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	03/06/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on observation, interview, and record review, the facility did not ensure that the resident right to self-administer medications was clinically appropriate and safe. Specifically, for 1 out of 27 sampled residents, a resident was observed to have medications in her closet and was not evaluated to determine if they were safe to self-administer medications. Resident identifier: 25. Findings included: Resident 25 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis of vertebra, methicillin resistant staphylococcus aureus infection, paraplegia, and encephalopathy. On 3/3/25 at 10:09 AM, an observation was conducted of resident 25's room. A large bottle of store-brand B-complex medication supplement was observed inside resident 25's closet. An interview was immediately conducted with resident 25. Resident 25 stated that the doctor said it was okay for her to take supplements to help her heal. Resident 25 stated that if the facility provided supplements for her, it would cost a lot more money. Resident 25 stated, due to this her daughter brought them to her and she was just taking them herself to save money. Resident 25's medical record was reviewed on 3/3/25 through 3/6/25. On 1/7/25, resident 25's Self-Administration Of Medication assessment documented no that the resident did not wish to self administer medications. Resident 25's care plan was reviewed and no care areas were identified for self administration of medication. An admission Minimum Data Set assessment dated [DATE], revealed that resident 25 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated an intact cognition. A nurse's note dated 3/2/25 at 5:54 PM, revealed that resident 25's daughter brought in a pill case of vitamins approved by the Medical Director over the phone. The pill case was now missing Saturday's slot. On 3/4/25 at 1:38 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that if she saw medications or supplements at a resident's bedside or in their room, she would inform the nurse. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 1:56 PM, an interview was conducted with CNA 2. CNA 2 stated if medications or supplements were in a resident's room, she would have a nurse come and/or talk to the nurse. CNA 2 stated that the residents were not allowed to have medications in their room or left at the bedside. 38031 On 3/6/25 at 11:03 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 25's cognitive status was alert and oriented times two to self and location. RN 1 stated that resident 25 had episodes of frequent confusion, needed reminders about her care, and had short term memory deficits. RN 1 stated that resident 25 was not able to self administer medications. RN 1 stated that resident 25 did not have a self administration evaluation that concluded the resident was safe to self administer medication. RN 1 stated that resident 25's family member had brought medication to the facility and had left it at the bedside. RN 1 stated that they collected the medication and gave it to nurse management. RN 1 stated that she would administer resident 25's medication in the morning and then she would forget that she had taken it. RN 1 stated that resident 25 was not safe to self administer medication because she often forgot that she had taken medication previously and she would be at risk for administering too much medication. On 3/6/25 at 11:13 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 25 had a BIMS score of 15/15, which would indicate that the resident was cognitively intact. The DON stated that she did not see that resident 25 had any diagnoses of memory deficits. The DON stated that she should not have medications at the bedside for self administration based on the completed self administration of medication assessment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review, the facility did not notify and consult with the physician when there was a need to alter the resident's treatment. Specifically, for 2 out of 27 sampled residents, a resident's suprapubic catheter order was changed and the physician was not notified. Additionally, a resident's intravenous antibiotic was not administered per the physician ordered times and the physician was not notified. Resident identifiers: 3 and 41. Findings included: 1. Resident 3 was admitted to the facility on [DATE] with diagnoses which included quadriplegia Cervical (C)1-C4 incomplete, neuromuscular dysfunction of the bladder, flaccid neuropathic bladder, and autonomic neuropathy. On 3/3/25 at 8:55 AM, an interview was conducted with resident 3. Resident 3 stated that he needed the catheter changed due to it being plugged and the facility did not have the correct size in stock and he had to wait for a replacement. Resident 3's medical record was reviewed. On 2/3/25, resident 3 had a physician order that documented, Change PRN [as needed] - Suprapubic Catheter: 24 French Size [SPECIFY] 10ML [milliliter] Balloon as needed for Occlusion or Leakage As Needed. On 2/24/25 at 10:29 PM, resident 3's Treatment Administration Record documented that resident 3's suprapubic catheter was changed with a 24 French Size, 10 ml balloon per the physician order. Resident 3's progress notes revealed the following: a. On 12/17/24 at 3:45 PM, the note documented, 20 g [gauge] suprapubic catheter placed and bag replaced, due to pt [patient] leaking. Pt tolerated it well and has had no new complaints. b. On 12/30/24 at 5:25 PM, the note documented, Catheter and bag replaced today. Catheter size 20/10. No issues. Pt reports no pain or discomfort. c. On 1/4/25 at 2:12 PM, the note documented, Patient catheter change, 22 French, 30mL, skin intact, dressing in place. d. On 2/22/25 at 3:54 PM, the note documented, pt scheduled for cath [catheter] change today. pt it [sic] 22 gauge. we are out of 22 gauge. offered to go one size smaller. pt declined and stated he will wait. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 11:49 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 3's catheter size was a 24 French per the physician order. RN 1 checked the supply room for the 24 French catheter and stated that they did not have any 24 French suprapubic catheters in stock. RN 1 stated that she would not be able to change the catheter if it needed to be done because they did not have any in stock. RN 1 stated that the Certified Nursing Assistant Coordinator (CNAC) was in charge of reordering supplies. On 3/4/25 at approximately 11:55 AM, an interview was conducted with the CNAC. The CNAC stated that earlier this week RN 2 told her that they were out of stock of the 24 French suprapubic catheter. The CNAC stated that she informed RN 2 that they had a 22 French catheter with a 30 ml balloon available and asked if they could use that one instead until they got the other one in stock. The CNAC stated that she did not know what catheter size RN 2 used for resident 3's treatment. On 3/4/25 at 12:17 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if staff placed a 22 French catheter instead of the 24 French they should have contacted the physician and put an order in for the change. The DON stated that she would have to reach out to the nurse to see if the treatment was completed. On 3/4/25 at 2:30 PM, a follow-up interview was conducted with the DON. The DON confirmed that resident 3 had a 22 French suprapubic catheter inserted. The DON stated that the physician was not notified of the 22 French insertion and she did not have an order for it. [Cross-refer F690] 2. Resident 41 was admitted to the facility on [DATE] with diagnoses which included polyneuropathy, type 2 diabetes mellitus, osteomyelitis, non-pressure chronic ulcer, gas gangrene, cutaneous abscess of left foot, and cellulitis. On 3/3/25 at 10:22 AM, an interview was conducted with resident 41. Resident 41 stated that the facility did not have enough staff and that he did not receive his intravenous (IV) antibiotics on time. Resident 41's medical record was reviewed. Resident 41's physician orders revealed the following: a. Daptomycin-Sodium Chloride Intravenous Solution 500-0.9 milligram (mg)/50ML, give 750 mg intravenously every 24 hours for Infection. The medication order documented an administration time of 1:00 PM daily. b. Micafungin Sodium Chloride Intravenous Solution 100-0.9 MG/100ML, give 100 mg intravenously every 24 hours for infection. The medication order documented an administration time of 10:00 PM. The Medication Treatment Record documented that the Daptomycin was administered late on the following days: on 2/13/25 at 3:29 PM, on 2/18/25 at 4:01 PM, on 2/22/25 at 2:52 PM, and on 2/25/25 at 2:55 PM. It should be noted that no documentation could be found to indicate that the physician was notified of the late administrations of the antibiotic. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Treatment Record documented that the Micafungin was administered late on the following days: on 2/14/25 at 2:38 PM, on 2/16/25 at 2:55 PM, on 2/18/25 at 6:08 PM, on 2/23/25 at 11:48 PM, and on 2/25/25 at 11:43 PM. It should be noted that no documentation could be found to indicate that the physician was notified of the late administrations of the antibiotic. On 3/4/25 at 9:08 AM, an interview was conducted with RN 3. RN 3 stated that resident 41's Daptomycin was scheduled to be administered every 24 hours at 1:00 PM, and the Micafungin was scheduled every 24 hours at 10:00 PM. RN 3 stated that the medication could be administered 30 minutes before or after the scheduled time and still be considered on time. RN 3 stated that if the antibiotic was not given on time she would notify the physician. On 3/6/25 at 8:39 AM, an interview was conducted withe the DON. The DON stated that the antibiotic could be administered 30 minutes before or 30 minutes after the scheduled time. The DON stated that the physician needed to be notified if the medication was not administered per the ordered schedule. The DON stated that staff should have notified the physician of the delay in treatment. [Cross-refer F760]

