STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465125	A. Building B. Wing	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Cottage on Vine	835 East Vine Street Murray, UT 84107

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33215 Based on observation, interview, and record review, the facility did not ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and did not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable. Specifically, for 1 out of 29 sampled residents, a resident that was unable to reposition on their own and was not frequently repositioned by staff developed a pressure ulcer. Resident identifier: 21. Findings included: Resident 21 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, encounter with orthopedic aftercare, chronic diastolic heart failure, type two diabetes mellitus with foot ulcer, complication of kidney transplant, moderate protein-calorie malnutrition, chronic kidney disease stage 4, repeated falls, essential hypertension, and dementia. Resident 21's medical record was reviewed on 6/13/23. A care plan Problem with a start date of 9/22/22, documented Category: Skin Integrity [resident 21] is at risk for alteration to skin integrity secondary to Weakness/ulcers/DM [diabetes mellitus]/HLD [high-density lipoprotein]. Edited: 06/12/2023. A care plan Goal documented Long Term Goal Target Date: 09/12/2023 [resident 21] will have no unaddressed alteration to skin integrity, through next review. Edited: 06/12/2023. The care plan interventions included: a. Approach start date 9/22/22. Assist with turning/frequent repositioning, as needed (PRN). b. Approach start date 9/22/22. Provide skin and incontinence care assistance, PRN. c. Approach start date 9/22/22. Standard facility Pressure Reduction mattress. d. Approach start date 9/22/22. Weekly skin check per facility schedule, notify Medical Doctor of alterations for prompt/proper intervention. (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 0686 Level of Harm - Actual harm Residents Affected - Few	A Braden Scale for Predicting Pressure Sore Risk dated 12/23/22, documented that resident 21 was at Moderate Risk for pressure sores with a score of 14. A score of 13 to 14 indicated Moderate Risk. [Note: This was the most recent Braden Scale for Predicting Pressure Sore Risk in resident 21's medical record.] A quarterly Minimum Data Set (MDS) assessment dated [DATE], documented that resident 21 required extensive assistance of two persons for bed mobility and resident 21 was always incontinent of bladder and bowel. Bed mobility included how a resident moved to and from a lying position, turned side to side, and positioned body while in bed or alternate sleep furniture. In addition, the MDS assessment documented that resident 21 was at risk of developing pressure ulcers and resident 21 had no unhealed pressure ulcers. A care plan Problem with a start date of 4/4/23, documented Category: Skin Integrity [resident 21] has an actual skin impairment/wound. Left lateral lower extremity. Edited: 06/12/2023. A care plan Goal documented Short Term Goal Target Date: 09/12/2023 [resident 21] will have no unaddressed complications to skin/wound or prescribed treatments through next review. Edited: 06/12/2023. The care plan interventions included: a. Approach start date 4/4/23. In house wound care provider to assess and treat once a day. b. Approach state dated 4/4/23. Treatments as prescribed once a day. On 6/8/23 at 11:29 AM, a Nursing progress note documented Nurse found a wound that looks like a bedsore on her lt. [sic] back/ coccyx area. Cleaned with NS [normal saline] and applied meta honey [sic] and covered it with boarded gauze. A physician's order dated 6/8/23, documented Clean bedsore on lt. [sic] coccyx area and apply dressing on. Once A Day Clean bedsore on lt. [sic] coccyx area with NS, apply med honey and cover with optifoam nonboarded dressing 06/08/2023 - Open Ended. On 6/9/23 at 2:40 PM, a Dietary progress note documented . Nursing reports resident has possible new skin impairment to back/coccyx area- wound care team to assess. On 6/9/23 at 3:47 PM, a Nursing progress note documented Bandage to coccyx wound changed per orders. Site had scant drainage present and no odor. Patient tolerated treatment okay with some signs of pain present. Pain medication given per orders. On 6/10/23 at 1:44 PM, a Nursing progress note documented Bandage changed to coccyx wound site after patients shower. No drainage present but site is still open. On 6/10/23 at 4:49 PM, a Certified Nursing Assistant (CNA) progress note documented [Resident 21] had a hard time sitting upright due to pain on coccyx and her demeanor appeared 'lethargic'. She was getting nervous and was yelling 'I'm going to fall.' I placed her back in bed and continued to give her a bed bath. She appeared more at ease and comfortable. On shower days, continue to do bed baths only. