

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 06/04/2026
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)		
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Specifically, for 4 of 36 sampled residents, a resident's skin condition was not evaluated and treated, a resident had wound care provided without orders, a resident was hospitalized and no documentation was found of the resident's change in condition, and a resident expired at the facility and no documentation could be found of the resident's change in condition. Resident identifiers: 9, 59, 61, and 62. Findings included: 1. Resident 9 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, cerebral infarction, morbid obesity, type 2 diabetes mellitus, fracture of right toe and non-pressure injury of left foot. On [DATE] at 1:09 PM, an interview was conducted with resident 9. Resident 9 stated that he skinned his toes. Resident 9 stated that sometimes the staff wrapped the toes when they bled and put salve on the wounds, and this was approximately every 3-4 days. Resident 9 stated that the wounds had never healed. Resident 9's bilateral feet were observed with open wounds on the second toe of each foot. Both toes were observed with dried blood on the wounds. Resident 9 had a physician order for WOUND CARE: Abrasion to Left Second Toe: Remove dressing. Cleanse wound. Apply skin prep to periwound. Apply hydrogel to wound bed. Cover with border dressing one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for Wound care AND as needed for Wound Care. The order was initiated on [DATE]. Resident 9's progress notes revealed the following: a. On [DATE] at 11:40 PM, the Skin Check documented, . New skin Issue. Location: Right Dorsum 2nd Digit (Second toe) Issue type: Laceration. Progress: New: new wound. Wound acquired in-house. Wound is new. Incision approximated: Yes. Closure method: Sutures. # of Sutures: 4 . Measurements not documented as part of this assessment. Reason measurements not documented as part of this assessment: unable to measure, wrapped from ER [emergency room]. b. On [DATE] at 2:31 PM, the Skin Check documented, Skin issue has not been evaluated. Location: Right Dorsum 2nd Digit (Second toe) Issue type: Laceration. Wound acquired in-house. Wound is new. c. On [DATE] at 2:46 PM, the Skin check documented, Skin issue has not been evaluated. Location: Right Dorsum 2nd Digit (Second toe) Issue type: Laceration. Wound acquired in-house. Wound is new. d. On [DATE] at 11:15 AM, the Skin Check documented, Skin issue is resolved. Location: Right Dorsum 2nd Digit (Second toe) Progress: Resolved: Wound healed and / or closed. e. On [DATE] at 12:25 PM, the Skin Check documented, New skin Issue. Location: Left Dorsum 2nd Digit (Toe). Issue type: Abrasion. Progress: Improving: overall wound characteristics improved. Wound acquired in-house. f. On [DATE] at 2:34 PM, the Nurse Note documented, Right toe assessed with purulent drainage present. Resident unsure when condition began. Wound cleansed and antiseptic applied per protocol. Provider notified; podiatry referral requested for further evaluation. g. On [DATE] at 2:37 PM, the Skin Check documented, New (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 0684 Level of Harm - Actual harm Residents Affected - Few	skin Issue. Location: Right Dorsum 1st Digit (Hallux). Issue type: Open lesion. Progress: New: new wound. Wound acquired in-house. It is unknown how long the wound has been present. Signs and symptoms of infection: Erythema/edema. Signs and symptoms of infection: Red and bleeding surface or granulation tissue. h. On [DATE] at 5:40 PM the Skin Check documented, Skin issue has not been evaluated. Location: Right Dorsum 1st Digit (Hallux). Issue type: Open lesion. Wound acquired in-house. It is unknown how long the wound has been present. i. On [DATE] at 10:09 AM, the Skin Check documented, Skin issue has not been evaluated. Location: Right Dorsum 1st Digit (Hallux). Issue type: Open lesion. Wound acquired in-house. It is unknown how long the wound has been present. On [DATE], the hospital history and physical records documented a laceration of the right little toe after resident 9 fell out of bed. The resident had a laceration repair conducted to the 1 centimeter laceration at the base of the right little toe. The repair included 4 sutures to close the laceration. It should be noted that the suture repair to the laceration was on the fifth metatarsal and not the second metatarsal as documented in the progress note. Resident 9's care plan focus area for at risk for alteration to skin integrity was initiated on [DATE]. The care plan had an intervention for weekly skin check per facility schedule and to notify the provider of any alterations for prompt/proper interventions. On [DATE] at 8:57 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she was the wound care nurse. The ADON stated that nursing staff conducted weekly skin checks and she looked through those notes daily to identify any new skin issues. The ADON stated that if a concern was not on the skin check the staff would message her on tiger text and send a secure photo of the wound for her evaluation. The ADON stated that resident 9 had abrasions on his left toes and they were doing wound care with hydrogel. The ADON stated she was not aware of the right second toe's abrasion. The ADON stated that she should have been notified of the wound on the right foot so that she could evaluate it. The ADON stated that she had wound care standing orders for an abrasion and she would evaluate the wound with the provider on the next wound care day. The ADON stated that the wound on the right second toe was first identified on [DATE]. The ADON confirmed that the wound did not have wound care orders and had not been evaluated by herself or the provider. On [DATE] at 12:41 PM, a follow-up interview was conducted with the ADON. The ADON stated that she went and assessed resident 9's right foot wound. The ADON stated that she put orders in for wound care for the right foot and was waiting to hear back from the provider. The ADON stated that she assessed a wound on the second digit of resident 9's right foot. The ADON stated that she did not measure the wound, and that she typically obtained measurements but had forgotten on this occasion. The ADON stated that she cleaned the wound with wound cleaner and applied a bordered foam dressing. The ADON stated that she was waiting to hear from the provider about new orders. The ADON stated that resident 9's left foot had scattered scabbing along all of the toes of the foot. The ADON stated that she was not notified of the wound on the second toe of the right foot and she should have been informed of the wound. 