Upon entering the nurse saw that the curtain was closed. Upon opening the curtain the nurse witnessed residents participating in sexual activity with [resident 3]. [Resident 1] was giving oral sex to [resident 3]. Residents were separated immediately. DON (Director of Nursing), abuse coordinator, social worker and provider were notified. Resident placed on Q15 (every 15 minute) checks, and charting for emotional distress [for] 7 days. A form 359 was submitted to the State Agency regarding the incident on 1/9/24. The form 359 indicated that resident 1 had been very friendly towards other male residents. [Other residents] also indicated that she has been asking others for money and cigarettes. Staff documented that both residents denied anything happened. The form 359 indicated staff had verified that sexual abuse had occurred, and that both residents are cognitively impaired and unable to give consent to sexual acts. Review of resident 1's progress notes revealed that on 1/12/24, a Certified Nursing Assistant (CNA) was walking down the hallway to pick up food trays and noticed [resident 1] in a male residents room, she went to grab another CNA to remove [resident 1], when the second CNA went in to get [resident 1], [resident 1] was pulling down her shirt, the CNA asked '[resident 1] why were you doing that', in which [resident 1] replied 'I didn't do anything', but as she was being wheeled out she stated 'I didn't mean to show my breasts.' (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident 1's progress notes revealed that on 4/17/24, Resident was present in another residents room when alleged drug abuse occurred. Resident was separated immediately and placed in a safe location. Resident denies using any drug abuse. Residents vitals are stable, resident has been educated about drug use and the danger of behaviors. Provider has been notified . Resident will be monitored for emotional distress, . and vitals will be monitored for the next 24 hours. On 5/6/24, a form 358 was submitted to the State Agency. The form 358 indicated that resident 3 reported to a staff member that resident 3 had touched his penis. Resident 1's behavior care plan was reviewed. The behavior care plan was dated 12/20/23, and indicated that the resident has physical behavioral symptoms toward others (e.g., hitting, kicking, pushing, scratching, abusing others sexually). Review of the care plan revealed that it had not been updated after 12/20/23, including after resident 1's sexual behaviors as listed above. On 5/14/24 at 11:10 AM, an interview was conducted with the DON. The DON was asked what interventions had been put in to place to prevent and address resident 1's behaviors. The DON stated that resident 1 had been placed on one on one, and then changed to a line of sight observation. The DON also stated that the facility had been purchasing cigarettes for resident 1, in case the behaviors were transactional in nature. The DON also stated that resident 1's medications had been evaluated. The DON confirmed that resident 1's care plan should have been updated with interventions to prevent and address behaviors.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview and record review it was determined, for 1 of 11 sampled residents, that each resident did not receive adequate supervision to prevent accidents. Specifically, a resident's neurological assessments were not completed after sustaining falls. Resident identifier: 10. Findings include: Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included suicide attempt, fall on same level, morbid obesity, obstructive sleep apnea, suicidal ideations, difficulty walking, dissociative identity disorder, need for assistance with personal care, hypothyroidism, type II diabetes mellitus, hypertension, atrial fibrillation, bipolar disorder, post traumatic stress disorder, chronic kidney disease stage 3 and panic disorder. Resident 10's medical record was reviewed on 5/14/24. Progress notes were reviewed and revealed the following: 1. On 3/21/24 at 11:51 PM, Resident on alert charting for recent fall on 3/21. Neuros started, frequent checks, call light within reach. No complaints or concerns. Vitals WNL [within normal limits] WCTM [will continue to monitor] . 2. On 3/27/24 at 12:10 AM, resident found sitting in bathroom floor. she states that she fell . small abrasion on left arm no other injuries noted. patient did not hit head. patient was able to stand on one leg with assistance and return to wheelchair . 