STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465129	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Maple Dell	55 South Professional Way Payson, UT 84651

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #2) was free from significant medication errors for one of 12 residents sampled for medication administration. Specifically, Resident #2 was inadvertently administered 13 medications intended for their roommate, including high-risk antihypertensives and antidiabetics, resulting in hypoglycemia, hypotension, and the need for acute hospitalization.The facility's noncompliance was determined to be Past Noncompliance. The facility developed and implemented a corrective action plan which was completed and verified by March 28, 2026.Resident #2 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Dementia, and Hypertension.A review of a Nurses Note dated March 16, 2026, at 1:31 PM, revealed that at approximately 9:00 AM, Resident #2 was administered a complete medication pass intended for their roommate. The medications administered in error included, but were not limited to:Amlodipine 5 mg (Antihypertensive)Furosemide 40 mg (Diuretic/Antihypertensive)Clonidine 0.2 mg (Antihypertensive)Metformin 1000 mg (Antidiabetic)Glimepiride 4 mg (Antidiabetic)Saxagliptin 5 mg (Antidiabetic)Apixaban 5 mg (Anticoagulant)Lyrica 300 mg (Neuropathic/Anticonvulsant)A Nurses Note dated March 16, 2026, at 1:03 PM, documented that following the error, Resident #2's blood glucose dropped from 138 mg/dL to 87 mg/dL. The resident's blood pressure dropped to a critical level of 67/48 mmHg. The resident was documented as sleepy but arousable only with painful stimuli.Review of Hospital Discharge Summaries dated March 18, 2026, indicated Resident #2 required a three-day hospitalization (March 16-18) for Toxic Encephalopathy and Hypotension due to accidental drug overdose and hypoglycemia.During an interview on May 4, 2026, at 2:51 PM, the Assistant Director of Nursing (ADON) confirmed that Resident #2 received the roommate's medications because the room assignments listed on the nursing report sheet were incorrect. The ADON confirmed that an agency nurse performed the administration without verifying the resident's identity against the Medication Administration Record (MAR).Past Noncompliance (PNC) Justification:The facility's failure to ensure a resident was free from significant medication errors resulted in Actual Harm (Scope/Severity: G). However, the facility met the criteria for Past Noncompliance as the following corrective actions were implemented and validated by March 28, 2026:Immediate Protection: The agency nurse involved was removed from the facility schedule and is no longer permitted to provide care at the location.Root Cause Analysis/Systemic Correction: The facility identified that the Nurse Report Sheets contained inaccurate room numbers. All report sheets were audited and corrected to ensure accurate resident location identification.Education: All licensed nursing staff (including internal and agency) received re-education on the Six Rights of Medication Administration, specifically emphasizing resident identification.Monitoring/Auditing: * The facility conducted an internal medication administration audit for all current nursing staff.An external pharmacy consultant was contracted to perform a secondary independent audit of medication passes to ensure systemic compliance.Because the facility identified the deficiency, implemented a plan to prevent recurrence, and internal monitoring showed the plan was effective prior to the start of the survey, this citation is documented as Past Noncompliance.

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