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/11/23 at 4:22 PM, a Nursing progress note documented Bandage changed to coccyx wound site during brief change. No drainage present but site is still open. Patient tolerated treatment well. On 6/14/23 at 2:46 PM, a Nursing progress note documented Professional wound clinic NP [Nurse Practitioner] into see resident, coccyx wound, left leg wound and toes, cleaned, measured and redressed. Resident tolerated well. WCTM [will continue to monitor]. The Point of Care History was reviewed. The following was documented regarding how the resident moved in bed. [Note: According to documentation resident 21 was not repositioned every two to three hours.] a. On 6/1/23 at 5:27 AM, extensive assistance. b. On 6/1/23 at 11:22 AM, activity did not occur. c. On 6/2/23 at 3:35 AM, limited assistance. d. On 6/2/23 at 7:56 AM, extensive assistance. e. On 6/4/23 at 3:15 AM, limited assistance. f. On 6/5/23 at 2:30 AM, limited assistance. g. On 6/5/23 at 11:39 AM, extensive assistance. h. On 6/5/23 at 9:36 PM, limited assistance. i. On 6/6/23 at 12:31 AM, extensive assistance. j. On 6/7/23 at 1:26 AM, extensive assistance. k. On 6/7/23 at 9:28 AM, extensive assistance. l. On 6/8/23 at 12:10 AM, extensive assistance. m. On 6/9/23 at 9:54 AM, extensive assistance. n. On 6/9/23 at 4:48 PM, total dependence. o. On 6/10/23 at 4:50 PM, activity did not occur and supervision. p. On 6/11/23 at 4:52 AM, limited assistance. q. On 6/11/23 at 1:52 PM, total dependence. r. On 6/11/23 at 2:33 PM, total dependence. s. On 6/12/23 at 1:43 PM, total dependence. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	t. On 6/12/23 at 11:27 PM, total dependence. On 6/13/23 at 10:37 AM, a continuous observation was conducted. Resident 21 was observed lying flat in the bed with her head turned to the right and the television on. At 11:41 AM, the nurse went into resident 21's room and obtained resident 21's blood sugar. Resident 21 was not repositioned at this time. At 12:04 PM, the NP was observed in resident 21's room listening to resident 21's lungs and talking with resident 21. Resident 21 was not repositioned at this time. At 1:04 PM, resident 21's lunch tray was delivered. The CNA provided meal tray set up, raised the head of the bed, and assisted resident 21 with eating. [Note: Resident 21 was not repositioned or provided a brief change during the 2 hour and 27 minute continuous observation.] On 6/14/23 at 11:08 AM, an observation of resident 21's wound care was conducted. Licensed Practical Nurse (LPN) 1 was observed to donn gloves and removed the old dressing from resident 21's coccyx. LPN 1 stated that resident 21 was not on an air mattress but the mattress was really soft. NP 1 stated that the area to resident 21's coccyx appeared to be open. NP 1 was observed to clean and dress resident 21's pressure ulcer. NP 1 stated to use medihoney with a boarder foam dressing on the coccyx pressure ulcer. NP 1 was observed to measure the coccyx pressure ulcer. NP 1 stated the pressure ulcer measured 0.8 by 0.6 centimeters and the depth was unable to be determined. NP 1 stated that the pressure ulcer was unstageable. NP 1 stated that she saw resident 21 last week for her legs but NP 1 did not know resident 21 had a coccyx wound. NP 1 asked LPN 1 who had set the wound orders. [Note: LPN 1 did not state who had set the wound orders.] On 6/14/23 at 12:07 PM, an interview was conducted with CNA 1. CNA 1 stated that resident 21 was incontinent of bowel and bladder. CNA 1 stated that he would change resident 21's brief every three hours. CNA 1 stated that resident 21 did not eat or drink a lot so resident 21 had very little output. CNA 1 stated that he would check on resident 21 every twoish hours and would change resident 21 every threeish hours. CNA 1 stated when he changed resident 21 he would but a pillow underneath her other side and reposition. CNA 1 stated that he had noticed that the other CNAs had not been repositioning resident 21 as much. CNA 1 stated if he told resident 21 to reposition while he were standing next to her resident 21 would reposition, but to tell resident 21 to reposition herself every two hours resident 21 would not do that. On 6/14/23 at 2:10 PM, an interview was conducted with CNA 2. CNA 2 stated that resident 21 was incontinent of bowel