STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465168	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Riverton	3419 West 12600 South Riverton, UT 84065

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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 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** 44640 Based on observation, interview, and record review, the facility did not ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, for 1 out of 22 sampled residents, a resident had a urinary catheter without a physician's order. Resident identifier: 180. Findings included: Resident 180 was admitted to the facility on [DATE] with diagnoses which included encounter for other orthopedic aftercare, diffuse large B-cell lymphoma, lymph nodes of head, face, and neck, other acute postprocedural pain, cellulitis of right lower limb, muscle weakness, obstructive sleep apnea, fracture of shaft of right fibula, subsequent encounter for closed fracture with routine healing, fracture of shaft of right tibia, subsequent encounter for closed fracture with routine healing, heart failure, venous insufficiency, hypothyroidism, hyperlipidemia, dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, bipolar disorder. On 9/23/24 at 10:39 AM, at interview was conducted with resident 180. Resident 180 stated she was unsure how long she has had the catheter. Resident 180 was observed to point in the direction of a whiteboard on the wall and stated that there was a note on the whiteboard from her daughter, who was a Nurse Practitioner. The whiteboard was observed and the writing in the right upper corner of the whiteboard read, Take out catheter before she gets an infection. Resident 180 stated she had no pain, burning or itching from the catheter. The catheter was observed to be hanging on the bed lower than the resident, tubing and bag observed to be clean, no sediment observed in the urine. Resident 180's medical record was reviewed on 9/23/24 through 9/26/24. A physician's order for a urinary catheter was not located in the medical record. No care plan entries for a urinary catheter or catheter care were located in the medical record. The hospital discharge notes dated 9/11/24, were reviewed and revealed that resident 180 was discharged with an Indwelling Urinary Catheter 9/10/24 Latex 16 Fr [French]. The Nurse to Nurse Report Sheet dated 9/11/24, documented resident 180 was admitted with a Foley catheter due to NWB [non-weight bearing] status that was last changed on 9/9/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Point of care history dated 9/11/24, documented resident 180 had a urinary catheter and was incontinent of urine. A Daily Skilled Charting note dated 9/12/24, documented that resident 180 did not have any genitourinary appliances. On 9/25/24 at 9:33 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 180 did really great and that she was a minimal assist. CNA 1 stated resident 180 had an unwillingness to do therapy and to get out of bed. CNA 1 stated resident 180 had a bladder infection right now and that she had a catheter. CNA 1 stated the CNAs did catheter care every shift, chart the amount of fluid we get out, and the peri area that we had done. CNA 1 stated whenever there was a new admit the nurse would get report if they had catheter. CNA 1 stated she was unsure if the nurses checked the catheter. CNA 1 stated she did not notice the note on resident 180's white board. CNA 1 stated resident 180 had not complained to her of any urinary discomfort. On 9/25/24 at 9:42 AM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated if a resident had a catheter they would have orders in the chart, it should be checked every shift by the nurse, the down drain bag should be changed weekly, and the catheter should be changed every month. Observation was made as RN 2 looked in resident 180's medical record and stated, There are no orders for a catheter or catheter care, so the nurses would not even know to look for it. RN 2 stated the admit nurse was supposed to verify the orders that central admitting put into the medical record and correct any that were not right, but it was agency so that was why it got missed. RN 2 stated resident 180 complained of burning on Monday and her urine was tested and showed an infection so she was started on antibiotics. RN 2 stated she did notice the note on the white board and that they were going to talk to the provider to see what she wanted them to do with the catheter. RN 2 stated they were not checking resident 180's catheter because it was not in the orders and they did not know it was there. On 9/26/24 at 10:44 AM, interview conducted with the Director of Nursing (DON). The DON stated central admitting put all the orders in for new admits and the floor nurse was expected to verify those orders were correct. The DON stated the Assistant Director of Nursing was the third check of the orders and the DON was the final check of the new patient orders, so she was unsure how resident 180's catheter order was missed. The DON stated there should have been an order for a catheter, catheter care, enhanced barrier precautions, and a care plan put into place. The DON stated resident 180 was missed, the CNAs were doing the catheter care but the order was missed. The DON stated it was the expectation the CNAs would do the cares and inform the nurses when the cares were completed. The DON stated the nurses did not do the cares. The DON stated she was unaware the family wanted the catheter removed and that they were not really sure how her catheter had gotten missed with all of the medical record checks.