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, the facility did not inform each resident periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. Specifically, for 1 out of 3 sampled residents, a resident was not issued a Notice of Medicare Non-coverage (NOMNC) when the Medicare part A services were terminated. Resident identifier: 100. Findings included: Resident 100 was admitted to the facility on [DATE] with diagnoses that included pneumonia, septicemia, renal insufficiency, and diabetes mellitus. Resident 100 was discharged to home on 10/3/24. Resident 100's medical record was reviewed on 3/6/25. A NOMNC was not found in resident 100's medical record. On 3/6/25, a request was made with the Administrator (ADM) to provide a copy of resident 100's signed NOMNC form. On 3/6/25 at 11:12 AM, an interview was conducted with the ADM who stated he was unable to find a NOMNC for resident 100.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52146 Based on observation and interview, the facility did not provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Specifically, for 1 out of 27 sampled residents, it was observed that the resident's shower had a bad odor, black substance along the grout lines, white buildup on tile surfaces, and circular red rings along the shower floor. Resident identifier: 23. Findings included: Resident 23 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, atherosclerosis, unspecified protein-calorie malnutrition, rhabdomyolysis and osteoarthritis. On 3/3/25 at 10:31 AM, it was observed that the resident's shower had a bad odor, black substance along the grout lines, white buildup on tile surfaces, and circular red rings along the shower floor. On 3/5/25 at 9:07 AM, it was observed that the black substance along the grout lines, white buildup on tile surfaces, and circular red rings along the shower floor remained as the previous observation. The bad odor had decreased in intensity. On 3/5/25 at 9:33 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that residents typically showered in their room bathrooms, not a shower room. On 3/5/25 at 11:40 AM, an interview was conducted with the Housekeeping Supervisor (HS). The HS stated that residents' rooms and bathrooms were cleaned daily and as needed. The HS stated that when cleaning rooms and bathrooms focus was put on locations the patients frequently touch. On 3/5/25 at 12:49 PM, an observation of resident 23's shower was made with the HS present. The HS stated that housekeeping had not completed daily cleaning in resident 23's room and bathroom yet. The HS stated that Housekeeping used Contender Cleaner and Destainer with bleach on the shower in resident 23's shower during the next daily cleaning. On 3/5/25 at 12:59 PM, an interview was conducted with the Housekeeper (HK). The HK stated that residents' bathrooms were cleaned daily. The HK stated that cleaning the bathroom included spraying the shower floor and walls with bathroom cleaner and scrubbing with a scrub brush. Resident 23's bathroom was observed with the HK. The HK stated that resident 23's bathroom's daily cleaning had not been completed. The HK stated that the tile and grout in resident 23's bathroom were possibly stained. On 3/5/25 at 1:50 PM, an observation was made of resident 23's shower after daily cleaning had been completed by the HK. The HK was present in the bathroom. There was an odor of bleach, the floors and walls were wet. A damp scrub brush was observed. The black substance along the grout lines, white buildup on the tile surfaces, and the circular red rings along the shower floor remained the same as previous observations. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 1:57 PM, an interview was conducted with the Maintenance Director while observing resident 23's shower. The Maintenance Director stated that the circular red rings along the shower floor are rust marks from shower chair feet. The Maintenance Director stated that the black substance in the grout could be dirt. The Maintenance Director stated that he completed visual inspections in the resident rooms and bathrooms once a week. The Maintenance Director stated that housekeeping and staff report maintenance needs in the Maintenance Binder kept at the nursing station. The Maintenance Binder recorded who reported the maintenance need, when the maintenance need was reported, a description of the maintenance need, who addressed the maintenance need and when the maintenance need was addressed. On 3/5/25 at 2:28 PM, an interview was conducted with the Corporate Nurse (CN) while observing resident 23's shower. The CN acknowledged the black substance along the grout lines, white buildup on tile surfaces, and circular red rings along the shower floor.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review, the facility did not ensure that all alleged violations involving abuse were reported immediately, but no later than 2 hours after the allegation was made to the Administrator (ADM) of the facility, State Survey Agency (SSA), and Adult Protective Services (APS). Specifically, for 1 out of 27 sampled residents, a resident reported an allegation of verbal abuse to a staff member and that information was not reported to the facility ADM, the SSA, or APS. Resident identifier: 10. Findings included: Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of chronic kidney disease, morbid obesity, type 2 diabetes mellitus, borderline personality disorder, Post Traumatic Stress Disorder, bipolar disorder, anxiety disorder, and hypertension. On 3/3/25 at 9:35 AM, an interview was conducted with resident 10. Resident 10 stated that last night she requested the male nurse check her blood sugar early so she could go to bed. Resident 10 stated that the nurse told her where to go and replied fuck you to her request. Resident 10 stated that the Certified Nursing Assistant Coordinator (CNAC) provided her with incontinence care at 4:00 AM, and she reported the incident to her. Resident 10's medical record was reviewed. On 11/20/24, resident 10's Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15/15, which would indicate that the resident was cognitively intact. Review of the facility abuse investigations revealed no documentation for the investigation of the allegation of verbal abuse as alleged by resident 10 on 3/3/25. On 3/5/25 at 10:11 AM, an interview was conducted with the CNAC. The CNAC stated that resident 10 reported to her on Monday morning that the night nurse was rude to her. The CNAC stated that resident 10 had stated that the way the nurse spoke to her when providing her medication was rude. The CNAC stated that she told resident 10 that she would let nursing management know about the incident. The CNAC stated that she did not report the incident to anyone. The CNAC stated that the facility abuse coordinator was the ADM, and any allegation of abuse needed to be reported immediately to the ADM. The CNAC stated that she should have reported the incident on Monday immediately, but she was not sure if it was an allegation of abuse. On 3/5/25 at 10:46 AM, an interview was conducted with the ADM. The ADM stated that he was just informed of an incident with resident 10 and a staff member. The ADM stated that he interviewed resident 10 and the resident had reported that the nurse told her fuck you. The ADM stated that he would initiate an abuse investigation and that he was aware that he was late in reporting the allegation to the SSA.