3. On 3/28/24 at 8:52 AM, Resident on alert charting for two recent falls on 3/21 and 3/27. Neuros started, frequent checks, call light within reach. No complaints or concerns. Vitals WNL. WCTM. 4. On 3/28/24 at 7:57 PM, Resident on alert charting for recent falls on 3/21, 3/27 and 3/28. Neuros started, frequent checks, call light within reach. No complaints or concerns. Vitals WNL. WCTM. 5. On 4/10/24 at 5:54 PM, Resident was found on the floor in her (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room at 1700 [5:00 PM]. Head to toe assessment was done by floor nurse. No visible injuries noted. Resident stated she was trying to self transfer from the bed to her chair and hit her head on the bedside table when she feel and passed out. Resident was a/ox3 [alert and orient times 3] when found and vitals within baseline, PERRLA [pupils are equal round reactive to light and accommodation] . MD [medical doctor] notified and ordered for resident to be sent out . On 4/16/24 a late entry note was made for 4/10/24 which revealed, [resident] get help into the bathroom and was transferring herself from the toilet to her wheelchair and her R [right] foot slipped and she fell on her L [left] side hitting her head. When CNA [certified nursing assistant] brought Nurse into the room she reported not hitting her head and shortly after getting her back into her wheelchair via sit to stand hoyer she said that she had lied about not hitting her head because she didn't want to go to the hx (hospital). Vitals were taken and bp [blood pressure] was elevated 167/83 the rest were normal and neuro checks performed and purla [PERRLA] WNL. pt [patient] reported neck pain and DON [director of nursing] was notified. 6. On 5/6/24 at 5:52 PM, Resident called nurses desk and stated that she had fallen in the bathroom. Floor nurses found resident on the floor laying on her right side. Resident stated she accidentally stepped on her other foot and slipped and feel on her back side as she was getting up from the toilet. Resident stated she did not hit her head. Some c/o [complains of] of mild pain on her back from the fall but no open skin or injuries noted. Floor nurse did a head to toe and saw no abnormalities and vitals were checked and were within normal limits. Resident A/Ox3, PERRLA and strong hand grasps. DON and provider notified. Resident on Neuro checks and will start fall precautions. Neurological assessments were not located in resident 10's medical record or supplied by the facility when requested. On 5/14/24 at 10:15 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 10 has had some falls. CNA 1 stated when a resident has an unwitnessed fall the staff start neuro checks and then turn it in to the Director of Nursing. CNA 1 stated they do not chart neuro checks in the medical record. On 5/14/24 at 10:26 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated if a resident falls and no one sees them fall then they would start neuro checks after the resident had been assessed. RN 1 stated the resident is also started on alert charting so the staff can be aware of the fall. RN 1 stated the nurse on duty is supposed to fill out the alert charting section for their shift. On 5/14/24 at 1:52 PM, an interview was conducted with the DON. The DON stated the staff are expected to do neuro checks when a resident had a fall that was unwitnessed or if the resident hit their head. After the neuro checks were completed they were given to the nursing administration and then scanned into the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview and record review, it was determined for 1 of 11 sampled residents that the facility did not ensure the needed behavioral health care services were provided to achieve the highest practicable physical, mental and psychosocial well-being. Specifically, a resident was not offered behavioral health care services who was admitted with psychological diagnoses and after she was suspected of self harm. Resident identifier: 10. Findings include: Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included suicide attempt, fall on same level, morbid obesity, obstructive sleep apnea, suicidal ideations, difficulty walking, dissociative identity disorder, need for assistance with personal care, hypothyroidism, type II diabetes mellitus, hypertension, atrial fibrillation, bipolar disorder, post traumatic stress disorder, chronic kidney disease stage 3 and panic disorder. Resident 10's medical record was reviewed on 5/14/24. A complaint form was submitted to the State Agency on 5/3/24 regarding resident 10. The complaint indicated that resident 10 had a history of self-injurious behaviors and inflicted another wound with an unknown implement. No protocol for self-harm or suicidal ideation was put into place; the only new order was for bactracin to the wound. On 5/14/24 at 1:10 PM, an interview was conducted with resident 10. Resident 10 stated she coped by talking with others, residents or staff but mostly staff because they were closer to her age. Resident 10 stated she liked to listen to music, play with dice and crochet to help her calm down. Resident 10 stated she is not suicidal right now. She stated she had had her ECT (electroconvulsive therapy) yesterday and that usually it helps but this time when she woke up she was achy all over. Resident 10 stated her therapist/psychologist/psychiatrist - she could not remember title but she had been seeing him for [AGE] years and he was the one prescribing her medications. Resident 10 stated she had talked with him today via a virtual appointment and stated she was not feeling good emotionally or physically but would not elaborate and stated that she had not told staff. Resident 10 stated that she did have a history of cutting and that was her preference of self-harm. She