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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** 44640 Based on interview and record review, the facility did not ensure that each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicated that the dose should be reduced or discontinued. Specifically, for 1 out of 22 sampled residents, a resident's blood pressure (BP) support medication was administered outside of the physician's ordered parameters. Resident identifier: 21. Findings included: Resident 21 was admitted to the facility on [DATE] with diagnoses which included cellulitis of right lower limb, cellulitis of left lower limb, pressure ulcer of sacral region, localized edema, muscle weakness, infection and inflammatory reaction due to internal right knee prosthesis, chronic kidney disease, protein-calorie malnutrition, essential hypertension, acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, type 2 diabetes mellitus with unspecified complications, sepsis, organism-right shoulder, iron deficiency anemia secondary to blood loss, and chronic atrial fibrillation. Resident 21's medical record was reviewed on 9/23/24 through 9/26/24. A physician's order dated 8/11/24, documented, Midodrine tablet 5 mg [milligrams]; oral. Special instructions: Hypotension - Hold for systolic > [greater than] 100 with meals 08:00 [8:00 AM], 12:00 [PM], 17:30 [5:30 PM]. The August 2024 Medication Administration Record (MAR) was reviewed and revealed Midodrine was administered outside of parameters on the following dates: a. On 8/13/24 at 5:50 PM, BP 134/46 b. On 8/19/24 at 8:00 AM, BP 132/60 c. On 8/19/24 at 12:00 PM, BP 132/60 d. On 8/20/24 at 8:00 AM, BP 125/57 e. On 8/20/24 at 12:30 PM, BP 129/41 f. On 8/23/24 at 5:30 PM, BP 117/52 g. On 8/24/24 at 8:00 AM, BP 148/57 h. On 8/24/24 at 12:30 PM, BP 148/57 i. On 8/25/24 at 5:30 PM, BP 119/53 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. On 8/27/24 at 5:30 PM, BP 135/52 k. On 8/28/24 at 8:00 AM, BP 160/57 l. On 8/30/24 at 8:00 AM, BP 121/57 m. On 8/30/24 at 12:00 PM, BP 121/57 n. On 8/30/24 at 5:30 PM, BP 121/57 The September 2024 MAR was reviewed and revealed Midodrine was administered outside of parameters on the following dates: a. On 9/1/24 at 8:00 AM, BP 124/62 b. On 9/1/24 at 12:00 PM, BP 116/81 c. On 9/1/24 at 5:30 PM, BP 116/81 d. On 9/3/24 at 8:00 AM, BP 133/62 e. On 9/3/24 at 5:30 PM, BP 128/53 f. On 9/6/24 at 8:00 AM, BP 119/55 g. On 9/6/24 at 12:00 PM, BP 119/55 h. On 9/6/24 at 5:30 PM, BP 119/55 i. On 9/10/24 at 8:00 AM, BP 137/87 j. On 9/10/24 at 12:00 PM, BP 137/87 k. On 9/10/24 at 5:30 PM, BP 137/87 l. On 9/16/24 at 8:00 AM, BP 159/69 m. On 9/16/24 at 12:00 PM, BP 159/69 n. On 9/19/24 at 5:30 PM, BP 162/75 o. On 9/23/24 at 8:00 AM, BP 112/70 The September 2024 MAR was reviewed and revealed Midodrine was held on 9/22/24 at 8:00 AM, BP 96/74. The Midodrine should have been administered. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/24 at 10:45 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated some orders had parameters and each nurse should follow those parameters. RN 1 stated blood pressure medications sometimes had parameters and should only be given if they fall within the ordered parameters. RN 1 stated if a medication was held, they were supposed to call the provider to let them know. On 9/26/24 at 10:39 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that with medications which had parameters the nurses were expected to follow those parameters. The DON stated the nurses were supposed to have given the medication within an hour, notify the provider if it was held, and enter a progress note in the medical record. The DON stated the nurses should have looked at the order and held the medication when the systolic blood pressure was more than 100 and should have given the medication when the systolic was less than 100.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 43212 Based on interview, the facility did not employ a clinically qualified full-time dietitian or another clinically qualified nutrition professional to serve as the director of nutrition services. Specifically, the facility did not employ a full time Registered Dietitian (RD) and the Dietary Manager (DM) did not meet the requirements to serve as the director of nutrition services. Findings included: On 9/23/24 at 8:51 AM, an initial walk-through of the kitchen was completed. An interview was conducted with the DM who stated she had not completed the training required to serve as the DM. The DM stated she was ServeSafe certified and had taken the RD consulting company's menu training. The DM stated the RD came to the facility every Wednesday, and was available by phone if she had questions or concerns. The DM stated the RD conducted a kitchen audit every week when she was in the facility, but she did not receive the information from those audits. 