2. Resident 59 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, type 2 diabetes mellitus, acquired absence of the right and left leg above the knee, infection of left amputation stump, and chronic pain. On [DATE] at 1:02 PM, an interview was conducted with resident 59. Resident 59 stated that she had pain in the right stump and that there was a wound there. Resident 59 stated that the wound was not open and they did not do a dressing change on it. Resident 59 stated that the wound on the right stump had been present for approximately 1.5 weeks. Resident 59 had a physician order for L [left] stump: Cleanse with NS [normal saline]. Apply silver alginate to wound bed. Cover with bordered dressing. every day shift every Mon, Wed , Fri . The order was initiated on [DATE]. On [DATE] at 12:15 PM the Nurse Practitioner note documented, .Infection of amputation stump, right (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	the change of condition assessment, and notified the family and provider. The DON stated the change of condition should be passed on during the nurse to nurse report. The DON stated the change in condition should be documented and include labs or whatever the provider ordered. The DON stated there was alert and change in condition charting that should be initiated in the resident's electronic medical record. The DON stated resident 61 was transferred to the hospital and she did not know why resident 61 did not return. The DON stated nurses were expected to document when there was a change in condition and resident 61 refusing medication with nausea and vomiting was a change in condition. The DON stated the change of condition assessment and alert charting should have been completed.		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for 2 of 36 sampled residents, the facility did not provide each resident assisted nutrition to maintain acceptable parameters of nutritional status. In addition, a resident was not offered a therapeutic diet when there was a nutritional problem. Specifically, a resident who was provided a tube feeding lost a significant amount of weight when the tube feeding was discontinued for 5 days and her oral intake was not meeting her nutritional needs. This example will be cited as a harm. In addition, a resident with a high potassium was not provided low potassium foods when the dialysis center ordered it. Resident identifiers: 6 and 13. Findings included:1. Resident 13 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, severe protein-calorie malnutrition, alcohol induced chronic pancreatitis, thyrotoxicosis, disorders of electrolyte and fluid balance, peptic ulcer, diverticulosis of intestine, irritable bowel syndrome, alcohol hepatitis without ascites, dysphagia, and abnormal levels of other serum enzymes. On 6/2/26 at 8:41 AM, an interview was conducted with resident 13. Resident 13 was observed to have a nasogastric (NG) tube in place and tube feed supplies in her room. Resident 13 was not hooked up to the tube feed and had just returned from breakfast in the main dining area. Resident 13 stated the staff did a good job but they harped on her that she was not doing enough or eating enough. Resident 13 stated that she was below weight and she tried to eat breakfast that morning. Resident 13 stated that she tried to mix it up with dry cereal instead of eggs and sausage and she felt that she did pretty well. Resident 13 stated that her tube feed usually ran all the time. A care plan Focus initiated on 5/21/26, documented [resident 13] requires a feeding tube which places them at risk for nutritional deficits and other medical complications. The interventions initiated on 5/21/26, included, Dietitian/Nutritional evaluation and treatment, as needed. Elevate head of bed at least 30 degrees while the feeding tube was running and for at least 30 minutes after. Enhanced barrier precautions. Ensure supplies, formula, and tubing are changed, as prescribed. Ensure tube placement, as prescribed. Evaluate for signs and symptoms of aspiration, and notify physicians of positive signs or symptoms. Obtain and monitor lab/diagnostic work as prescribed. Report results to the Medical Director and follow up as indicated. Tube feeding insertion site cares, as prescribed. Notify physicians with positive signs or symptoms of complications. On 5/21/26, resident 13 weighed 106.2 pounds (lbs). On 5/26/26, resident 13 weighed 101.6 lbs which was a -4.33% weight loss in five days. On 5/20/26 at 5:05 PM, an Order Note documented The order you have entered Fibersource HN [high nitrogen] Enteral Liquid Give 1080 ml [milliliters] via NJ [nasojejunal]-Tube every shift for nutrition supplement for 5 Days Run at 45mL/hr [milliliters per hour] for 24 hours. The physician order was discontinued on 5/25/26. On 5/21/26 at 1:18 AM, an Orders - Administration Note documented Fibersource HN Enteral Liquid Give 1080 ml via NJ-Tube every shift for nutrition supplement for 5 Days Run at 45mL/hr for 24 hours. notified on call nurse manager [name omitted] regarding the flush order. ordered to hold enteral feed till AM shift. It should be noted that the Fibersource was not held. On 5/21/26 at 5:28 PM, a Nutritional Evaluation documented an ideal weight range of 119 to 130 lbs. Dietary related medications included mirtazapine. Dietary intervention included recommending Med Pass three times a day for low body mass index, body weight, and low intake. It should be noted that the Med Pass was not implemented and the mirtazapine was not implemented until 5/27/26. A physician order with a start date of 5/27/26, documented Mirtazapine Oral Tablet 15 MG [milligrams] (Mirtazapine) Give 1 tablet by mouth one time a day for appetite stimulant. The order was discontinued on 5/28/26. A physician order with a start date of 5/29/26, documented Mirtazapine (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Oral Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth one time a day for appetite stimulant. On 5/30/26 at 7:00 AM, a Provider note documented . She was seen today for rehab followup visit and is concerned about losing weight. Reviewed her vitals; everything looks fine except her weight was 101.6 lbs today, down from 106.2 lbs on 5/21. Patient says she has been eating okay but does not have a really good appetite, though she does have an NG tube feeding in place. The nurse was looking for an order to continue the feeding. On 5/30/26 at 6:46 PM, an Orders - Administration Note documented Enteral Feed Order every shift Enteral: Continuous Feed: Check every 4-6 hours, prior to irrigation and PRN [as needed] (Confirm with physician regarding withholding feedings) Order does not specify rate for feeding. ADON [Assistant Director of Nursing] notified and notified provider. Still waiting on response so feed was not started today. Pt has been eating orally. On 5/31/26 at 12:35 PM, an Order Note documented The order you have entered Fibersource HN Enteral Liquid (Nutritional Supplements) Give 45 ml/hr enterally every 4 hours for Nutrition Start at 20mL/hr, titrate by 10-20mL/hr every 4 hours to goal . It should be noted that resident 13 went without the tube feeding from 5/25/26, night shift until 5/31/26 at 4:00 PM. On 5/31/26 at 3:55 PM, a Nutrition Evaluation documented . Macronutrients Feed calories 1296 kcal [kilocalorie] (27 kcal/kg [kilocalorie per kilogram]) Total protein 58 gm [grams] (1.2 gm/kg [grams per kilogram]) Total carbs [carbohydrates] 177 gm Total fat 43 gm Fluid Feed water 875 mL Water flushes 480 mL (80 mL Q4hr [every four hours]) Total fluids 1355 mL (28 mL/kg [milliliters per kilogram]) Daily needs 1350 mL (1 mL per kcal). It should be noted that the macronutrients were not calculated during the Nutrition Evaluation on 5/21/26. No additional interventions were included on 5/31/26. On 5/26/26, resident 13 weighed 101.6 lbs. On 6/1/26, resident 13 weighed 93.4 lbs which was a -8.07% weight loss in six days. It should be noted that resident 13 lost an additional 8.2 lbs since 5/26/26. On 5/21/26, resident 13 weighed 106.2 lbs. On 6/1/26, resident 13 weighed 93.4 lbs which was a -12.05% total weight loss. The Task: NUTRITION - Amount Eaten was reviewed for the time frame that resident 13 went without the tube feeding. a. On 5/25/26 