liked to use knives, any type of knife, and while smiling she stated that she liked to break a plastic spoon to cut because it made a very sharp edge. Resident 10 stated she was not observed while eating or restricted on what utinsels she could use while eating. Resident 10 stated she came to the facility after being in the hospital for a broken ankle and then the psych hospital for about a month. The resident stated she has multiple personalities who live inside of her and that one of the other personalities is the one that cut her leg. Resident 10 stated the staff put some ointment on it and decided it did not need stitches. She stated that she did try to harm herself when she cut her leg. Resident 10 stated the staff did not set up any mental help services for her. A weekly skilled review report dated 3/6/24 revealed that resident 10 was in a psych unit prior to admission and had the anticipated need of SI [suicidal ideation] precautions and how actively SI patient is. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 10's care plan was reviewed. The focus adjustment to placement was dated 3/12/24 and indicated that the resident was at risk for adjustment/psychological well-being issues secondary to recent need for skilled nursing . With an approach which indicated 1:1 with social services to discuss any psychosocial concerns; LCSW (licensed clinical social worker) consult, PRN (as needed) N/A - Not Applicable. Review of the care plan revealed that it had not been updated since it's initial entry of 3/12/24 and no entries were observed for specific behaviors. Review of resident 10's progress notes revealed the following: a. On 5/4/24 at 4:30 PM, [resident 10] took this RN [registered nurse] to the side and stated that another personality of hers had initiated self-harm behaviors, inflicting an incision of approximately half an inch on the front of her right thigh. The incision was very clean and straight, as if made by a razor blade. The other RN on duty made a search, with [resident 10's] consent, of her room and purse. No implements capable of inflicting such a wound were found. On-call provider and administrator notified; close monitoring ordered as well as bacitracin ointment to prevent infection of wound. Staff will monitor closely. b. On 3/16/24 at 2:32 AM, Resident returned to facility via ambulance at 2330 [11:30 PM]. Resident stated the hospital found 2 butter knives in my cast and removed them. Resident stated another person put them in her cast and it wasn't her. Resident vitals WNL. [within normal limits] Returned to room, all possessions still present, no c/o [complains of] pain. No statements of SI [suicidal ideations] this shift. Resident stated to nurse, when asked how she was feeling, that she was having some mental health issues but she was doing better than she used to be doing. Resident socializing with staff at this time. c. On 3/16/24 at 3:34 AM, Resident's husband called. He said he just talked with his wife [resident 10], and she sounded very suicidal. He said I think she is planning to commit suicide tonight. Nurse informed husband that staff would check on wife at least every 15 minutes, if not more, throughout the night. Staff checked on resident after call with husband and found her in room asleep. ADON [assistant director of nursing] notified. d. On 3/13/24 at 6:41 PM, Received a call for [outpatient] psychiatric clinic saying that pt [patient] called yesterday and told them feeling unsafe and wanting to hurt herself, so she wanted to be one on one. Personally talked to [provider] and DON [director of nursing] about. Patient very positive today with no signs of depression, anxiety or desires to hurt herself. Will continue monitoring. e. On 3/30/24 at 8:45 PM, At approximately 1600 [4:00 PM] nurse witnessed resident sitting in w/c [wheelchair] on on the sidewalk close to the main road. When nurse asked how she was feeling and why she was outside she responded I am always having suicidal thoughts Np [nurse practitioner] and Adon Notified. f. On 4/1/24 at 1:26 PM, I spoke with resident this afternoon for an hour or so regarding recent SI behaviors - more specifically on her voiced plans or possibilities of self-harming. She has agreed to meet with Psychiatrist [provider] this week for an evaluation who will be on site early this week. Resident states (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I won't do anything dumb; these feelings have always been there since I was [AGE] years old. Scabbed over scratches noted to both arms which residents admits to using a plastic knife to cut with. She let me know that while she does not have the said knife in her possession, various possibilities are brought to her mind with random objects around the facility that she could use for potential harm. Resident has expressed interest in being placed on a 1:1. Nursing staff notified of this. Resident has many resources and people in her phone contacts that she reaches out to via phone call or text when feeling suicidal and depressed (various Psych [psyhology]/PCP [primary care] Providers, MCOT [mobile crisis outreach team], family, etc.). She voiced