and bladder. CNA 2 stated that resident 21 was suppose to be changed every two hours but sometimes resident 21 did not have a lot of output. CNA 2 stated that resident 21 was suppose to be repositioned every two hours. CNA 2 stated that resident 21 would allow the staff to reposition her because she would get uncomfortable. On 6/14/23 at 2:15 PM, a follow up interview was conducted with LPN 1. LPN 1 stated the NP would send the notes from today to the Assistant Director of Nursing (ADON) and the ADON would input the changes. LPN 1 stated that the mattress resident 21 was on was not the standard mattress but the next mattress up for those residents that stay in bed a lot. LPN 1 stated that she had thought that resident 21 may have refused the air mattress. LPN 1 was not sure if resident 21's pressure ulcer was preventable. LPN 1 stated that resident 21 did not eat well and the staff would position resident 21 and resident 21 would move herself back to a different position. LPN 1 stated that resident 21's coccyx area was open at one time, it was fairly large, and the area had closed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/15/23 at 9:07 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated if a wound was identified in house she would take a picture of the wound and send the picture to the NP. RN 1 stated that she would offer suggestions regarding the wound if she had any. RN 1 stated that usually the NP would refer to the wound team. RN 1 stated if the floor nurse found the wound first they would stage the wound but usually the wound team would do that. RN 1 stated that she thought resident 21 was on a standard mattress but she would need to check. RN 1 was observed to check resident 21's mattress and RN 1 stated that resident 21 was on a regular mattress. RN 1 stated that if the nurse received the wound care order they would set interventions or the management team if they received the orders. RN 1 stated that resident 21 was to receive wound care daily to her coccyx. RN 1 stated that resident 21 was to be repositioned and changed every two to three hours. RN 1 stated that resident 21 was incontinent of bowel and bladder. RN 1 stated that resident 21 was not really able to reposition herself. On 6/15/23 at 10:24 AM, an interview was conducted with the ADON. The ADON stated that more often than not resident 21 refused meals and cares. The ADON stated management had approached resident 21 about enrolling in hospice cares on several occasions. The ADON stated resident 21's family had pushed physical therapy and resident 21 failed because she would not participate. The ADON stated the mattress that resident 21 was on was a four layer foam mattress. The ADON stated that all the residents in the facility had the four layer foam mattress. The facility policy regarding Pressure Injury Prevention Guidelines was reviewed. Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Policy Explanation and Compliance Guidelines: 1. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics). 2. The goal and preferences of the resident and/or authorized representative will be included in the plan of care. 3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. 4. In the absence of prevention orders, the licensed nurse will utilize nursing judgment in accordance with pressure injury prevention guidelines to provide care, and will notify physician to obtain orders. 5. Prevention devices will be utilized in accordance with manufacturer recommendations (e.g., heel flotation devices, cushions, mattresses). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	6. Guidelines for prevention may be utilized in obtaining physician orders. The facility may use facility specific guidelines. a. The guidelines are to be used to assist in treatment decision making. b. Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances. c. When physician orders are present, the facility will follow the specific physician orders. 7. Interventions will be documented in the care plan and communicated to all relevant staff. 8. Compliance with interventions will be documented in the medical record. a. For at-risk residents: treatment or medication administration records. b. For residents who have a pressure injury present: treatment or medication administration records; weekly wound summary charting. 9. The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound. Considerations for needed modifications include: a. Development of a new pressure injury. b. Lack of progression towards healing or changes in wound characteristics. c. Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.