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview and record review, the facility in response to allegations of abuse, neglect, exploitation, or mistreatment, failed to provide evidence that all alleged violations were thoroughly investigated and failed to report the results of all investigations to the State Survey Agency (SSA), within 5 working days of the incident. Specifically, for 2 out of 27 sampled residents, two allegations of abuse/neglect by staff members were not thoroughly investigated. Resident identifiers: 200 and 201. Findings included: 1. Resident 200 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, chronic kidney disease, bipolar disorder, type 2 diabetes mellitus, and morbid obesity. On 6/14/24 at 2:24 PM, an entity 358 report was received by the SSA. The report stated that on 6/13/24, during the evening shift, resident 200 alleged that a Certified Nursing Assistant (CNA) told her to go to the bathroom in your pants and that she did not have time to help the resident. The report also stated that the resident alleged that the CNA pulled up her shirt without the resident's permission. The report stated the CNA had been placed on administrative leave and Adult Protective Services (APS) had been notified. The report stated resident 200 was at baseline with no signs of injury or distress. The entity 359 investigation report could not be found in the abuse binder provided by the facility. On 3/6/25 at 11:51 AM, an email was provided by the Administrator (ADM). The email contained the following information, [CNA 3] denies lifting up the resident's shirt in an abusive manner. [CNA 3] denies refusing to assist the resident. A summary of interviews with other residents who may have had contact with the alleged perpetrator included, I conducted interviews with multiple residents regarding [CNA 3] and her performance and demeanor. [Resident 3] reports that [CNA 3] is a good CNA. [Resident name redacted] report no concerns with [CNA 3]. [Resident name redacted] reports [CNA 3] is a good employee and caring. A summary of interviews with staff responsible for oversight and supervision of the location where the alleged victim resides included, [Registered Nurse (RN) 1] was interviewed, [RN 1] reports that [resident 200] is at her baseline mood and behavior and does not present with any signs or symptoms of psychosocial trauma or abuse. A summary of interviews with staff responsible for oversight and supervision of the alleged perpetrator revealed, [RN 1] has not had any concerns related to [CNA 3]'s performance behavior. The allegation appears to be inconclusive although no information was provided as to how it was determined. Actions taken as a result of the investigation included, resident's plan of care was updated to reflect new intervention and approaches to reduce behaviors and falls. No plan for oversight was provided, No actions were identified to address policies or training to prevent potential abuse. It should be noted the above information was provided from the previous administrator's email, and could not be verified to have been submitted to the SSA. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident 201 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included atrial fibrillation, heart failure, and depression. On 5/22/24 at 3:58 PM, the facility received an anonymous report, via the facility compliance hotline, that resident 201 had been left soiled due to lack of care or neglect. APS the SSA were notified. An entity 358 Facility Reported Incident form revealed the alleged perpetrator of neglect was unknown and the facility became aware of the incident on 5/22/24 at 3:30 PM. The time when the incident occurred was unknown and no injury was noted. The report stated the Resident is at baseline and not displaying signs of psychosocial trauma. The resident was assessed by nursing and no injuries were noted. The report states, Resident interviewed by facility administrator. Denies abuse/neglect at this time. Witnesses were unknown and APS was notified. The entity 359 investigation report could not be found in the abuse binder provided by the facility. No other documentation was provided. On 3/6/25 at 11:42 AM, an interview was conducted with the Director of Nursing (DON) who stated the administration takes complaints and allegations very seriously. The DON stated, depending on who the resident comes to first the investigation would be given to the appropriate team member. The DON stated if the allegation was regarding abuse or neglect, it would be given to the ADM who was the abuse coordinator. The DON stated information was shared in the morning stand up meeting regarding the resident and the complaints or allegations. The DON stated if necessary, social work would get involved. The DON stated a corporate meeting was held every morning to discuss concerns also. The DON stated that the ADM would take the lead on investigations and delegate tasks as needed. The DON stated the ADM liked to do the interviews himself and make decisions accordingly. The DON stated instructions were on the wall by the nurse's station as to the requirements for notification and reporting. The DON stated the facility used text messaging to report information immediately.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record the review, the facility did not ensure that residents who were continent of bladder received services and assistance to maintain continence unless his or her clinical condition was or became such that continence was not possible to maintain. In addition, the facility did not ensure that residents with urinary catheters received services based on the resident's comprehensive assessment. Specifically, for 2 out of 27 sampled residents, a resident that was assessed as a candidate for scheduled toileting was not on a toileting program and a resident with a suprapubic catheter did not have the correct size inserted per physician orders. Resident identifiers: 3 and 99. Findings included: 1. Resident 99 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, metabolic encephalon, acute kidney failure, low back pain, generalized anxiety disorder, macular degeneration, chronic pain, and urinary tract infection (UTI). On 3/3/25 at 11:46 AM, an interview was conducted with resident 99. Resident 99 stated that she currently had a UTI. Resident 99 stated the staff did not come quick enough when she needed to use the toilet and staff told her that she was better off wearing diapers. Resident 99 stated that she could use the restroom if staff assisted her. Resident 99 stated that she thought she got UTIs because she had to urinate in the diaper. Resident 99 stated that she could not get up without assistance. Resident 99's medical record was reviewed on 3/3/25 through 3/6/25. A care plan Focus initiated on 2/12/25, documented [Resident 99] is incontinent secondary to anxiety, history of UTIs, pain, anxiety, depression, HTN [hypertension], macular degeneration. The Goal documented that resident 99 would not experience any adverse effects of incontinence through the next review. The Interventions included, but were not limited to, provide assistance for toileting. A care plan Focus initiated on 2/21/25 and revised on 2/24/25, documented [Resident 99] has bladder incontinence r/t [related to] Active infections with symptoms of UTI. The Interventions included, bur were not limited to, encourage fluids during the day to promote prompted voiding responses. On 2/28/25, the facility completed a Bowel and Bladder Program Screener for resident 99. The screener documented that resident 99 did not always, but at least daily voided appropriately without incontinence. Resident 99 was immobile or required a two person assist, forgets but follows commands, and was sometimes aware of the need to toilet. Resident 99 was categorized as a Candidate for Schedule toileting (timed voiding). (continued on next page)

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Rocky Mountain Care - Cottage on Vine	835 East Vine Street Murray, UT 84107