at 5:30 PM, the dinner meal was refused.b. On 5/26/26 at 4:06 PM, 0-25% was eaten. At 5:31 PM and 5:36 PM, 26-50% was eaten.c. On 5/27/26 at 1:32 PM and 1:33 PM, 0-25% was eaten. At 5:00 PM, 76-100% was eaten.d. On 5/28/26 at 3:19 PM, 51-75% was eaten. At 5:23 PM, the dinner meal was refused.e. On 5/29/26 at 4:54 PM, 0-25% was eaten, 26-50% was eaten, and Resident Not Available was marked.f. On 5/30/26 at 8:00 AM, 76-100% was eaten. At 1:00 PM, 51-75% was eaten. At 5:00 PM, 26-50% was eaten.g. On 5/31/26 at 11:19 AM, 0-25% was eaten. At 3:23 PM, resident 13 refused. On 6/4/26 at 12:12 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the Registered Dietitian (RD) extended the tube feed order because resident 13 kept losing weight. The DON stated if a resident was receiving Med Pass it would be documented on the Medication Administration Record. The DON stated the physician order for the tube feed was started on 5/31/26, but the new order was not scanned into the medical record and the progress note was not in by the nurse but it was by the RD. The DON stated the Med Pass physician's order was not started but she put it in today. The DON stated to ensure resident 13 was maintaining her nutritional status staff would update the physician order, resident 13's tube feeding was increased today, and staff would encourage food. The DON stated the doctor started mirtazapine to increase resident 13's appetite. The DON stated the tube feeding was more for a supplement because resident 13 could eat. The DON stated the tube feeding was stopped because the order from the hospital was completed. The DON stated the RD and the nurse should know to continue the tube feed based on the original assessment on admission. The DON stated that staff would do a trial to discontinue the tube feed and if the resident was able to eat the tube feed would be discontinued. The DON stated if the resident was not maintaining their nutritional needs the tube feed would continue. The DON stated the provider (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	note on 5/26/26, was when the provider decided to start the mirtazapine for resident 13. On 6/4/26 at 2:50 PM, an interview was conducted with the RD. The RD stated that she was not aware that resident 13 was without the tube feed for 5 to 6 days. The RD stated when she saw resident 13 yesterday she saw a trial order for the tube feed for 5 days. The RD stated she received a phone call over the weekend from the facility that resident 13 did not have any orders and needed a tube feed and she figured that out. The RD stated that resident 13 did take food by mouth. The RD stated that yesterday she saw resident 13 and resident 13 wanted the tube feed reduced. The RD stated she spoke with resident 13 and told her that she could not reduce the tube feed but she could reevaluate the tube feed in a week. The RD stated she got a notification from the DON today that resident 13 had lost weight and needed to up the level of the tube feed so the RD increased resident 13's tube feed. The RD stated that her recommendations were communicated in the nutrition at risk (NAR) meeting and if she did not attend the meeting she would list the recommendations and email the DON. The RD stated the recommendations were also on the NAR meeting report. The RD stated that resident 13's intake was hit and miss and the RD did not want to overload resident 13 with the tube feed if she was eating. The RD stated that she did not think it was okay for resident 13 to not have her tube feed for 5 days. The RD stated that she thought that resident 13 had lost too much weight to not have the tube feed. The RD stated if the staff did not have orders for the tube feed she should have been called within 24 to 48 hours at the latest. 2. Resident 6 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease, dialysis, type 1 diabetes mellitus and pulmonary hypertension due to lung disease, and hypoxia. A Nutrition Evaluation was completed on 5/6/26, which revealed resident 6 had a consistent carbohydrate diet with a 1000 milliliter fluid restriction and a renal house supplement daily. Resident 6 had a high potassium on 4/29/26, of 5.3 millimoles per Liter [mmol/L] according to the evaluation. The RD documented monthly weight triggered significant loss against weight from 3/27/26. The RD documented resident 6's Weights are otherwise stable and [resident 6] continues frequent monitoring during NAR (nutrition at risk) meetings secondary to dialysis dependency. Will continue to monitor labs, no other nutrition considerations at this time. Recommend continue current POC (plan of care). A nurse's note dated 5/27/26 at 6:18 PM, Pt [patient] noted to have a critical potassium of 6.0 [mmol/L]. Pt received dialysis, which likely reduced k [potassium] level Follow up lab draw was ordered/recommended to confirm post-dialysis k level. however pt refused repeat lab draw despite ed [education] provided. Pt monitored for signs/symptoms of electrolyte imbalance. A risk verse benefit dated 6/4/25, revealed resident 6 was educated on the benefits of a carbohydrate controlled diet. There was no information regarding a renal or low potassium diet. On 6/4/26 at 2:13 PM, an interview was conducted with the Dietary Manager (DM). The DM stated resident 6 was on a liberalized renal diet but it depended on what the dialysis RD ordered. The DM was observed to check resident 6's meal ticket and it had carbohydrate controlled, regular texture, fluid restriction, and disliked melon. The DM stated the meal ticket should have if the resident required low potassium foods. On 6/4/26 at 2:28 PM, a phone interview was conducted with the RD. The RD stated she had not been able to get into contact with the RD at the dialysis center. The RD stated she used to get lab results from the dialysis RD but had not received them with the new dialysis RD. The RD stated she was not provided information that resident 6's potassium was at 6. The RD stated she thought resident 6 was on a liberal renal diet which meant the diet was somewhat restricted. The RD stated resident 6 might have a risk vs benefit signed which meant staff had chatted with the resident about what diet they were ordered and why it was helping them. The RD stated staff were still expected to offer the resident the prescribed diet and then provide them foods they requested. At 3:38 PM, a follow up interview was conducted with the RD. The RD stated she had (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	misspoken about resident 6's diet order and the resident should be served the diet according to the physician's order. On 6/4/26 at 2:20 PM, an interview was conducted with the Assistant Director of Nursing (ADON) and the DM. The ADON stated they reviewed resident 6's nursing notes for 5/27/26, and resident 6 had a critically high potassium level and another lab draw was completed on 6/3/26, and the potassium was normal. The ADON stated resident 6 had a risk versus benefit signed in the medical record. The ADON confirmed resident 6 was on a carbohydrate controlled diet and not a renal diet. On 6/4/26 at 3:21 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated resident 6 was readmitted from the hospital on 2/25/25, with a diet order of carbohydrate control diet and not a liberalized renal diet. The RNC stated resident 6 was on a renal diet with regular consistency prior to discharging to the hospital. The RNC stated the RD and physician evaluated the need for diet changes.		