33215 On 9/25/24 at 10:11 AM, an interview was conducted with the RD. The RD stated that she had worked for the facility for two years and was full time with the RD consulting company. The RD stated that the DM started at the facility as a cook and in November 2023 the DM was hired as the DM. The RD stated that the DM had not started the Certified Dietary Manager (CDM) course as of yet. The RD stated that the Medical Records staff member was the past DM but she did had not completed the CDM course either. The RD stated that the Medical Records staff member was the DM for a year and switched to Medical Records because she did not want to put in the time to complete the CDM course. The RD stated that the DM had completed the videos and training's that the RD consulting company had on how to run the kitchen and the forms to use. On 9/26/24 at 11:28 AM, an interview was conducted with the Administrator. The Administrator stated that he was waiting see if the DM was going to stick before they signed her up for the CDM course. The Administrator stated he was going to sign the DM up for a Spanish speaking class. The Administrator stated that he thought the facility had a year for the DM to complete the CDM course.

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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. 43212 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, the dish machine was not running properly to sanitize the dishes after meals. Findings included: On 9/23/24 at 8:51 AM, an initial walk-through of the kitchen was conducted. On 9/23/24 at 9:17 AM, an observation was made of the dish machine. The Dietary Manager (DM) was running dishes through the dish machine, three racks had gone through the machine, and were on the belt. A fourth rack was inside the dish machine. The wash cycle was running at a temperature of 160 degrees Fahrenheit. After the wash cycle finished, no water entered the dish machine for a rinse cycle. A container of dish machine detergent was noted to be connected to the dish machine. When questioned what it was, the DM stated that it was empty and did not replace it. On 9/23/24 at 9:18 AM, an observation was made of the dish machine temperature log. The temperatures listed the wash temperature, the rinse temperature, and a sanitizer solution Parts per Million (PPM). The temperatures on the log were as follows: (B=Breakfast; L=Lunch; D=Dinner). It should be noted that all temperatures were in degrees Fahrenheit. a. On 9/1/24, B: wash 160/ rinse 120 PPM 400, L: 165/130 400, D: 165/170 400 b. On 9/2/24, B: 165/110 400, L: 160/110 400, D: 160/110 400 c. On 9/3/24, B: 160/120 400, L: 165/130 400, D: 1/65/120 400 d. On 9/4/24, B: 165/110 400, L: 170/120 400, D: 160/110 400 e. On 9/5/24, B: 170/140 400, L: 165/120 400, D: 105/120 400 f. On 9/6/24, B: 160/100 400, L: 170/130 400, D: 170/120 400 g. On 9/7/24, B: 160/100 400, L: 170/130 400, D: 170/120 400 h. On 9/8/24, B: 160/100 400, L: 160/130 400, D: 165/120 400 i. On 9/9/24, B: 150/100 400, L: 165/120 400, D: 170/110 400 j. On 9/10/24, B: 160/120 400, L: 170/110 400, D: 170/130 400 k. On 9/11/24, B: 175/110 400, L: 160/170 400, D: 160/110 400 l. On 9/12/24, B: 160/120 400, L: 165/130 400, D: 165/120 400 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	m. On 9/13/24, B: 170/130 400, L: 165/120 400, D: 165/120 400 n. On 9/14/24, B: 170/130 400, L: 170/120 400, D: 165/110 400 o. On 9/15/24, B: 160/120 400, L: 165/120 400, D: 165/120 400 p. On 9/16/24, B: 165/120 400, L: 170/130 400, D: 160/110 400 q. On 9/17/24, B: 165/120 400, L: 175/110 400, D: 175/130 400 r. On 9/18/24, B: 165/120 400, L: 175/110 400, D: 175/130 400 s. On 9/19/24, B: 165/120 400, L: 175/110 400, D: 175/130 400 t. On 9/20/24, B: 167/110 400, L: 180/110 400, D: 170/120 400 u. On 9/21/24, B: 160/110 400, L: 180/110 400, D: 165/120 400 v. On 9/22/24, B: 155/105 400, L: 160/110 400, D: 165/120 400 It should be noted that a high temperature dish machine uses hot