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 8:52 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated the facility had a toileting program. CNA 2 stated any resident that was able to move the staff would try to encourage the resident to use the toilet. CNA 2 stated the CNAs were to round on the residents every two hours. CNA 2 stated that some CNAs would tell the residents if they had a brief on they were fine and go in the brief but if the resident was able to move the staff should be encouraging the resident to use the toilet if they were capable. CNA 2 stated it was hard with agency staff to get them trained. CNA 2 stated agency staff would tell the residents to use the brief if the resident had one on. CNA 2 stated that some residents would let staff know they need to use the toilet. CNA 2 stated if it was time for rounds and the resident was wet the staff should still be encouraging the resident to use the toilet. CNA 2 stated that resident 99 should be on a toileting program. CNA 2 stated she had heard that some of the CNAs have said that resident 99 did not want to use the toilet. CNA 2 stated that resident 99 would use her call light if she needed to use the toilet. CNA 2 stated in the resident medical record toileting times could be scheduled as a task. On 3/6/25 at 9:46 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility had a toileting program. The DON stated the toileting program would be waking, at bedtime, and after meals. The DON stated the documentation of the toileting program would be part of the task. The DON stated that it looked like resident 99 was not on a toileting program but we do have an order for increased hydration. 38031 2. Resident 3 was admitted to the facility on [DATE] with diagnoses which included quadriplegia cervical (C)1-C4 incomplete, neuromuscular dysfunction of the bladder, flaccid neuropathic bladder, and autonomic neuropathy. On 3/3/25 at 8:55 AM, an interview was conducted with resident 3. Resident 3 stated that he needed the suprapubic catheter changed due to it being plugged and the facility did not have the correct size in stock and he had to wait for a replacement. Resident 3 stated the last time the catheter was changed the nurse who performed the treatment was dirty and did not change his gloves or use antispetic to clean the insertion site. Resident 3's medical record was reviewed. Resident 3's physician orders revealed the following: a. Flush catheter with 60 milliliters (ml) of acetic acid twice a week and as needed (PRN) every night shift on Tuesday and Friday. b. Ensure privacy/dignity bag was in place for catheter down drain bag every shift. c. Catheter - Monitor urine for abnormal color, clarity, odor - if abnormal notify the Medical Director every shift. d. Change PRN - Suprapubic catheter: 24 French size 10 ML balloon for occlusion or leakage as needed. e. Urinary catheter: irrigate with normal saline at bedtime. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. Urinary catheter care every shift. On 2/24/25 at 10:29 PM, resident 3's Treatment Administration Record documented that resident 3's suprapubic catheter was changed with a 24 French size, 10 ml balloon per the physician order. Resident 3's progress notes revealed the following: a. On 12/17/24 at 3:45 PM, the note documented, 20 g [gauge] suprapubic catheter placed and bag replaced, due to pt leaking. Pt [patient] tolerated it well and has had no new complaints. b. On 12/30/24 at 5:25 PM, the note documented, Catheter and bag replaced today. Catheter size 20/10. No issues. Pt reports no pain or discomfort. c. On 1/4/25 at 2:12 PM, the note documented, Patient catheter change, 22 French, 30mL, skin intact, dressing in place. d. On 2/22/25 at 3:54 PM, the note documented, pt scheduled for cath [catheter] change today. pt it [sic] 22 gauge. we are out of 22 gauge. offered to go one size smaller. pt declined and stated he will wait. On 12/18/24, resident 3's risk versus benefit form documented, .has a suprapubic catheter, which needs to be flushed each shift. He has been refusing, stating he only wants it done when it is not flushing or draining. It was explained that was why it was getting clogged was because it needs to be flushed regularly. He then stated he would be ok with it done at night and then as needed for other times. On 8/31/2020, resident 3 had a care plan initiated for .requires a suprapubic catheter at this time secondary to Urinary retention/neurogenic bladder. Interventions identified on the care plan were to flush the catheter as ordered; provide suprapubic site care as ordered; catheter care every shift; and change the suprapubic 20 French 30 ml balloon per providers orders. It should be noted that the care plan did not accurately reflect the current physician orders for the suprapubic catheter size. On 3/4/25 11:49 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 3's catheter size was a 24 French per the physician order. RN 1 checked the supply room for the 24 French catheter and stated that they did not have any 24 French suprapubic catheters in stock. RN 1 stated that she would not be able to change the catheter if it needed to be done because they did not have any in stock. RN 1 stated that the CNA Coordinator (CNAC) was in charge of reordering supplies. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at approximately 11:55 AM, an interview was conducted with the CNAC. The CNAC stated that she was in charge of ordering supplies for the facility. The CNAC stated that a reorder form was placed on the front of her door, in the medication room, and at the nurse's station for staff to add requested supplies to. The CNAC stated that she ordered supplies every week by Wednesday and then received the order on Thursday. The CNAC stated that she ordered resident 3's suprapubic catheter by the case and he was the only resident that used them. The CNAC stated that when they were close to running out the nurse would inform her and she would place a new order. The CNAC stated that earlier this week RN 2 told her that they were out of stock of the 24 French suprapubic catheter. The CNAC stated that she informed RN 2 that they had a 22 French catheter with a 30 ml balloon available and asked if they could use that one instead until they got the other one in stock. The CNAC stated that she did not know what catheter size RN 2 used for resident 3's treatment. The CNAC stated that they should have the correct size suprapubic catheter in stock for resident 3 at all times. The CNAC stated that the item was not reordered in this week's shipment because she had already placed the order when she became aware that it was out of stock. On 3/4/25 at 12:17 PM, an interview was conducted with the DON. The DON stated that the CNAC was responsible for reordering all stock supplies for the facility. The DON stated that resident 3 should have a 24 French suprapubic catheter available in the supplies. The DON stated that if staff placed a 22 French catheter instead of the 24 French they should have contacted the physician and put an order in for the change. The DON stated that she would have to reach out to the nurse to see if the treatment was completed. On 3/4/25 at 2:30 PM, a follow-up interview was conducted with the DON. The DON confirmed that resident 3 had a 22 French suprapubic catheter inserted. The DON stated that the physician was not notified of the 22 French catheter insertion and she did not have an order for it. The DON stated that she notified the provider and he was currently speaking to the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52146 Based on interview and record review, the facility did not provide routine and emergency drugs to its residents. Specifically, for 1 out of 27 sampled residents, a resident that was prescribed a medication to manage neuropathic pain did not have the medication available for administration due to pending delivery. Resident identifier: 28. Findings Included: Resident 28 was admitted to the facility on [DATE] with diagnoses which included, but were not limited, to neuropathy, osteomyelitis, type 2 diabetes mellitus, left leg below knee amputation, right toe amputation, and epilepsy. Resident 28's medical record was reviewed on 3/3/2025 through 3/6/2025. On 3/3/25 at 9:44 AM, an interview was conducted with resident 28. Resident 28 stated that she was concerned that the facility did not always have medications in stock. Resident 28 stated that she had missed scheduled medications in the past due to the facility not having the medications in stock. A review of the Medication Administration Record (MAR) for February 2025 was completed. It was noted that five consecutive doses of pregabalin capsule 100 milligrams (mg) were not administered between 2/14/25 and 2/15/25. On 2/14/25, pregabalin was not given at the scheduled 6:00 AM, 10:00 AM, and 06:00 PM, administration windows. On 2/15/25, pregabalin was not given at the scheduled 6:00 AM and 10:00 AM, administration windows. The chart code documented in the MAR for all five missed administrations was code 11, indicating Med [medication] not available. On 2/14/2025 at 9:29 PM, an Orders - Administration Note documented Note Text: Pregabalin Capsule 100MG Give 1 capsule by mouth three times a day for nerve pain Unable to locate. On 2/15/2025 at 8:31 AM, an Orders - Administration Note documented Note Text: Pregabalin Capsule 100MG Give 1 capsule by mouth three times a day for nerve pain pending delivery. On 2/15/2025 at 12:42 PM, an Orders - Administration Note documented Note Text: Pregabalin Capsule 100MG Give 1 capsule by mouth three times a day for nerve pain pending delivery. On 3/4/25 at 10:27 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 Stated that when there was an out of stock medication in the medication cart she would confirm if the medication had been ordered. RN 3 stated that she would call the pharmacy to verify the delivery date if the order for the medication had been made more than two days previously. RN 3 stated that there was a back up supply of over the counter medications in the room behind the nurses station. RN 3 stated that there was not a back up supply of prescription medications available in the facility. RN 3 stated that she would order more medications from the pharmacy if there were less than a 7 day supply available in the medication cart. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 11:53, an interview was conducted with RN 1. RN 1 stated that if a medication in the medication cart that has less then a 5 day supply new medication would be ordered for delivery from the pharmacy. RN 1 stated that the pharmacy routinely delivered medications once a day. RN 1 stated that if there was an urgent order a separate delivery from the pharmacy would be made. RN 1 stated urgent orders usually were delivered within the shift that they were ordered. RN 1 stated that back up medications, including prescription medications like narcotics or antibiotics, were stocked in the emergency medication system located in the room behind the nurses station. RN 1 stated that if an ordered medication could not be located in the medication cart or the emergency medication system the nurse should chart that the medication was unavailable; notify the provider for new orders; notify nursing management; and attempt to obtain the out of stock medication by requesting an urgent delivery from the pharmacy. A review was made of the Agency Nurse Binder located at the nurses station. The steps for unavailable medications during normal business hours were listed as follows: Call pharmacy for delivery, if late get from ekit [emergency kit], if not in ekit call pharmacy for emergency delivery, if not obtained timely notify MD [Medical Director] and ask for orders/instructions. If a medication was not available in normal business hours the following steps should be taken: Get med from ekit, if not in ekit call on call pharmacist. If emergency delivery is not available contact MD to obtain orders/instructions. Further guidelines provided were: Do not just document that the medication is unavailable - document the steps you are taking to get it.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review, the facility did not ensure that residents were free from significant medication errors. Specifically, for 3 out of 27 sampled residents, a dialysis resident did not receive his phosphate binding medication with meals as ordered, a resident with a chronic wound and osteomyelitis did not receive his scheduled intravenous (IV) antibiotic medication as ordered, and a resident's seizure medication was not held when ordered by the provider. Resident identifiers: 11, 21, and 41. Findings included: 1. Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which consisted of end stage renal disease, dependence on renal dialysis, edema, renal osteodystrophy, and posthemorrhagic anemia. On 3/3/25 at 12:05 PM, an interview was conducted with resident 21. Resident 21 stated that he was having a problem getting his medication on time. Resident 21 stated that his phosphorus binder medication needed to be taken with meals or at the latest 30 minutes after meals. Resident 21 stated that he was receiving the medication an hour to an hour and a half late or sometimes not at all. Resident 21 stated that he would ask the Certified Nursing Assistants to tell the nurse that he needed his medication and the nurse would not come to administer it. Resident 21 stated that this happened frequently. Resident 21 stated that he reported the problem to the Director of Nursing (DON). Resident 21 stated that the DON stated that she had put in the computer that his medication was a priority and should be administered first. Resident 21 stated that it flagged in the electronic medical records as red to draw attention to the nurses. Resident 21 stated that this change was done two weeks ago and there had been no real change since then. Resident 21 stated that he had the dialysis center and the dietician talk to the facility about the timing of his medication. Resident 21 stated that the problem was having so many agency nurses who did not know what needed to be done. Resident 21 stated sometimes he had a nurse that was on top of it but a lot of times it did not happen. Resident 21's medical record was reviewed. On 2/3/25, an order was initiated for Auryxia Oral Tablet 1 GM [gram] 210 MG [milligram] (Iron) (Ferric Citrate), give 2 tablet by mouth before meals for end stage renal disease (ESRD) with meals. On 2/3/25, an order was initiated to administer all medications before dialysis on Monday, Wednesday, and Friday. The Medication Administration Record (MAR) documented the Auryxia medication administration times were scheduled at 7:30 AM, 11:30 AM, and 4:30 PM. Resident 21's February and March 2025 MAR documented the following administration times for the Auryxia: a. On 2/20/25 at 10:03 AM, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 2/22/25 at 4:06 PM, c. On 2/25/25 at 3:32 PM, d. On 2/26/25 at 4:15 PM, e. On 2/27/25 at 9:38 AM, f. On 2/28/25 at 5:44 AM, g. On 2/28/25 at 4:30 PM, h. On 3/1/25 at 5:21 AM, i. On 3/1/25 at 3:48 PM, j. On 3/2/25 at 9:59 AM, k. On 3/2/25 at 3:46 PM, l. On 3/3/25 at 6:25 AM, and m. On 3/4/25 at 10:03 AM. It should be noted that the medication administration times were not done in conjunction with scheduled meal times. Meal schedule times posted in the dining room documented the following for meal service: Breakfast dining room [ROOM NUMBER]:00 AM - 8:45 AM Breakfast hall carts 8:15 AM - 9:00 AM Lunch dining room [ROOM NUMBER]:00 PM - 12:45 PM Lunch hall carts 12:15 PM - 1:00 PM Dinner dining room [ROOM NUMBER]:00 PM - 5:45 PM Dinner hall carts 5:15 PM - 6:00 PM Resident 21's progress notes documented: a. On 2/15/25 at 11:17 AM, the Orders - Administration Note documented that the Auryxia was not administered due to too close to next dose. b. On 2/18/25 at 3:23 PM, the Orders - Administration Note documented that the Auryxia was not administered due to missed dose. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 2/19/25 at 10:18 AM, the Orders - Administration Note documented that the Auryxia was not administered due to pt [patient] at dialysis. d. On 2/19/25 at 12:20 PM, the Orders - Administration Note documented that the Auryxia was not administered due to pt at dialysis. e. On 2/20/25 at 1:38 PM, the Orders - Administration Note documented that the Auryxia was not administered due to Pt off site at an appt. [appointment] f. On 2/21/25 at 8:11 PM, the Orders - Administration Note documented that the Auryxia was not administered due to pt at dialysis. g. On 2/21/25 at 12:22 PM, the Orders - Administration Note documented that the Auryxia was not administered due to pt at dialysis. h. On 2/23/25 at 5:35 PM, the Orders - Administration Note documented that the Auryxia was not administered due to medication was not found in medication cart. It should be noted that the MAR documented a check mark indicating administered at 4:30 PM, and also documented a code 11 which meant medication was not available at the same time. i. On 2/26/25 at 6:53 AM, the Orders - Administration Note documented that the Auryxia was not administered due to pt at dialysis. j. On 2/26/25 at 10:16 AM, the Orders - Administration Note documented that the Auryxia was not administered due to pt at dialysis. k. On 3/4/25 at 5:56 AM, the Orders - Administration Note documented that the Auryxia was not administered due to not available will administer when available. On 3/4/25 at 2:02 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated she located two Auryxia medication bottles in the medication cart. One bottle had nine tablets remaining and the other bottle was full. RN 3 stated that one bottle had a fill date of 12/20/24, and the second bottle had a fill date of 10/31/25. RN 3 stated that the medication was highlighted in green in the electronic MAR and that meant something had been charted on that medication such as given or refused. RN 3 stated that the medication was scheduled to be administered 30 minutes before meals at 6:00 AM, 10:00 AM, and 4:00 PM. On 3/4/25 at 3:32 PM, an interview was conducted with the DON. The DON stated that she was aware of resident 21's concern with his Auryxia administration. The DON stated that on 2/22/25, she updated the nurse report sheet to indicate that the resident should get his medication first before meals. His medications were moved from the general medication room into the medication cart and was labeled on top of the bottle. The DON stated that they updated the narcotic book to speed up the count time at shift change to minimize delays for the oncoming nurse. The DON stated that resident 21's medication administration time was moved to 5:00 AM, to administer first before he went to breakfast. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/5/25 at 12:24 PM, a follow-up interview was conducted with resident 21. Resident 21 was on his way to the dining room for lunch. Resident 21 stated that he had not yet received his Auryxia medication. At 1:19 PM, resident 21 was observed taking his Auryxia medication. Resident 21 stated that the nurse did not know he was back from dialysis and he had to go ask her for the medication. Resident 21 stated that he finished lunch at about 1:00 PM. On 3/6/25 at 9:04 AM, a follow-up interview was conducted with the DON. The DON stated that resident 21's dashboard in the electronic medical record documented the Auryxia administration times. The DON stated that she educated the agency nurse yesterday on resident 21's medication needs. The DON stated that the agency nurses should see the medication instructions on the resident dashboard. 2. Resident 41 was admitted to the facility on [DATE] with diagnoses which included polyneuropathy, type 2 diabetes mellitus, osteomyelitis, non-pressure chronic ulcer, gas gangrene, cutaneous abscess of left foot, and cellulitis. On 3/3/25 at 10:22 AM, an interview was conducted with resident 41. Resident 41 stated that the facility did not have enough staff and that he did not receive his IV antibiotics on time. Resident 41's medical record was reviewed. Resident 41's physician orders revealed the following: a. Daptomycin-Sodium Chloride Intravenous Solution 500-0.9 MG/50 milliliters (ml), give 750 mg intravenously every 24 hours for Infection. The medication order documented an administration time of 1:00 PM daily. b. Micafungin Sodium Chloride Intravenous Solution 100-0.9 MG/100 ML, give 100 mg intravenously every 24 hours for infection. The medication order documented an administration time of 10:00 PM. The Medication Administration Record documented that the Daptomycin was administered late on the following days: on 2/13/25 at 3:29 PM, on 2/18/25 at 4:01 PM, on 2/22/25 at 2:52 PM, and on 2/25/25 at 2:55 PM. The Medication Administration Record documented that the Micafungin was administered late on the following days: on 2/14/25 at 2:38 PM, on 2/16/25 at 2:55 PM, on 2/18/25 at 6:08 PM, on 2/23/25 at 11:48 PM, and on 2/25/25 at 11:43 PM. On 2/10/25, resident 41 had a care plan initiated for .an actual skin impairment/wound tarsometatarsal amputation site to left foot with an intervention to provide treatments as prescribed. On 3/4/25 at 9:08 AM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated that resident 41's Daptomycin was scheduled to be administered every 24 hours at 1:00 PM, and the Micafungin was scheduled every 24 hours at 10:00 PM. RN 3 stated that the medication could be administered 30 minutes before or after the scheduled time and still be considered on time. RN 3 stated that if the antibiotic was not given on time, she would notify the physician. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/25 at 8:39 AM, an interview was conducted withe the DON. The DON stated that the antibiotic could be administered 30 minutes before or 30 minutes after the scheduled time. The DON stated that the physician needed to be notified if the medication was not administered per the ordered schedule. The DON stated that staff should have notified the physician of the delay in treatment. The Corporate Nurse stated that the delayed antibiotic administration should have been entered as a medication error. 33215 3. Resident 11 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, localization-related symptomatic epilepsy and epileptic syndromes and convulsions. Resident 11's medical record was reviewed on 3/4/25 through 3/6/25. On 2/21/25 at 4:00 PM, a Nurses Note documented Note Text: Lacosamide level done yesterday WNL [within normal limits] 11.6, provider reviewed with no new orders at this time. On 2/21/25 at 8:38 PM, a Labs Results Report documented a lacosamide serum level result of 11.6. The reference range on the report was 1.0-10.0. The report flagged the result as High. On 2/23/25 at 9:55 AM, an Orders - Administration Note documented Note Text: LACOSAMIDE 200MG TABLET Give 1 tablet by mouth two times a day for EPILEPSY MEDICATION IS LOCATED IN THE NARCOTIC DRAWER Per Oncall NP [Nurse Practitioner] Hold Lacosamide x [for] 2 doses. The February 2025 MAR was reviewed. It should be noted that the lacosamide was held for one dose on 2/23/25 at 6:00 AM. On 2/24/25 at 12:30 PM, a NP - Senior Health Services note documented . Over the weekend, the patient had a lab draw, and her lacosamide level was elevated. The on-call provider [name redacted was contacted, who ordered for the patient's lacosamide to be held for 2 doses. On review of the patient's level, it was 11, slightly elevated. The patient will resume her lacosamide, as the 2 doses have been held. The patient is stable with no signs or symptoms of toxicity at this time and will restart taking her lacosamide as ordered. On 3/6/25 at 8:06 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated the high lacosamide lab was reported to the facility Medical Director (MD) and the MD did not give orders. LPN 1 stated the night nurse reported the high lacosamide lab to the on call MD and they gave orders to hold the medication for two days. LPN 1 stated when she reported to work the next morning she reported to the MD and he said not to hold the medication and resident 11 was fine. LPN 1 stated they were drawing another lacosamide level today and then a month from now. LPN 1 stated a phlebotomist came to the facility twice a week. LPN 1 stated if the lab was ordered immediately the facility staff would draw the lab. On 3/6/25 at 9:11 AM, a follow up interview was conducted with LPN 1. LPN 1 stated that she would usually call the MD to get a faster response than texting. LPN 1 stated on that day she had called the MD.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, the facility did not file in the resident's clinical record the laboratory reports that were dated and contained the name and address of the testing laboratory. Specifically, for 4 out of 27 sampled residents, the residents did not have laboratory results filed in their medical record. Resident identifiers: 3, 12, 15, and 25. Findings included: 1. Resident 12 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included paraplegia, generalized muscle weakness, neurogenic bladder, and other cystostomy status. On 5/8/24 at 2:45 PM, a nursing note documented, New order to start Levofloxacin 750mg [milligrams] PO [by mouth] Q24h [every 24 hours] x [times] 5 days for UTI [urinary tract infection]. It should be noted that a review of resident 12's medical record revealed that the urinalysis results and urine culture and sensitivity from 5/8/24, were not documented in the medical record. On 3/6/24 at 8:48 AM, an interview was conducted with Assistant Director of Nursing (ADON). The ADON stated that she would ensure a urinalysis was conducted if a resident had a history of UTI's, exhibited symptoms, and had a catheter. The ADON stated she needed to be more vigilant in monitoring such situations and planned to print the lab results, have the nurse practitioner sign them, and submit them to medical records for uploading so they would be properly documented in the resident's chart. On 3/06/25 at 10:28 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she was not able to locate the urinalysis results from 5/8/24 and the results should have been uploaded into the medical record. 38031 2. Resident 3 was admitted to the facility on [DATE] with diagnoses which included quadriplegia Cervical (C) 1-C4 incomplete, neuromuscular dysfunction of the bladder, flaccid neuropathic bladder, and autonomic neuropathy. On 3/5/25, the facility infection control tracking and trending log was reviewed. The December 2024 tracking documented that resident 3 had a urinary tract infection and the organism was Leukocyte esterase. The log documented that the infection was treated with Bactrim double strength (DS) 800-160 mg two times a day. Resident 3's Medication Administration Record documented that Bactrim DS tablet, 800-160 mg by mouth two times a day was administered on 11/26/24 through 11/30/24, and 12/1/24 through 12/4/24, for a total of 18 doses administered. No documentation could be found of a urinalysis with a culture and sensitivity report in resident 3's medical record. (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/25 at 8:21 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated that she obtained a copy of the laboratory result on the lab's website. The IP confirmed that the lab report was not located in resident 3's medical record and that it was missed in the process of uploading the document to the medical record. The IP stated that prior to the new electronic medical records she would obtain the laboratory reports, give them to the provider to sign, and then give them to the medical records to upload into the resident's electronic medical record. 