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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. Based on observation and interview it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, the dishmachine temperatures were below the required manufacture temperatures for sanitizing dishes. Findings included: On 6/1/26 at 9:45 AM, an observation was made of the dishmachine. The following temperatures were observed: [Note: All temperatures were in degrees Fahrenheit.] Wash was 160 and rinse was 150 for 3 loads of dishes. Wash was 160, rinse was 150 and final rinse was 135. Wash was 160, rinse was 155 and final rinse was 140. Wash was 165, rinse was 155 and final rinse was 130. The above cycles were observed to have cups, plates, domes, mugs and bowls. The items were observed to be taken from the dish machine baskets and placed with the clean dishes. On 6/1/26 at 9:55 AM, an interview was conducted with [NAME] 1. [NAME] 1 stated the wash temperature needed to be above 150, rinse above 160 and final rinse above 180. [NAME] 1 stated those temperatures were listed directly on the dishmachine. An observation was made of the dishmachine and the temperatures listed by the manufacturer for this high temperature dishmachine were wash above 150, rinse above 160 and final rinse above 180. On 6/1/26 at 10:00 AM, an interview and observation was conducted with the Dietary Manager (DM). The DM observed the dishmachine and stated the wash was 165, the rinse was 155 and the final rinse was 130. The DM stated the staff were able to put a thermometer through the dishmachine to check temperatures. The DM obtained a thermometer and stated the batteries were dead so it did not work. The DM stated the dish machine company needed to be contacted and they were going to call them. At 2:24 PM, a follow up interview was conducted with the DM. The DM stated dishes needed to be washed in the 3 compartment sink until the dish machine company was able to look at the machine. The DM stated staff should have stopped washing dishes and notified the DM when the thermometers were not reaching the temperature.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review, for 3 of 36 sampled residents, the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, a resident's multiple sclerosis medication was not available for administration, another resident's Clonidine, Hydralazine, and Ferrous Fumarate were documented as not available for administration, and a third resident's potassium chloride, topiramate, Myrbetriq, and duloxetine were documented as not available for administration. Resident identifiers: 6, 29, and 39. Findings included: 1. Resident 29 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis (MS), protein calorie malnutrition, chronic pain syndrome and major depressive disorder. On 6/2/26 at 8:59 AM, an interview was conducted with resident 29. Resident 29 stated there were problems with reordering her MS medications and the scheduled dose was usually changed when medications were reordered. Resident 29 stated the nurses struggled to get her MS medication every month and it was due every 28 days. A progress note dated 3/13/26 at 11:37 PM, documented Administered Kesimpta with [name of another nurse] as second witness, no issues with administration will reorder medication so we can [sic] for next month. According to the Medication Administration Record for April 2026 Kesimpta Subcutaneous Solution Auto-injector 20 milligrams (mg)/0.4 milliliter. Inject 1 application subcutaneously every night shift every 28 days for MS. The order instructed to have 2 nurses verify and document that the shot was given. The injection was not administered on 4/7/26 because other/See Progress note. There was no documentation regarding why the medication was not administered. On 5/18/26 at 11:45 AM, the Nurse Practitioner (NP) documented .resident does take Percocet once every 28 days however has not had the medication due to an error with her insurance. Even though this has been corrected and the resident is to continue receiving her injection, the medication has not arrived and pharmacy is to be contacted to determine where the medication is. She had been without her Kesimpta (ofatumumab) for a few weeks due to an insurance issue; she anticipates restarting in May. It should be noted that the physician wrote Percocet instead of Kesimpta. On 6/4/26 at 10:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 29 was very anxious about losing control of her body and mind. The DON stated resident 29 had an injected medication for her MS. The DON stated once the medication was administered, then insurance needed to be notified so it could be approved for administration 28 days later. The DON stated her and the Assistant Director of Nursing were in charge of making sure the medications were ordered and available for administration. The DON stated resident 29 did not get the MS medication in April 2026, her and her family were informed of what was going on. The DON stated there were no other medications that could be used to substitute. The DON stated she would look into (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	why the medication was not available. At 12:42 PM, the DON stated there was an NP progress note saying to hold the medication until May 2026. The progress note was from 5/18/26, but there was no documentation around 4/7/26, when the medication should have been administered. 2. Resident 6 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included kidney transplant rejection, end stage renal disease, dependence on renal dialysis, pulmonary hypertension, congestive heart failure, and hypertension. On 2/25/25, resident 6 had an order initiated for Hydralazine Hydrochloride (HCl) Tablet 25 mg by mouth three times a day for hypertension. On 8/15/25, resident 6 had an order initiated for Clonidine HCl tablet 0.1 mg by mouth one time a day for hypertension. On 2/4/26, resident 6 had an order initiated for Ferrous Fumarate Tables 325 mg by mouth two times a day for anemia. Resident 6's May 2026 Medication Administration Record (MAR) was reviewed. Clonidine was documented as not available for administration on 5/19/26. The Hydralazine was documented as not available for administration on 5/27/26. The Ferrous Fumarate was documented as not available for administration on 5/28/26. On 6/3/26 at 10:23 AM, an interview was conducted with the DON. The DON stated that if an area on the MAR was left blank that usually meant that the medication was unavailable. The DON stated that the MAR had an option to enter a code for medications not administered or held. Per the MAR a code 11 indicated that the medication was not available for administration. The DON stated that medication refills were obtained in a refill option on the electronic medical record system or they could be faxed directly to the pharmacy. The DON stated that the nurse should send the medication refill request 7 or 8 days before the last dose so they did not run out of the medication. 