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	11/05/2025

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 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. (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility failed to ensure that each resident received adequate supervision to prevent accidents. Specifically, a resident had left the facility and was unaccounted for approximately 18 hours before management was alerted. Resident identifier: 3Findings included:Resident 3 was admitted to the facility on [DATE] and discharged on 5/28/25 with diagnoses which included sequelae of cerebral infection, injury of left kidney, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.Resident 3's medical record was reviewed on 11/5/25. An admission Minimum Data Set (MDS) dated [DATE] revealed that resident 3 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated resident 3 was cognition was intactOn 5/24/25 at 3:29 PM, the facility reported to the State Survey Agency that on 5/24/25 at 11:00 AM, resident 3 left the building without checking out or letting staff know where he was going. The facility was unsure of the exact time he left but it was believed it was the evening before. Resident 3 spoke to a family member around 6:00 PM on 5/23/25 and told them he was still in the facility. The facility's investigation dated 5/24/25 revealed the following:During the evening shift Certified Nursing Assistant (CNA) went to check on resident 3 several times and noticed that his television was on during the shift and his dinner was untouched. The CNA asked about resident 3 due to her being an agency CNA and wasn't familiar with resident 3, but did not get any concrete answers on where he could be. During shift change the CNA told the Night CNA about resident 3's absence and documented it in the medical record. The night shift CNA reported that resident 3 had been gone the whole day; the previous aide said it was like it was normal and did not know that resident 3 was missing. The 5/24/25 day shift CNA reported during the shift change report they were informed that resident 3 was not there and under the impression that resident 3 was with family. The day shift CNA did not know the resident was missing.The administrator interviewed resident 3, he stated that he had left to go to the convenience store, while he was there he saw a bus and decided to get on it for no reason. Resident 3 traveled up to Salt Lake City and did not feel like coming back at the time and went to a friend's house. Resident 3 said he had forgotten that he needed to sign out or let someone know he was leaving.On 11/5/25 a review of the resident 3's medical records revealed the following:On 5/24/25 at 3:23 PM, a Nurses Note revealed that the patient was not here all day long, meds not given today. Police called, the Director of Nursing (DON) notified and came into the facility. On 5/24/25 at 4:51 PM, a late entry nursing note revealed the following. Administrator and DON notified this morning that the patient had been gone on a leave of absence (LOA) since yesterday. The patient was alert and oriented at times four and able to communicate effectively, however he did not sign out or tell anyone where he was going. Although the patient was not considered an elopement risk, elopement procedure was activated and facility and surrounding grounds were searched and the patient was not found. All the patient belongings were still in his room. The sister and provider were notified by the floor nurse. A family member was called and stated that she talked to the patient on Friday afternoon. She had told him that his brother was being discharged from the hospital and being admitted to a skilled nursing facility (SNF) today. She thinks that he may be going there as he and his brother are very close and usually were not apart. She also stated that we may want to check the jail. The SNF was notified that if they have seen the patient to call DON. The jail roster was checked and the patient was not booked yesterday or today. Police called and a missing person was reported. The patient was set to discharge on 5/28 to an assisted living facility (ALF). On 5/25/25 at 8:17 PM, a late entry nursing note revealed the following: The patient was picked up at a pharmacy by facility DON and unit manager. The patient was found in the lobby waiting to get his belongings that had been left there after his stay prior to coming to the facility. He was in good condition with no visible injuries at this time. When asked why he left, he stated that he went to the store to get a soda and then could not find his way back. So he stated that he went to a friend's house who lived nearby and today he got on the bus to go up to the pharmacy to get his medications. He agreed to come back to the facility and finish his antibiotic treatment then be properly discharged to the ALF. He stated that he would not leave until then. The patient was brought back to the facility and he was fed. Floor nurse to do a head to toe assessment and skin check. The sister and provider were notified at this time. The police were called to let them know that a patient had been found. The patient again verbalized that he would not leave again without telling anyone. On 11/5/25 at 1:20 PM, an interview was conducted with certified nurse assistants (CNA) 2 and 3. Both CNA 2 and 3 stated that they were agency staff and were not permanent employees of the