3. Resident 15 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, acute kidney failure, and hypertension. On 3/5/25, the facility infection control tracking and trending log was reviewed. The January 2025 tracking documented that resident 15 had a urinary tract infection and the organism was Klebsiella pneumonia. Resident 15's Medication Administration Record documented that Nitrofurantoin macrocrystal capsule 100 mg by mouth two times a day for a urinary tract infection was administered on 1/9/25 through 1/18/25, for a total of 20 doses administered. No documentation could be found of a urinalysis with a culture and sensitivity report in resident 15's medical record. On 3/5/25 at 3:58 PM, an interview was conducted with the IP. The IP stated that she had just received a faxed copy of the laboratory results for resident 15's urinalysis with a culture and sensitivity report. The IP confirmed that the laboratory report was not located in resident 15's medical record. 47431 4. Resident 25 was admitted to the facility on [DATE] with diagnoses which included Osteomyelitis of vertebra, methicillin resistant staphylococcus aureus infection, paraplegia, and encephalopathy. Resident 25's medical record was reviewed on 3/3/25 through 3/6/25. On 1/20/25 at 6:52 PM, a nursing progress note revealed the following. New order received to collect routine stool sample and send it to be tested for Clostridioides difficile. It should be noted that no laboratory results could be located in the medical record. On 1/27/25 at 1:37 PM, a nursing progress note revealed the following. Face sheet and prerequisite lab work filled out to be drawn on 1/28/25. Lab work to be completed included a comprehensive metabolic panel, Complete Blood Count with differential (CBC w/diff), Creatine Kinase, and C-Reactive Protein. It should be noted that no laboratory results could be located in the medical record. On 1/28/25 at 6:27 PM, a nursing progress note revealed the following. On call provider notified of labs, new order for urgent (STAT) CBC w/diff. (continued on next page)

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It should be noted that no STAT laboratory results could be located in the medical record. On 3/6/25 at 12:37 PM, an interview with the ADON was conducted. The ADON stated that she needed to call the central lab to get the lab results for 1/20/25 and 1/28/25. The ADON stated that she was unable to find the labs on the medical record. The ADON stated the lab results were not in the medical record.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 50200 Based on observation, interview, and record review, the facility did not follow menus that met the nutritional needs of residents in accordance with established national guidelines. Specifically, correct portion sizes were not provided to residents. Findings included: On 3/5/25 at 12:28 PM, an observation was made of lunch being plated. The cook in training was observed to pick up two pieces of meat, potatoes, Brussels sprouts, and pour gravy over the meat and potatoes with a ladle. It should be noted that the meat, Brussels sprouts, and potatoes were being picked up with tongs and placed on plates. No measurement scoops were observed to be used. On 3/5/25 at 12:42 PM, an interview was conducted with the cook in training. The cook in training stated that she tried to give all the residents an even amount of food in order to fill the plate. On 3/5/25 at 1:50 PM, a review of the menu daily spreadsheet revealed the portion sizes for the lunch meal were: a. [NAME] Pot Roast: 3 ounces for regular portion and 4 ounces for large portion. b. Roasted Yukon Potatoes: #8 scoop (4 ounces) regular potion and #6 scoop (5.3 ounces) large portion. c. Fresh Brussels Sprouts with Bacon: #8 scoop (4 ounces) regular portion and #6 scoop (5.3 ounces) large portion. d. Yukon Gold Mashed Potatoes: #8 scoop (4 ounces) and Gravy 1 ounce. It should be noted that the Yukon Gold mashed potatoes were served with an ice cream scoop that was 2.3 ounces, the gravy was served with a ladle that was 2 ounces, the Brussels sprouts, potatoes, and pot roast were not measured. On 3/6/25 at 9:10 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that the cook in training became flustered during lunch service yesterday and used the wrong serving scoops. The DM stated the cook in training was new to the role. The DM stated that the lunch meal should have been served using correct scoops to ensure residents received the appropriate portion sizes according to the menu. The DM stated that the pot roast had not been measured before serving because it was a crumbly texture and it made it difficult to portion accurately. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/25 at 9:35 AM, an interview was conducted with the Registered Dietitian (RD). The RD stated that the resident menus included specific portion sizes and should be followed using standardized spoons and ladles. The RD stated that the menus were designed to ensure residents received their daily nutritional requirements. The RD stated that failing to follow the menus could negatively impact residents' health. On 3/6/25 at 10:32 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she expected the kitchen staff to follow the menus correctly.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50200 Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, there was undated food in the refrigerator and freezer, the dietary manager was not wearing a hair net, and the dish machine and sanitizer buckets were not testing at the required levels. Findings included: On 3/3/25 at 8:04 AM, an initial tour of the kitchen was conducted. The following observations were made: a. There was a jar of mayonnaise opened in the refrigerator but without an opened date. b. There was a box of green peppers in the refrigerator that were not labeled or dated. c. There was an opened whipped topping in the refrigerator without an opened date. d. There was a box of opened sausage links in the refrigerator without an opened date. e. There was a box of lettuce in the refrigerator without an opened date. f. There was an opened container of filled churros in the freezer without an opened date. g. There was a box of donuts, open to air, in the freezer without an opened date. h. There was a box of opened pork egg rolls in the freezer without an opened date. i. There was a container of opened ice cream that was undated. j. The Dietary Manager (DM) was inside the kitchen without a hairnet. On 3/3/25 at 8:19 AM, during the initial tour the chemical dish machine was observed. The DM stated that the dish machine was tested this morning. The DM was observed to run a dish cycle and used a chemical strip to check the amount of sanitizer. The strip was observed to not change color. On 3/3/25 at 8:25 AM, an observation was made of the DM running another cycle in the chemical dish machine. The DM was observed to use the sanitizer strips to check the amount of sanitizer. The strip was observed to not change color. The DM stated that the chemicals were not sanitizing and she would have to get the dish machine serviced. The DM stated that the kitchen would not wash dishes until the dish machine was serviced. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/3/25 at 8:33 AM, during the initial tour the sanitizer buckets were observed. The DM stated that the sanitizer was changed three times a day-before breakfast, lunch, and dinner. The DM was observed to use the sanitizer strips to check the amount of sanitizer. The strip was observed to not change color. The DM stated that there was not enough sanitizer in the bucket and she should let the chemicals run more into the bucket. The DM stated that there needed to be over 200 parts per million (PPM) to effectively sanitize. On 3/5/25 at 8:40 AM, a follow up tour was conducted. The following was observed: a. There was an opened box of frozen filled churros without an opened date. b. There was an opened box of frozen rolls without an opened date. On 3/5/25 at 8:44 AM, the facility dish machine was observed. The DM was observed to run the dish machine and the sanitizer solution was tested with test strips. The sanitizer test strip changed to a deep purple and read at 100 PPM. The DM stated that the dish machine was serviced on 3/3/25 and 3/4/25. On 3/5/25 at 8:47 AM, the facility sanitizer buckets were observed. The DM was observed to dip a sanitizer strip into the bucket. The DM stated that the sanitizer strip read 300 PPM and this was too high. The DM stated there were too many chemicals in the sanitizer bucket and she would have to consult with the Registered Dietitian (RD) on how to remedy this. The DM stated if the sanitizer chemicals were too high, the chemicals would stay on the dishes and come off in the resident's mouth. The DM stated that this was dangerous to the residents. On 3/5/25 at 8:48 AM, a follow-up interview was conducted with the DM. The DM stated that