3. Resident 39 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, post traumatic stress disorder, borderline personality disorder, generalized anxiety disorder, cognitive communication deficit, and depression. On 5/25/26 at 7:57 AM, an Orders - Administration Note documented Potassium Chloride ER [extended release] Oral Tablet Extended Release 20 MEQ [milliequivalent] Give 20 mEq by mouth one time a day for Supplement medication currently not available. pharmacy states medication will be delivered today. On 5/25/26 at 7:57 AM, an Orders - Administration Note documented Topiramate Oral Tablet 100 MG Give 100 mg by mouth one time a day for Migraines medication currently not available. pharmacy states medication will be delivered today. On 5/25/26 at 7:58 AM, an Orders - Administration Note documented Myrbetriq Oral Tablet Extended Release 24 Hour 25 MG Give 25 mg by mouth one time a day for OAB [over active bladder] medication (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	currently not available. pharmacy states medication will be delivered today. On 6/2/26 at 7:38 AM, an Orders - Administration Note documented DULoxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG Give 120 mg by mouth one time a day for Depression med [medication] not available, on order, provider notified. On 6/4/26 at 9:33 AM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated if he needed to refill a resident's medication he would remove the tab from the medication card and fax the tab to the pharmacy. RN 5 stated if it was a medication that the resident needed immediately he would pull from the facility emergency medication cart. RN 5 stated if the medication was not available in the emergency cart he would call the DON or the NP to make sure that he was not missing something.		

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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** Based on interview and record review, for 1 of 36 sampled residents, the facility did not ensure that all alleged violations involving abuse and neglect were reported to the State Survey Agency (SSA). Specifically, the facility waited 5 days to report an allegation of abuse or neglect to the SSA, after a resident sustained a fall which resulted in a fracture. Resident identifier: 76. Findings included: Resident 76 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included fall with fracture, major depressive disorder, muscle weakness and osteoporosis. The facility reported on 12/31/25 to the SAA that resident 76 sustained a witnessed fall on 12/25/25. Resident 76 was transferred to the hospital where a fracture of the sacrum was identified. On 6/4/26 at 1:36 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility became aware of resident 76's broken sacrum on 12/25/26. The DON stated she did not know it was not reported until 12/31/25 to SSA. On 6/4/26 at 1:58 PM, an interview was conducted with the Administrator (ADM). The ADM stated it was before he started so he did not know why it was not reported to the SSA within 24 hours. The ADM stated it should have been reported on 12/25/25.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for 1 of 36 sampled residents, the facility did not provide appropriate treatments and services to maintain or improve his or her ability to carry out the activities of daily living, which included hygiene and bathing. Specifically, a resident was not provided showers and was observed to have a body odor. Resident identifier: 57. Findings included: Resident 57 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, protein-calorie malnutrition, anxiety disorder and failure to thrive. On 6/2/26 at 8:42 AM, an observation was made of resident 57. Resident 57 was in his room and was observed to have strong body odor. On 6/3/26 at 9:21 AM, an observation was made of resident 57. Resident 57 was observed to bring a meal tray to the nurses station from his room. Resident 57 was observed to have strong body odor and was in the same clothing from 6/2/26. An annual Minimum Data Set assessment dated [DATE] revealed resident 57 needed set up or clean up assistance with bathing. A care plan dated 4/15/25 revealed resident 57 had alterations in Activities of Daily Living (ADL) function secondary to muscle weakness. Interventions included ADL needs will be met each day through next review; Assist in completing ADL tasks each day; Provide dignity and respect, and encourage independence. Another care plan dated 12/28/25 revealed resident 57 displayed behavioral symptoms: refusals of care. Interventions included allow resident 57 to make choices for their care, including the choice to refuse care; Encourage participation in activities of interest; make reports to the appropriate entities; and praise resident 57 when behavior was appropriate. The Certified Nursing Assistant (CNA) tasks section of resident 57's medical record revealed showers were scheduled Tuesday, Thursday and Saturday evenings. Resident 57 was showered on 5/5/26, 5/23/26 and 5/26/26. Resident 57 refused a shower on 6/3/26. Resident 57 was not available on 5/7/26, 5/9/26, 5/14/26, 5/19/26, 5/21/26, 5/28/26 and 5/30/26. On 6/3/26 at 9:42 AM, an interview was conducted with the Restorative Nursing Aide (RNA). The RNA stated resident 57 received a shower about once a week. The RNA stated it was difficult for resident 57 to understand showers and told staff that he will take care of it when he goes home. The RNA stated if staff offered him a shower in morning he would tell them no that he would get dirty anyway. The RNA stated that staff offered showers at night and a lot of times he still refused. On 6/3/26 at 10:06 AM, an interview was conducted with CNA 1. CNA 1 stated resident 57 was independent with his showers and staff had to remind him to shower. CNA 1 stated resident 57 sometimes refused showers and then the next day he showered. CNA 1 stated if resident 57 had not showered for a few days, a male CNA would ask him to shower and sometimes he still refused. CNA 1 stated resident 57 sometimes had body odor. CNA 1 stated if he refused an evening shower then he was showered the next day. On 6/3/26 at 10:11 AM, an interview was conducted with CNA 2. CNA 2 stated resident 57 required set up assistance with showers. CNA 2 stated resident 57 refused showers or he did them on his own time. CNA 2 stated if a resident was not showered on an assigned shower day, then it was communicated in shift to shift report. CNA 2 stated resident 57 sometimes smelled and would not be surprised if he had body odor. On 6/3/26 at 10:57 AM, an interview was conducted with the Director of Nursing (DON). The DON stated a resident's shower schedule was in their tasks section of the medical record and it populated to the CNA charting. The DON stated if a resident refused a shower, then a sheet was filled out and scanned into the miscellaneous section of the medical record. The DON stated if a resident was not available for a shower that meant the resident was out with family and the shower should be rescheduled. The DON (continued on next page)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if a resident was cognitively impaired, staff should make multiple attempts to offer. The DON stated the CNA and nurse signed the shower sheet. The DON stated if a resident was cognitively impaired, starting to smell, they would have another staff member offer shower assistance. The DON stated she was always willing to step in and help staff get residents to shower. At 2:01 PM, the DON stated resident 57 had been going through a time where he wanted showers at night and she did not know why it was marked that resident 57 was unavailable for showers.