

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Rocky Mountain Care - the Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 544 East 1200 South Heber City, UT 84032	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470</p> <p>Based on interview and record review, it was determined that the facility did not ensure, for 1 of 17 sampled residents, that residents received treatment and care in accordance with professional standards of practice. Specifically, the facility did not conduct wound care orders at prescribed by the physician. Resident identifier: 2.</p> <p>Findings Include:</p> <p>1. Resident 2 was admitted to the facility on [DATE] following surgical repair of a fractured ankle.</p> <p>On March 18, 2025, the surveyor completed a review of Resident 2's medical record and the following entries were observed:</p> <p>Resident 2 had a wound care order that started on October 24, 2024 and was discontinued on November 1, 2024. The order had instructions to complete wound care to the right ankle on Mondays, Wednesdays, and Fridays.</p> <p>Resident 2's Medication Administration Record (MAR) revealed that the wound care order was not completed on October 25, 2024 with a note from the nurse that stated, Resident Unavailable.</p> <p>Resident 2 had a wound care order that started on November 1, 2024 and was discontinued November 12, 2024. The order had instructions to complete wound care to the right foot once a day and as needed.</p> <p>Resident 2's MAR revealed the wound care order was not completed on November 7, 2024 with a note from the nurse that stated, Could not track down resident while they were not busy.</p> <p>The surveyor reviewed the facility's Wound Treatment Management Policy. The policy stated, Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.</p> <p>On March 17, 2025, Admin 1 communicated with the surveyor via email that if the resident was unavailable for wound care, the order should be passed on to the next shift, and the physician should be notified. Follow-up actions for the missed wound care orders for Resident 2 were not carried out in accordance with the facility's policy.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45490</p> <p>Based on interview and record review, the facility did not ensure residents were free of significant medication errors. Specifically, for 1 of 17 sampled residents, multiple doses of medications, including antibiotics and insulin, were not administered as ordered by the physician. Resident identifier: 9.</p> <p>Findings included:</p> <p>Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis which included type 1 diabetes mellitus and hypertension.</p> <p>The surveyor reviewed Resident 9's October 2024 and November 2024 Medication Administration Record (MAR). The MAR revealed Resident 9 was scheduled to receive multiple medications, including medications for hypertension (Amlodipine and Losartain-Hydrochlorothiazide), an antibiotic (Ciprofloxacin), and insulin (Lispro and Lantus). The following medications were observed by the surveyor as not administered per the MAR:</p> <p>In October 2024, the resident did not receive 4 of 13 scheduled doses of Ciprofloxacin.</p> <p>In November 2024 the resident did not receive 3 of 30 doses of amlodipine, 5 of 30 doses of the once a day insulin lispro, 4 of 30 doses of the before meals and bedtime insulin lispro, 5 of 30 doses of Lantus, and 2 of 30 doses of losartain-hydrochlorothiazide.</p> <p>These medications were noted to have been unavailable, or the resident was unavailable and were not administered according to the prescribing order for the number of doses listed above.</p> <p>A review of the Unavailable Medications policy revealed staff should notify the physician and obtain alternative treatment orders when a medication was unavailable for administration or was not given. Follow-up actions for the missed and unavailable medications for Resident 9 were not carried out in accordance with the facility's policy.</p> <p>On March 17, 2025, in an email communication with Admin 1, they were unable to explain why the missed medications for Resident 9 were marked as unavailable on multiple dates in October and November 2024. Admin 1 stated that medications should not be marked as unavailable without follow-up actions.</p>		