understanding when I told her that if she is unable to keep herself safe, this SNF [skilled nursing facility] is not the right fit for her to which she actually agreed on. She even mentioned a possible discharge facility she is interested in called [facility name] that has a mental health program she's looked at online. No documentation of 15 minute checks or 1:1 observation located in medical record. No documentation of mental health services were located in resident 10's medical record. On 5/14/24 at 10:22 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated resident 10 can get depressed when she was in her room too much. LPN 1 stated he had heard resident 10 tried to hurt herself before but was unsure what was being done about it. LPN 1 stated they were unsure if resident 10 was seeing a mental health provider. On 5/14/24 at 10:26 AM, an interview was conducted with RN 1. RN 1 stated if she had a question about a resident she would look in the Alert Charting binder at the nurses desk or the progress notes for an update on the resident. RN 1 stated that resident 10 had not voiced hurting herself to RN 1. On 5/14/24 at 10:30 AM, an interview was conducted with LPN 1. LPN 1 stated stated the alert charting binder should be updated every shift and the nurses cross off or add information as needed to keep it up to date for each resident they are caring for. LPN 1 stated that all of the nurses are in charge of writing in it. On 5/14/24 at 10:35 AM, an observation was made of the Alert Charting binder located at the nurses desk. The sheet had 5 columns labeled as date, resident, reason for alert charting, notes and end date. The latest entry in the date column for resident 10 was 4/24/24 and under the reason for alert charting Depression, SI, bleeding risk and psychotropic's was written, the end date was written as open there were not notes entered. No entries in the binder were observed to be crossed out or written over. On 5/14/24 at 10:50 AM, an interview was conducted with CNA 1. CNA 1 stated that sometimes the staff would find out if a resident had behavioral issues in report. CNA 1 stated that there really was not a place in the chart to look for that information. CNA 1 stated they could look under the diagnoses and figure out from there that they may have issues, otherwise they would just figure it out when they went in there room to work with them. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24 at 1:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that scheduling of mental health providers was done by nursing management and that there was not a resident that she was aware of who had virtual/telehealth appointments for mental health. The DON stated she was unaware of a SI assessment in the medical record but their was behavior tracking and alert charting. The DON stated resident 10 did not have any care plan entries for her specific behaviors, ideally that should be care planned. The DON stated she was aware of resident 10's behaviors and psychological issues and that her medications were being managed but her behaviors were not being managed, especially for someone who was self harming. The DON stated the CNA's are expected to use their report sheet and look at the CNA brain book to find the information about resident cares and behaviors. And that the nurses can get the information from report and the progress notes. The DON stated there was not one specific place where all of the information could be located in the medical record. On 5/14/24 at 2:59 PM, an observation was made of the CNA brain book at the nurses desk. It was observed to have the CNA schedule, an agency sign in sheet, shower sheets, vital signs sheets, sheet informing which residents are independent and dependent, and what type of transfer a resident required. The census sheet that was used for reference in the book was dated 2/14/24. It was observed that resident 10 was not on any of the sheets. On 5/14/24 at 3:00 PM, a follow up interview was conducted with CNA 1. CNA 1 stated they have a binder at the nurses desk that gives information on resident transfers, independent/dependent, and bathing but it does not given any information about their mental health. On 5/15/24 at 10:00 AM, a follow up interview was conducted with the DON. The DON stated residents with psychological issues are usually monitored for depressive symptoms every shift, can be seen by the facility psychological provider, and may be referred out for mental health services but all of that should be in the care plan and for resident 10 it was not. The DON stated it could affect resident 10's quality of life by not having her mental health issues supported and managed appropriately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465125	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Cottage on Vine	835 East Vine Street Murray, UT 84107