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for 1 of 36 sampled residents, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident with decreased sensation in her feet utilized hot packs heated in the microwave and staff were not able to determine the temperature prior to application. Resident identifier: 29. Findings included: Resident 29 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, protein-calorie malnutrition, chronic pain syndrome and major depressive disorder. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed resident 29 had a Brief Interview of Mental Status score of 15 which indicated resident was cognitively intact. The MDS further revealed no acute onset of mental status change, inattention, disorganized thinking, or altered level of consciousness. On 6/2/26 at 8:59 AM, an interview was conducted with resident 29. Resident 29 stated her feet were really cold because she had restricted blood flow. Resident 29 stated that she had a heated blanket that the facility removed from her room. Resident 29 stated she had a loss of sensation in her feet but was able to feel hot and cold. Resident 29 stated her heated blanket made her quality of life better. Resident 29 stated she had hot packs that staff provided her in place of the heated blanket. An observation was made of homemade hot packs on her table. A behavioral health note dated 2/25/26 at 8:45 AM, revealed . Patient used the example of the new director coming in and taking away her heated blanket. This event triggered feelings that she did not have control, which then led into feelings of shame. These shame feelings connected with thoughts of not being a good mother, not doing enough in her life to help those around her, and then feelings of just wanting to give up. She reported not getting out of bed for several days as a result of this cycle. It was noted that this cycle is perpetuated by thinking errors. There were no notes regarding resident 29's heated blanket being taken away and another option provided to assist in warming her feet. On 6/4/26 at 10:23 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated resident 29's feet were always cold and she wanted to use a heated blanket on them but that was not allowed. CNA 1 stated resident 29 had heat packs that she microwaved for 45 seconds to warm them up. CNA 1 stated she did not obtain a temperature of the heat packs but if she was able to touch the hot pack, then it was at the correct temperature. CNA 1 stated she asked resident 29 how the hot pack felt but she was not sure how much feeling resident 29 had in her feet. CNA 1 stated resident 29 let staff know when to remove the heat pack. On 6/4/26 at 10:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 29's feeling in her feet was minimal. The DON stated she kept several blankets and used the foot warmers that popped and did not go above a certain temperature. The DON stated she was not aware of hot packs that were being heated in the microwave. On 6/4/26 at 10:30 AM, an interview was conducted with the Administrator (ADM). The ADM stated resident 29 was not allowed to have a heated blanket and she was upset. The ADM stated in place of the heated blanket, resident 29 was offered the heat packs that can be popped to control the heat. The ADM stated the facility did not allow heating pads, heated blankets, or reusable heat packs that were warmed in the microwave. The ADM stated the concern would be knowing the temperature of the item prior to placing it on residents skin. The ADM stated the items could cause burns.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 1 out of 36 sampled residents, the facility did not conduct a post dialysis assessment after each dialysis session. Resident identifier: 6. Findings included: Resident 6 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included kidney transplant rejection, end stage renal disease, and dependence on renal dialysis. On 6/1/26 at 10:54 AM, an interview was conducted with resident 6. Resident 6 stated that she had dialysis today and would not be back until after 4:00 PM. Resident 6 stated that she had a dialysis port on her left chest. Resident 6 stated that the port dressing was changed weekly at dialysis and she did not have any signs and symptoms of infection in the port. Resident 6's medical records were reviewed. Resident 6's physician's orders revealed the following: a. Dialysis 3 times a week on Monday, Wednesday, and Friday (MWF). The order was initiated on 6/18/25. b. Only use DRY weight (wt) from dialysis. Enter weight after every dialysis visit MWF. Convert weight from kilograms to pounds. The order was initiated on 6/16/25. c. PRE-Dialysis (Pre-Visit Form) - Ensure dialysis communication form was completed and sent with residents every dialysis day. The order was initiated on 2/26/25. d. POST-Dialysis (Post-Visit Form) - Ensure dialysis communication form was returned to the facility, progress note if needed and scanned on every dialysis day. The order was initiated on 2/26/25. e. Dialysis - Fluid Restriction - Specify fluid restriction if applicable - (1000) milliliters (mL) every shift. The order was initiated on 2/25/25. f. Dialysis: Check site for bleeding and signs or symptoms (s/sx.) of infection every shift. The order was initiated on 2/25/25. Resident 6's May 2026 Medication Administration Record (MAR) documented that the dialysis fluid restriction was maintained, the pre and post-dialysis communication form was returned, dry wt. was documented from dialysis except on 5/15/26 and 5/29/26, and port was checked for s/sx of bleeding or infection except on 5/29/26. Resident 6's dialysis communication forms were reviewed. Post dialysis assessments were not completed for each dialysis appointment. Resident 6's care plan for required hemodialysis secondary to End Stage Renal Disease was initiated on 4/15/25. Interventions identified on the care plan included a fluid restriction of 1000 mL per day, monitor dialysis port as prescribed, monitor edema or fluid overload, and monitor weights and vital signs. On 6/3/26 at 10:37 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the nurse communicated with dialysis through the dialysis communication form or they called the dialysis center directly. The DON stated that the nurse should monitor the dialysis port for signs and symptoms of an infection every shift. The DON stated that the post dialysis form should document resident 6's weights post dialysis and any medications that were administered at dialysis or any labs that the dialysis center obtained. The DON stated that the floor nurse should fill out a post dialysis assessment after each dialysis visit to monitor resident 6's condition especially with her fragile diabetes. On 6/3/26 at 1:52 PM, a follow-up interview was conducted with the DON. The DON stated that the post dialysis assessments were not completed for resident 6 and they planned to start a performance improvement plan for this.		