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F 0689 Level of Harm - 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** 45470 Based on interview and record review, it was determined, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 1 out of 29 sampled residents, a resident who was a two-person assist with bed mobility was rolled out of bed and sustained a rib fracture during a brief change with one staff member. Resident identifier: 11. Findings included: Resident 11 was initially admitted to the facility on [DATE] and again on 12/2/20 with medical diagnoses which included acute chronic diastolic heart failure, obesity, vitamin deficiency, type 2 diabetes mellitus, muscle weakness, hypothyroidism, edema, hyperuricemia, cystitis, urinary tract infection (UTI), cellulitis, abdominal pain, dizziness, insomnia, hypokalemia, pain, acute recurrent sinusitis, personal history of UTIs, neuralgia, morbid obesity, major depressive disorder, sleep apnea, pure hypercholesterolemia, constipation, pain, erythematous, hypomagnesemia, gout, muscle weakness, hypokalemia, atypical femoral fracture, pain, long term use of anticoagulants, constipation, and bradycardia. On 6/12/23 at 10:13 AM, an interview with resident 11 was conducted. Resident 11 stated that on 3/17/23, a Certified Nursing Assistant (CNA) accidentally pushed her off the bed during a brief change. Resident 11 stated that the CNA was supposed to wait for another CNA because resident 11 required at least two people during brief changes. Resident 11 stated that she was rolled off the bed, hit her nose on the bedside table, and fell on to the floor. Resident 11 stated that she was sent to the hospital where it was discovered that she had fractured her rib from the fall. Resident 11's medical record was reviewed. Resident 11's annual Minimum Data Set assessment dated [DATE], revealed that resident 11 required a two-person physical assist with bed mobility and toilet use. A progress note dated 3/17/23 at 12:37 AM, revealed Resident rolled out of bed to floor, EMS [Emergency Medical Services] called, pt [patient] transported to ER [emergency room]. A progress note from 3/17/23 at 11:38 AM stated, Pt returned via stretcher, MD [Medical Doctor] notified. Request for records have been made from ER. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility reported incident dated 3/17/23, was reviewed. The report revealed that CNA 3 was with resident 11 during the bed mobility when resident 11 fell out of the bed and was sent to the hospital. A follow-up investigation was completed by the facility. The investigation included an interview with resident 11 that stated, [resident 11] states that while doing cares staff member [CNA 3] had her roll over and she pushed her side to assist the move but it was too much momentum from her and [resident 11] pulling on bed rails that she fell . She doesn't feel as if she did it on purpose but she does need to be more careful. The investigation included a summary of the interview with CNA 3 that stated, [CNA 3] states that her and another aid [CNA] saw her call light and went in and [resident 11] stated she made a bowel movement. [CNA 3] decided she would start cleaning as the other aid got the proper supplies. When cleaning she asked [resident 11] to roll over and she complied asking [CNA 3] to push on her hip to help. [CNA 3] complied and it went smoothly. After cleaning that part she asked [resident 11] to roll again and [resident 11] asked her to push on her hip as well and she pulled on the side rails. She then got rolled off the bed from too much momentum and her lower half hit the floor and she lowered herself the rest via rails [sic]. Notified nurse while res. [resident 11] was lowering herself [CNA 3] also tried to catch her but she was too heavy and out of arms reach. The investigation reported, Hospital diagnosed right rip fracture, fracture of transverse process of thoracic vertebra, acute lower back pain, and facial contusion. Last weight took was 3/15/23 and was 350lbs [pounds]. The investigation concluded that there was no abuse or neglect, and there was no malintent from CNA 3. On 6/13/23, an interview with the Corporate Resource Nurse (CRN) was conducted. The CRN stated that CNA 3 had been educated on two-person transfers prior to the incident on 3/17/23, with resident 11. The CRN stated that after the incident, the facility decided to stop working with CNA 3. On 6/14/23 at 9:17 AM, the State Survey Agency attempted to interview CNA 3 via a phone call. The State Survey Agency was unable to contact CNA 3. On 6/14/23 at 9:43 AM, an interview with CNA 4 and CNA 5 was conducted. CNA 4 and CNA 5 stated that resident 11 should always have two staff members during a brief change. On 6/14/23 at 11:16 AM, an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated that CNA 3 was completing a brief change for resident 11 without the assistance of another CNA. The ADON stated that the fall resulted in resident 11 obtaining a fractured rib. The ADON stated that the facility was unable to obtain the hospital records from 3/17/23, for resident 11. The ADON stated that the facility requested the hospital records multiple times. The ADON stated that CNA 3 should have waited for assistance during the brief change and after the incident the facility let CNA 3 go.