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on record review and interview it was determined, for 1 of 11 sampled residents, that the facility did not maintain medical records on each resident that were complete, accurately documented, and readily accessible. Specifically, the facility was not documenting progress notes timely and notes were not being documented into the medical record by the staff directly involved in the resident's care. Resident identifiers: 10. Findings include: Resident 10 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included suicide attempt, fall on same level, morbid obesity, obstructive sleep apnea, suicidal ideations, difficulty walking, dissociative identity disorder, need for assistance with personal care, hypothyroidism, type II diabetes mellitus, hypertension, atrial fibrillation, bipolar disorder, post traumatic stress disorder, chronic kidney disease stage 3 and panic disorder. Resident 10's medical record was reviewed on 5/14/24. The progress note section of the medical record documented the following notes as being recorded as late entry: a. Date of note 3/8/24 was documented as recorded 4 days after on 3/12/24. b. Date of note 3/8/24 was documented as recorded 60 days after on 5/7/24. c. Date of note 3/21/24 was documented as recorded 22 days after on 4/12/24. d. Date of note 3/22/24 was documented as recorded 21 days after on 4/12/24. e. Date of note 3/23/24 was documented as recorded 27 days after on 4/12/24. f. Date of note 3/23/24 was documented as recorded 45 days after on 5/7/24. e. Date of note 3/25/24 was documented as recorded 45 days after on 5/9/24. g. Date of note 3/25/24 was documented as recorded 18 days after on 4/12/24. h. Date of note 3/26/24 was documented as recorded 17 days after on 4/12/24. i. Date of note 3/26/24 was documented as recorded 42 days after on 5/7/24. j. Date of note 3/28/24 was documented as recorded 40 days after on 5/7/24. k. Date of note 3/28/24 was documented as recorded 15 days after on 4/12/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	l. Date of note 3/29/24 was documented as recorded 14 days after on 4/12/24. m. Date of note 3/29/24 was documented as recorded 39 days after on 5/7/24. n. Date of note 3/30/24 was documented as recorded 38 days after on 5/7/24. o. Date of note 3/30/24 was documented as recorded 13 days after on 4/12/24. p. Date of note 3/31/24 was documented as recorded 12 days after on 4/12/24. q. Date of note 4/1/24 was documented as recorded 11 days after on 4/12/24. r. Date of note 4/3/24 was documented as recorded 9 days after on 4/12/24. s. Date of note 4/3/24 was documented as recorded 34 days after on 5/7/24. u. Date of note 4/4/24 was documented as recorded 8 days after on 4/12/24. NOTE: Resident 10 was not in the facility when this note was entered. v. Date of note 4/5/24 was documented as recorded 7 days after on 4/12/24. w. Date of note 4/6/24 was documented as recorded 30 days after on 5/7/24. x. Date of note 4/6/24 was documented as recorded 6 days after on 4/12/24. y. Date of note 4/7/24 was documented as recorded 5 days after on 4/12/24. z. Date of note 4/8/24 was documented as recorded 29 days after on 5/7/24. aa. Date of note 4/9/24 was documented as recorded 28 days after on 5/7/24. bb. Date of note 4/10/24 was documented as recorded 27 days after on 5/7/24. cc. Date of note 4/10/24 was documented as recorded 30 days after on 4/12/24. NOTE: Resident 10 was not in the facility when this note was entered. dd. Date of note 4/11/24 was documented as recorded 26 days after on 5/7/24. ee. Date of note 4/12/24 was documented as recorded 25 days after on 5/7/24. ff. Date of note 4/13/24 was documented as recorded 24 days after on 5/7/24. gg. Date of note 4/13/24 was documented as recorded 24 days after on 5/7/24. hh. Date of note 4/14/24 was documented as recorded 23 days after on 5/7/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ii. Date of note 4/15/24 at 6:09 PM and 9:27 PM were documented as recorded 22 days after on 5/7/24. jj. Date of note 4/16/24 at 6:09 PM, 6:28 PM, and 10:27 PM were documented as recorded 21 days after on 5/7/24. kk. Date of note 4/17/24 at 5:09 AM and 9:28 PM were documented as recorded 20 days after on 5/7/24. NOTE: Resident 10 was not in the facility when this note was entered. ll. Date of note 4/18/24 was documented as recorded 19 days after on 5/7/24. NOTE: Resident 10 was not in the facility when this note was entered. On 5/14/24 at 1:52 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she was unaware that the Assistant Director of Nursing (ADON) was charting information she had obtained from the floor nurses as late entries into the medical records of residents. The DON stated the problem with late charting was you could not recollect what had happened accurately and late charting was never best practice. On 5/14/24 at 3:08 PM, an interview was conducted with the ADON. The ADON stated she would ask the floor nurse what had happened on the day in question and document the information in the medical record, regardless of how much time had lapsed between the day of occurrence and the day it was documented. The ADON stated that it would be more ethical for the floor nurse who was working directly with the residents to document the information in the medical record. The ADON stated that if the floor nurses could not remember what had happened with a resident then she would not chart it.