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NAME OF PROVIDER OR SUPPLIER Rocky Mountain Care - the Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 544 East 1200 South Heber City, UT 84032	
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the resident's drug regimen was free from any unnecessary drugs. An unnecessary drug was any drug used in excessive dose; for excessive duration; without adequate monitoring; without adequate indications for use; in the presence of adverse consequences; or any combination of the above. Specifically, for 2 out of 36 sampled residents, a resident had medications that were not administered with no documentation of the reason for omission, and insulin was held when it should have been administered per the physician ordered parameters. Additionally, a resident was administered blood pressure medications without a documented blood pressure reading. Resident identifiers: 6 and 59. Findings included: 1. Resident 6 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included kidney transplant rejection, end stage renal disease, dependence on renal dialysis, pulmonary hypertension, congestive heart failure, and hypertension. On 2/25/25, resident 6 had an order initiated for Hydralazine Hydrochloride (HCl) Tablet 25 milligram (mg) by mouth three times a day for hypertension. On 8/15/25, resident 6 had an order initiated for Clonidine HCl tablet 0.1 mg by mouth one time a day for hypertension. On 1/17/26, resident 6 had an order initiated for Insulin Lispro sliding scale. Inject as per sliding scale: if blood sugar was 201 - 300 = 0; 301 - 400 = 1; 401 - 499 = 2; 500+ = 3, subcutaneously before meals and at bedtime for Diabetic management. On 5/26/26, resident 6 had an order initiated for Pregabalin Capsule 50 mg by mouth one time a day for pain. Resident 6's May 2026 Medication Administration Record (MAR) was reviewed. The medication legend documented Code 9 was see progress note; and Code 4 was Blood Sugar/Vital Signs out of parameters for administration. The Clonidine was documented as a Code 9 on 5/17/26, and no documentation was found in the progress note for the reason of the medication omission. The Pregabalin was documented as a code 9 on 5/1/26 through 5/3/26, and no documentation was found in the progress note for the reason of the medication omission. The Hydralazine was documented as a Code 4 on 5/1/26 and 5/7/26, and no documentation was found of the blood pressure reading or reason for the medication hold. The Insulin Lispro was held when it should have been administered per the sliding scale on 5/11/26 (blood sugar was 204), on 5/22/26 (blood sugar was 203), and on 5/24/26 (blood sugar was 206). Additionally, the Insulin Lispro did not have any documentation on 5/27/26. On 6/3/26 at 1:53 PM, an interview was conducted with the Director of Nursing (DON). The DON confirmed that the Clonidine was held on 5/17/26, without a documented reason in the progress note. The DON confirmed that the Hydralazine was held on 5/1/26, without a documented blood pressure, and was held on 5/7/26, for BP of 115/97 without a documented progress note. The DON stated that the Hydralazine should have been administered on 5/7/26, and not held. The DON stated that the facility did not have any standing orders for blood pressure parameters to hold medications. The DON stated that per the current physician order the Insulin Lispro should have been administered on 5/22/26 and 5/24/26. 2. Resident 59 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, type 2 diabetes mellitus, acquired absence of the right and left leg above the knee, infection of left amputation stump, and chronic pain. On 4/12/26, resident 59 had an order initiated for Metoprolol Succinate Extended Release Tablet, Give 25 mg by mouth one time a day for rate regulation. Hold for systolic blood pressure less than 110 or a heart rate less than 60. On 4/13/26, resident 59 had an order initiated for Bumetanide Tablet 2 mg by mouth in the morning for cardiac health. Resident 59's May 2026 MAR was reviewed. The Bumetanide was documented as administered on 5/10/26, 5/11/26, and 5/29/26, without a documented blood pressure reading. The (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol was documented as administered on 5/11/26, 5/16/26, and 5/29/26, without a documented blood pressure reading. On 6/3/26 at 10:23 AM, an interview was conducted with the DON. The DON stated that if an area on the MAR was left blank that usually meant that the medication was unavailable. The DON stated that the MAR had an option to enter a code for medications not administered or held. The DON stated that vital signs should be documented and it populated to the MAR. The DON stated the MAR allowed the nurse to document that the order was completed even when vital signs were not listed.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide or obtain laboratory services to meet the needs of its residents. Specifically, a resident that had their complete blood count (CBC) and urinalysis (UA) cancelled did not have those labs redrawn. Resident identifier: 39. Findings included: Resident 39 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder, post traumatic stress disorder, borderline personality disorder, generalized anxiety disorder, cognitive communication deficit, and depression. On 5/22/26 at 10:47 AM, a physician's order documented to collect a CBC, comprehensive metabolic panel, and a UA with culture and sensitivity. On 5/22/26 at 6:45 PM, a physician's order documented to re-draw the CBC. On 5/25/26 at 6:00 AM, a physician's order documented to collect a UA culture and sensitivity. The lab reports were reviewed and revealed the CBC specimen clotted and the UA was cancelled because it was never received. On 6/4/26 at 12:10 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there was no notification from the laboratory of resident 39's UA or CBC being cancelled. The DON stated the UA and CBC were not redrawn. The DON stated when lab results were cancelled the lab called the nurses station.		