water temperatures to sanitize dishware. According to the specification sheet for this model, the wash temperature should be 160 degrees Fahrenheit, and the rinse temperature should be 180 degrees Fahrenheit. On 9/23/24 at 9:19 AM, an observation of the Dietary Aide (DA) was made putting away the plate covers that had gone through the dish machine. The cereal bowls were removed from the rack and stacked on a tray in preparation for another meal. At 9:31 AM, an observation was made of the silverware being put away into the silverware caddy. On 9/23/24 at 9:33 AM, an observation was made that the rinse cycle on the dish machine was not working. An interview was conducted with the DM. When asked if the dish machine was not working properly were the dishes being sanitized, the DM shrugged her shoulders. The DM stated the service company came a while ago and when she told him the rinse cycle was not working he told her it was okay. The DM stated she did not know how long the dish machine had not been working properly and could not remember the date when the service company came last. When asked if she had a service receipt, the DM stated that someone else took care of that. On 9/24/24 at 12:34 PM, an observation was made of the dish machine doing the lunch dishes. The rinse cycle was not working. The dish detergent had been replaced with a new container. The dish machine temperature log was reviewed and no temperatures were documented on 9/23/24 and the morning of 9/24/24. On 9/24/24 at 12:35 PM, an interview was attempted with the DA, but the DA stated she did not understand much English. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/24/24 at 12:35 PM, an interview was conducted with the DM who stated they were using a high temperature dish machine. The DM stated the temperature was what sanitized the dishware. The DM stated the temperatures should be 160 for the wash cycle and 180 for the rinse cycle. The DM stated if the dish machine was not meeting the temperature requirements she would contact the Medical Records (MR) staff member who used to be the DM, and the MR staff member would contact the service company. The DM also stated until the machine was fixed, the dishes would be washed with the three sink method. The DM stated she would know the dish machine was not functioning properly if the water temperatures were not high enough. The DM stated she would then call the service company. The DM stated a dish detergent was used in the dish machine with the wash cycle. When asked why the dish temperature log had 400 (indicating parts per million chemical concentration) written on it, the DM stated she did not know. The DM stated the service company came earlier in the morning, checked the machine temperatures, and replaced one of the thermometers. The DM stated again that the dish machine was high temperature and did not need a sanitizer. The DM stated the detergent attached to the machine was for washing. On 9/24/24 at 12:42 PM, an interview was conducted with the MR who stated she helped in the kitchen occasionally as she used to be the DM. The MR stated the service company representative came to the facility on the morning of 9/24/24, and replaced one of the temperature gauges. The MR stated the representative was going to send a statement by email detailing the work that was done, but she had not received it yet. On 9/24/24 at 1:37 PM, an observation was made of the dish machine being used by the DM. The DM stated she had not heard anything from MR about a service sheet from the service company representative. On 9/24/24 at 1:39 PM, an interview was conducted with the MR who stated she had not yet heard from the service company representative. The MR stated she had placed a call to him and was waiting for a return call. The MR stated she did not know if the service company representative ran a few dish cycles while in the kitchen. After being told the rinse cycle was not running at all, the MR told the DM to wash all the lunch dishes with the three sink process. On 9/25/24 at 8:50 AM, an observation was conducted of the DM washing the breakfast dishes in the three-compartment sink. Each compartment was set up correctly with a wash, rinse, and sanitizing sequence. The sanitizing test strip was used to determine the PPM of the sanitizing compartment and registered 400 PPM which was the required amount. An interview was conducted with the DM. The DM stated she was not using the dishwasher today because the rinse temperature was not getting to 180 degrees. The dishwasher was set up as a high temperature machine since it did not have a sanitizer injection. An observation of the dishwasher determined that rinse water was not entering the machine or just at a trickle. The dish machine did have detergent injecting into the wash cycle.