| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 465152 | A. Building<br>B. Wing | 01/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bella Terra St George | 178 South 1200 East<br>St. George, UT 84790 |

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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents did not receive psychotropic drugs pursuant to an as needed (PRN) order unless that medication was necessary to treat a diagnosed specific condition that was documented in the clinical record; and PRN orders for psychotropic drugs were limited to 14 days. Specifically, for 1 out of 32 sampled residents, a resident taking a PRN psychotropic did not have that psychotropic limited to 14 days and the prescribing practitioner did not document their rationale in the resident's medical record for the PRN order to be extended beyond the 14 days. Resident identifier: 8.Findings included: Resident 8 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, psychophysiologic insomnia, circadian rhythm sleep disorder, insomnia, major depressive disorder, and anxiety disorder.A physician's order dated 11/14/25, documented traZODone HCl [hydrochloride] Oral Tablet 50 MG [milligrams] (Trazodone HCl) Give 1 tablet by mouth every 18 hours as needed for insomnia. The order had an end date of indefinite.The Medication Administration Record for November 2025, December 2025, and January 2026 was reviewed. Resident 8 had received one dose of trazodone in December. On 1/8/26 at 10:33 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 8 originally had a PRN order for the trazodone that had a 14 day stop date and that was prior to resident 8 going to the hospital. The DON stated that resident 8 went to the hospital for behaviors and was there for about a month. The DON stated when resident 8 came back to the facility the hospital did not send discharge orders. The DON stated she spoke to the facility provider and he instructed staff to reactivate resident 8's previous orders. The DON stated when they finally received the hospital discharge orders the trazodone was scheduled. The DON stated that resident 8 was on some pretty heavy medications already. The DON stated when the provider saw resident 8 he recognized the scheduled PRN trazodone. The DON stated a psychotropic meeting was held upon resident 8's return and it was noted the trazodone was PRN and there were no other recommendations. The DON stated that resident 8 had taken the trazodone once and resident 8's average sleep was between 8 and 9 hours a day. The DON stated they were calling the provider to inquire about discontinuing the medication. |

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) |
|---|---|
| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. Specifically, for 2 out of 32 sampled residents, a resident's insulin was administered when it should have been held per the physician ordered parameters, and a resident's Midodrine was administered when it should have been held per the physician ordered parameters. Resident identifiers: 4 and 42.Findings included:<br><br>1. Resident 4 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis of type II diabetes mellitus.<br><br>On 5/5/25, resident 4's physician ordered Insulin Aspart Injection Solution, Inject 16 unit subcutaneously four times a day related to type 2 diabetes mellitus. Hold for blood sugar (BS) less than 150.<br><br>Resident 4's December 2025 Medication Administration Record (MAR) documented the insulin was administered when it should have been held per the physician ordered parameters on the following dates:<br><br>a. 12/1/25, PM dose BS 97<br><br>b. 12/4/25, AM dose BS 118<br><br>c. 12/6/25, AM dose BS 139<br><br>d. 12/6/25, hour of sleep (HS) dose BS 128<br><br>e. 12/8/25, BS 126<br><br>f. 12/11/25, PM BS 149<br><br>g. 12/12/25, AM BS 148<br><br>h. 12/13/25, PM BS 146<br><br>i. 12/15/25, HS BS 133<br><br>On 1/7/26 at 9:35 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated if a medication had hold parameters it would be viewable in the order summary. RN 1 stated that resident 4's insulin medication should be held if the BS was under 150.<br><br>On 1/7/26 at 9:41 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the nurse would see the parameters for holds in the order details. The DON stated that the nurses should be following the order parameters for medication administration.<br><br>2. Resident 42 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included malignant neoplasm of the frontal lobe, shock, and hypotension.<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician order dated 10/22/25, documented that two Midodrine Hydrochloride 5 milligram tablets were to be administered three times a day for hypotension. And the Midodrine was to be held for a systolic blood pressure (SBP) of greater than 115.<br><br>Resident 42's November and December 2025 MAR was reviewed and documented the Midodrine was administered outside of the physician ordered parameters on the following dates:<br><br>a. 11/6/25, AM dose SBP 121<br><br>b. 11/6/25, Afternoon dose SBP 140<br><br>c. 11/13/25, AM dose SBP 116<br><br>d. 11/17/25, AM dose SBP 124<br><br>e. 11/20/25, AM dose SBP 160<br><br>f. 11/20/25, Afternoon dose SBP 126<br><br>g. 11/21/25, Afternoon dose SBP 129<br><br>h. 11/22/25, Afternoon dose SBP 125<br><br>i. 11/26/25, Afternoon dose SBP 138<br><br>j. 11/28/25, Afternoon dose SBP 125<br><br>k. 12/1/25, AM dose SBP 118<br><br>l. 12/11/25, Afternoon dose SBP 126<br><br>m. 12/13/25, AM dose SBP 120<br><br>n. 12/13/25, Afternoon dose SBP 122<br><br>o. 12/26/25, Afternoon dose SBP 131<br><br>p. 12/29/25, PM dose SBP 118<br><br>Resident 42's January 2026 MAR was reviewed and documented the Midodrine was administered outside of the physician ordered parameters on 1/1/26, AM dose SBP 122<br><br>On 1/8/25 at 10:06 AM, an interview was conducted with the DON who stated she expected the staff to follow the orders as they were written by the physician. The DON stated if there were parameters the nurses were supposed to only administer the medication within the ordered parameters. The DON stated she had educated her staff on how to administer Midodrine but the nurses who were administering the Midodrine outside of the ordered parameters were new to the facility and had not yet received the education. |