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility did not file in the resident's clinical record laboratory reports that were dated and contain the name and address of the testing laboratory. Specifically, for 2 out of 36 sampled residents, the facility did not file the resident's laboratory results in their medical records. Resident identifiers: 6, and 9. Findings included: 1. Resident 6 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included kidney transplant rejection, end stage renal disease, dependence on renal dialysis, pulmonary hypertension, congestive heart failure, and hypertension. Resident 6's medical records were reviewed. On 3/9/26, resident 6 had a physician order for a lipid panel and hemoglobin A1c initiated. No documentation could be found in resident 6's medical records of the laboratory results for the lipid panel and A1c. On 6/3/26 at 1:53 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the lipid panel and A1c reports were requested from the laboratory and she would forward the results when they were obtained. 2. Resident 9 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, cerebral infarction, morbid obesity, type 2 diabetes mellitus, fracture of right toe, non-pressure injury of left foot. Resident 9's medical records were reviewed. On 10/22/25 and 10/29/25, resident 9 had a physician order for a Comprehensive Metabolic Panel (CMP) initiated. On 11/12/25, resident 9 had a physician order for a Basic Metabolic Panel (BMP) and a Hemoglobin A1c initiated. No documentation could be found of the ordered laboratory results in resident 9's medical records. On 6/2/26 at 2:44 PM, the DON emailed copies of the 11/12/25 BMP, A1C and the 10/22/25 and 10/29/25 CMP. All results had a print date of 6/2/26. None of the results were located in the resident's medical records. On 6/3/26 at 10:18 AM, an interview was conducted with the DON. The DON stated that the lab results were requested from the laboratory yesterday. The DON stated that she would get the results uploaded into the resident's medical record.		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure that radiology and diagnostic services were obtained to meet the needs of its residents. Specifically, for 1 of 36 sampled residents, the facility did obtain an x-ray of the right knee when ordered by the physician. Resident identifier: 9. Findings included:Resident 9 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, cerebral infarction, morbid obesity, type 2 diabetes mellitus, fracture of right toe and non-pressure injury of left foot.Resident 9's medical records were reviewed. On 2/6/26, resident 9's physician ordered an x-ray of the left and right knee.No documentation could be found of the right knee x-ray results in resident 9's medical records. On 6/2/26 at 2:44 PM, the Director of Nursing (DON) emailed copies of the left knee x-ray. The DON was informed that the right knee x-ray results were still not available. No results for the right knee x-ray were provided.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for 2 of 36 sampled residents, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, hand hygiene was not completed during a dressing change and the wound bed was cleaned with multiple cross swipes with the same gauze pad. Additionally, medication was placed back into a blister pack after a resident refused it. Resident identifiers: 68 and 59. Findings included: 1. Resident 68 was admitted to the facility on [DATE] with diagnoses which included osteomyelitis, severe sepsis with septic shock, and stage 2 pressure ulcers. On 5/30/26, an order was started for Oxycodone hydrochloride (HCL) Give 10 milligrams (mg) orally every 4 hours as needed for severe pain. On 6/4/26, at 10:09 AM, an observation was made of the medication cart for rooms 416 to 611 with Registered Nurse (RN) 1 present. The blister pack containing resident 68's Oxycodone HCl 10 mg was observed to contain 1 tablet that had been placed back in a blister cell, and the paper folded back over it. RN 1 stated that she had removed the tablet from the blister cell that morning to administer with all of resident 68's scheduled medications. RN 1 stated that when she went to administer the Oxycodone to resident 68, resident 68 stated that she did not want to take the Oxycodone at that time and preferred to wait to take it right before physical therapy. RN1 stated that because the Oxycodone was ordered as needed, and that the resident requested to take it during RN 1's shift, she placed the tablet back in the blister cell and folded the paper over the table to hold it in place. RN 1 stated that she normally would have used tape to secure it in place, but did not have any available. On 6/4/26 at 12:36 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a resident refused a narcotic medication that had been removed from a blister cell the nurse should dispose of it with another nurse and document it in the narcotic log. The DON stated that when a medication was placed back into a blister cell there was a risk for infection control to be compromised. Additionally, the DON stated that it was not possible to be certain the correct medication was returned to the blister cell. 2. Resident 59 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, type 2 diabetes mellitus, acquired absence of the right and left leg above the knee, infection of left amputation stump, and chronic pain. On 6/1/26 at 1:02 PM, an interview was conducted with resident 59. Resident 59 stated that she had pain in the right stump and that there was a wound there. Resident 59 stated that the wound was not open and they did not do a dressing change on it. Resident 59 stated that the wound on the right stump had been present for approximately 1.5 weeks. Resident 59 had a physician order for L [left] stump: Cleanse with NS [normal saline]. Apply silver (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alginate to wound bed. Cover with bordered dressing. every day shift every Mon [Monday], Wed [Wednesday], Fri [Friday]. The order was initiated on 4/22/26. On 6/3/26 at 11:50 AM, an interview was conducted with RN 4. RN 4 stated that resident 4 had a dressing on both the left and right stump and she only had orders for the left stump. RN 4 was observed providing wound care to resident 59. RN 4 performed hand hygiene and donned a gown and gloves. Resident 59 had a bordered foam dressing on her bilateral above the knee amputation (AKA) stumps. RN 4 removed the dressing from the right and left AKA stump. RN 4 stated that the right dressing did not have any drainage on the old dressing, and the left stump dressing had serosanguinous drainage. RN 4 doffed and donned new gloves, no hand hygiene was performed. RN 4 placed a disposable chuck pad underneath resident 59's stumps. RN 4 opened a 4x4 gauze pad and placed it into a cup squirting 20 milliliters of normal saline onto the gauze pads. RN 4 cleaned the left stump wound working from the inside outward. The RN folded the gauze pad over on itself and wiped the wound bed 2 more times with the same gauze pad. RN 4 cleaned the right stump with a new 4 x 4 gauze pad that was soaked in normal saline. RN 4 doffed her gloves and new gloves were donned, no hand hygiene was performed. RN 4 placed a sheet of silver alginate in the left wound bed and covered it with a bordered foam dressing. RN 4 placed a bordered foam dressing on the right stump. RN 4 doffed the gown and gloves, and performed hand hygiene with alcohol based hand rub prior to exiting the room. RN 4 stated that the right stump was newly closed. RN 4 stated that when she cleaned the right stump wound bed a scab came off and it was closed underneath. RN 4 stated that it made her believe that the wound was barely closed or was trying to break back open. RN 4 stated that she would notify the wound nurse to assess the right stump and put a treatment order in. On 6/3/26 at 12:49 PM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON was the facility wound care nurse. The ADON stated that staff should perform hand hygiene before wound care, at the time of glove changes, and at the end of wound care after doffing gloves. The ADON stated anytime staff doff and don gloves they should perform hand hygiene. The ADON stated that when performing wound care staff should clean from the center of the wound working inside out to avoid introducing bacteria into the wound bed. The ADON stated that staff should obtain a new gauze pad when cleaning the same area multiple times.		