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review, the facility did not establish 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, for 3 out of 22 sampled residents, staff were not using the appropriate personal protective equipment (PPE) for residents on Enhanced Barrier Precautions (EBP). In addition, a resident with a physician's order for EBP did not have signage posted on their door and PPE was not readily available. Resident identifiers: 21, 84, and 85. Findings included: 1. Resident 21 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, pyogenic arthritis, cellulitis of right lower limb, cellulitis of left lower limb, pressure ulcer of sacral region stage 3, localized edema, infection and inflammatory reaction due to internal right knee prosthesis, chronic kidney disease, protein-calorie malnutrition, essential hypertension, type 2 diabetes mellitus, congestive heart failure, sepsis, and chronic atrial fibrillation. On 9/26/24 at 9:30 AM, an observation was made of resident 21's room. The PPE storage holder on the back side of the door was empty other than a roll of garbage bags. No gowns or masks were observed in resident 21's room. Resident 21's medical record was reviewed on 9/26/24. A physician's order dated 8/9/24, documented Enhanced Barrier Precautions r/t [related to] PICC [peripherally inserted central catheter] line Every Shift. The physician's order was open ended. A physician's order dated 8/9/24, documented Enhanced Barrier Precautions r/t Wound Every Shift. The physician's order was open ended. On 9/26/24 at 9:44 AM, an observation of resident 21's wound care was conducted with the Unit Manager (UM). The PPE storage holder on the back side of resident 21's door contained garbage bags and no other PPE. The UM was observed to donn surgical gloves and cleaned resident 21's coccyx wound with wound cleaner. The UM was observed to doff the soiled surgical gloves and applied alcohol based hand rub (abhr) to her hands prior to donning a new pair of surgical gloves. The UM was observed to pack the coccyx wound with a collagen patch and allginate silver dressing. The UM was observed to doff the soiled surgical gloves and applied abhr to her hands. The UM was observed to cover the coccyx wound with a dressing. An immediate interview was conducted. The UM stated that she would use EBP if the resident had a urinary catheter. The UM stated she would put on a surgical gown if resident 21's wound was bigger. The UM stated that resident 21's coccyx wound had been irrigated before and the Wound Nurse would put on a surgical gown and a mask. The UM stated that resident 21's coccyx wound had gotten smaller. The UM stated that every Wednesday the Wound Nurse Practitioner would come to the facility. The UM stated the Wound Nurse would do all the resident skin assessments. The UM stated that the Certified Nursing Assistants (CNA) would wear PPE for the EBP residents any time the CNAs were doing catheter cares and or cleaning a bowel movement. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 21's room was observed to have an ENHANCED BARRIER PRECAUTIONS stop sign on the outside of the door. The sign documented EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing. Do not wear the same gown or gloves for the care of more than one person. The sign was endorsed by the United States Department of Health and Human Services Centers for Disease Control and Prevention (CDC). In addition, resident 21's room was observed to have a Multridrug-resistant organisms (MDRO) are a threat to our residents sign on the outside of the door. The sign documented Enhanced Barrier Precautions (EBP) Steps Perform Hand Hygiene Wear Gown Wear Gloves Dispose of Gown & Gloves in Room Use EBP during high-contact care activities for resident with: 1. Indwelling Medical Devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) 2. Wounds 3. Colonization or Infection with a MDRO Protect residents and stop the spread of germs. The sign was endorsed by the CDC. On 9/26/24 at 10:05 AM, an interview