all items should be labeled and dated in the refrigerator and in the freezer. The DM stated that fresh produce should be used within three days. The DM stated that she had thrown out all the undated and opened food. On 3/5/25 at 9:05 AM, an additional interview was conducted with the DM. The DM stated that for the sanitizer buckets that have too much sanitizer, she would need to add water and then keep testing the sanitizer until it reached the correct chemical amount. On 3/6/25 at 9:35 AM, an interview was conducted with the RD. The RD stated that a service company serviced the dishwasher on 3/3/25 and 3/4/25, and the sanitizing issue should now be resolved. The RD stated that if the sanitizer buckets showed a sanitizer level that was too high, staff should add water to dilute the chemicals and continue testing until the correct PPM was reached. The RD stated that if residents were served dishes with excessive sanitizer residue, there was a risk that it could contaminate the food and potentially cause gastrointestinal issues. The RD stated that all staff should wear hairnets while in the kitchen and that all food stored in the refrigerator and freezer should be properly labeled and dated. On 3/6/25 at 10:32 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that all kitchen staff were required to wear proper head coverings and follow the facility's kitchen policy. The DON stated that the DM was responsible for ensuring all food items were properly labeled and dated.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on interview and record review, the facility did not have an infection prevention and control program that included a system to monitor antibiotic use for the antibiotic stewardship program. Specifically, for 1 out of 27 sampled residents, a resident's urinalysis and urine culture and sensitivity was not completed. Resident identifier: 12. Findings included: Resident 12 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, paraplegia, neurogenic bladder, and neuromuscular dysfunction of bladder. Resident 12's medical record was reviewed on 3/3/25 through 3/6/25. A review of resident 12's progress notes revealed the following: a. On 11/4/24 at 6:43 AM, a physician progress note documented, . [resident 12] presents with a suspected urinary tract infection (UTI). She reports experiencing backache, stomachache, and headache, which she believes are typical symptoms of a UTI for her, patient is a quadriplegic and cannot feel dysuria. [Resident 12] also mentions feeling cold and unwell. She reports having fever and chills, but states she has been taking Tylenol, which may be masking the fevers. [Resident 12] has a cough but denies any congestion. She is concerned about the possibility of having the flu or another viral infection in addition to the UTI. The patient has previously been treated with Levaquin for UTIs and has responded well to it. She expresses a preference for receiving Levaquin without a urinalysis .-Plan: Prescribe Levaquin as the patient has had a positive response to this medication in the past. No need for a urinalysis at this time as the patient prefers to proceed with the antibiotic treatment. b. On 11/4/24 at 2:33 PM, a nursing note documented, [resident 12] c/o [complaining of] UTI like symptoms. Fever, chills, body aches. Reported to NP [Nurse Practitioner]. New order received to give Levaquin 250 mg [milligrams] PO [by mouth] q [every] 24 hours x [times] 5 days for UTI symptoms. RP [responsible party] aware of new order. It should be noted that a urinalysis culture and sensitivity dated 9/18/24 showed resident 12 grew bacteria that was resistant to Levaquin. On 3/4/25 at 1:34 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility had an infection preventionist responsible for overseeing all aspects of antibiotic stewardship. The DON stated that nurses were required to notify the medical doctor if a resident began showing signs of a suspected UTI. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 2:09 PM, an interview was conducted with the NP. The NP stated that resident 12 had a history of frequent UTIs and had a suprapubic catheter. The NP stated that he used McGreer's criteria to determine the appropriate treatment for infections. The NP stated he did not recall specific details from November but remembered possibly prescribing an antibiotic once without obtaining a urinalysis or urine culture. The NP stated that he typically ordered a urinalysis and culture for resident 12 to identify the specific bacteria and ensure the correct antibiotic was prescribed. On 3/6/24 at 8:48 AM, an interview was conducted with the Infection Preventionist (IP). The IP stated that resident 12 had gentamycin flushes but inconsistently accepted them. Sometimes, she allowed certain nurses to administer the flushes, while other times, she refused. The IP stated that if a resident showed symptoms of a urinary tract infection, staff needed to notify the doctor, who typically ordered a urinalysis and sometimes prescribed a broad-spectrum antibiotic. The IP stated if residents exhibited minimal symptoms, the doctor usually waited for urine culture results before prescribing antibiotics. The IP stated that she would always get a urinalysis done for residents with a history of UTIs, had urinary symptoms, or had a urinary catheter. The IP stated that she needed to be more vigilant about monitoring these cases. The IP stated she had some ongoing challenges with lab reports being faxed to the facility, causing confusion for both her and the NP. The IP stated that to address this issue, she planned to send a text to the NP to ensure lab results were reviewed while also documenting a note in the resident's chart about the labs and their results. The IP stated that prescribing antibiotics without a urinalysis or culture testing contributed to the development of antibiotic-resistant superbugs. The IP stated if a resident was given an antibiotic they were resistant to, it would not be effective, which posed a serious concern to the resident's health.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38031 Based on interview and record review, the facility did not ensure that each resident was offered the influenza and pneumococcal immunizations, had the opportunity to refuse the immunizations, and that the documentation indicated that the resident was offered education about the benefits and potential side effects of the immunizations and either received or declined the immunization. Specifically, for 2 out of 5 sampled residents, a resident had a signed consent form for the pneumococcal vaccine but the form did not contain any other documentation, and a resident had a signed consent form for the pneumococcal vaccine that indicated he wished to receive the vaccine but no other documentation was contained on the form. Resident identifiers: 19 and 28. Findings included: 1. Resident 19 was admitted to the facility on [DATE] with diagnoses which consisted of quadriplegia, type 2 diabetes mellitus, dysphagia, anemia, antiphospholipid syndrome, pressure ulcer of right buttocks, and hypertension. On 3/5/25, resident 19's medical record was reviewed. On 8/29/24, resident 19 signed the Pneumococcal vaccine form and gave consent to receive the vaccine. The form did not document if the vaccine was administered, the location of administration, the lot number of the vial of the vaccine, or the date of administration. 2. Resident 28 was admitted to the facility on [DATE] with diagnoses which consisted of osteomyelitis, type 2 diabetes mellitus, polyneuropathy, anemia, hypothyroidism, and pain. On 3/5/25, resident 28's medical record was reviewed. On 2/7/25, resident 28's Pneumococcal vaccine consent form contained the residents signature. The form did not document if the resident gave consent or declined the vaccination. No other information was documented on the form. On 3/6/25 at 9:10 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that for immunization administration the nurse should document the date, medication, time, manufacturer, lot number, and location of administration. On 3/6/25 at 11:38 AM, an interview was conducted with the Corporate Nurse (CN). The CN stated that resident 19 consented to the pneumococcal vaccine but they did not have any documentation of it being administered. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedures for Infection Prevention and Control Program documented under Influenza and Pneumococcal Immunizations that residents would be offered the vaccines each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. The policy stated that residents would be provided education on the benefits and potential side effects of the immunizations, have the opportunity to refuse the immunization, and the documentation would reflect that the education was provided and whether or not the resident received the immunization. The policy was last revised on 1/12/24.