was conducted with CNA 2. CNA 2 stated that she was just told about the EBP. CNA 2 stated that she was told to make sure to have the surgical gown on for resident 21's wounds. CNA 2 stated that she was told to use a surgical gown for anything regarding resident 21's wound or anytime she went into resident 21's room. CNA 2 stated that she did not wear a surgical gown just now while she was providing cares to resident 21 because there were no surgical gowns in resident 21's room. CNA 2 stated that she was Agency and had worked with resident 21 before and did not know about the EBP. 2. Resident 84 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, aftercare following joint replacement surgery, repeated falls, urinary tract infection, fracture of unspecified part of neck of right femur, essential hypertension, and depression. Resident 84's medical record was reviewed on 9/24/24. A physician's order dated 9/23/24, documented Enhanced Barrier Precautions- wounds Every Shift DAY, NIGHT. The physician's order was open ended. On 9/24/24 at 9:50 AM, an observation was conducted of resident 84's room. There was no EBP signage posted on the door and PPE was not available. 3. Resident 85 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, encounter for other orthopedic aftercare left hip open reduction and internal fixation, thrombophilia, disorders of bladder, bladder distention, gross hematuria, metabolic encephalopathy, presence of prosthetic heart valve, elevation of levels of liver transaminase levels, gram-negative sepsis, essential hypertension, epilepsy, acute kidney failure, urinary tract infection, severe sepsis with septic shock, and fracture of left femur. On 9/23/24 at 1:50 PM, an observation was conducted or resident 85's room. Resident 85 was observed to have EBP signage on the outside of the room posted on the door. There was no PPE observed inside or outside of resident 85's room. Resident 85's medical record was reviewed on 9/24/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465168	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Riverton	3419 West 12600 South Riverton, UT 84065

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order dated 9/23/24, documented Enhanced Barrier Precautions- catheter Every Shift DAY, NIGHT. The physician's order was open ended. On 9/26/24 at 9:31 AM, an observation was conducted of resident 85's room. A PPE storage holder was observed hanging on the back side of the door. The PPE storage holder contained one disposable surgical gown and clear garbage bags. On 9/23/24 at 10:06 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated they only needed to wear PPE when there was a sign on the door and if they change a dressing. On 9/26/24 at 9:20 AM, an interview was conducted with the UM. The UM stated that EBP were implemented when a resident had a urinary catheter, intravenous picc line, open wounds, or Coronavirus disease (COVID-19) . The UM stated if a resident had COVID-19 the facility had PPE bins that would be placed in front of the resident's room with signage. The State Survey Agency (SSA) Lead Surveyor observed the storage room with the UM where the PPE bins were stored. The UM stated that she thought resident 84's wounds were healed. The UM stated the wound nurse came to the facility everyday to assess resident wounds and new admissions. The SSA Lead Surveyor observed the PPE storage holder with the UM on the back side of resident room [ROOM NUMBER]. The PPE storage holder was observed to contain garbage bags and no other PPE. The UM stated the PPE storage holder for room [ROOM NUMBER] should contain surgical gowns. On 9/26/24 at 10:43 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that EBP should be implemented for any patient that had an open wound, MDRO, picc line, Foley catheter, or any unnatural opening that should not be there on the body. The DON stated that staff should be gowned and gloved with any direct patient care. The DON stated the night shift CNAs were to stock the PPE storage holders every night. The DON stated that with the regular staff there was constant training and with Agency staff it was harder. The DON stated that staff were trained to keep their brains up to date and the staff should be passing those things along in report. The DON stated that resident 84 had scarring on the coccyx and the EBP was implemented for the surgical wound to resident 84's hip. 44640