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45470 Based on observation, interview, and record review, it was determined, the facility failed to provide a risk and benefits of bed rails to the resident or resident representative and obtain informed consent prior to installation. Specifically, for 1 out of 29 sampled residents, a resident with half bedrails attached to the bed was not provided a risk and benefits. Resident identifier: 24. Findings included: Resident 24 was admitted to the facility on [DATE] with diagnoses which included posterior reversible encephalopathy syndrome, epilepsy, dependence on supplemental oxygen, difficulty in walking, lack of coordination, muscle weakness, iron deficiency, morbid obesity, dysphagia, anxiety disorder, nausea, pressure ulcer, muscle wasting and atrophy, depression, type 2 diabetes mellitus, systolic heart failure, pain, hypokalemia, major depressive disorder, and long term use of anticoagulants. On 6/12/23 at 12:26 PM, an interview with resident 24 was conducted. Resident 24 stated that she was concerned that her bed rails were too loose. Resident 24 stated that she used the bed rails to readjust herself in bed. Resident 24 stated that the maintenance person at the facility had tightened the bed rails in the past and she had told staff many times that she believed the bed rails needed to be tightened again. On 6/12/23, an observation of resident 24's bed rails were made. The bed rails had a slight give when pulling left and right on the bed rail. The bed rail felt attached to the bed when slightly moving the bed rail side to side. On 6/13/23, resident 24's medical record was reviewed. Resident 24's care plan stated, [resident 24] is at risk for altered ADL [activities of daily living] function . The goal stated, [Resident 24] will not have any unaddressed complications secondary to decreased ADL self-performance, through next review. The approach in the care plan stated, [resident 24] uses bed canes to help with her mobility. It was revealed that resident 24 did not have a risk and benefits of bed rails in her medical record. On 6/13/23 at 12:10 PM, an interview with the Maintenance Staff (MS) was conducted. The MS stated that he had not heard of resident 24's bed rails ever being loose. The MS stated that he had never needed to tighten the bed rails. The MS stated that he typically checked on the residents' beds and bed rails weekly to assure all the equipment was in good condition. On 6/13/23 at 3:34 PM, an interview with Corporate Resource Nurse (CRN) was conducted. The CRN confirmed that resident 24 did not have a risk and benefits for the bed rails. The CRN stated that the facility would obtain a risk and benefits of bed rails for resident 24 today. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/23 at 10:15 AM, an interview with resident 24 was conducted. Resident 24 stated that the MS came into the room and assessed the bed rails. Resident 24 stated that the MS explained that the bed rails can have a slight give when moving the bed rails side to side. Resident 24 stated that she felt safe using the bed rails.

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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** 45470 Based on interview and record review, it was determined, the facility did not provide or obtain laboratory (lab) services to meet the needs of its residents. Specifically, for 2 out of 29 sampled residents, a urinalysis took multiple attempts and 22 days before results were reported back to the facility, and a resident did not have ordered labs completed. Resident identifiers: 11 and 26. Findings included: 1. Resident 11 was initially admitted to the facility on [DATE] and again on 12/2/20 with medical diagnoses which included acute chronic diastolic heart failure, obesity, vitamin deficiency, type 2 diabetes mellitus, muscle weakness, hypothyroidism, edema, hyperuricemia, cystitis, urinary tract infection (UTI), cellulitis, abdominal pain, dizziness, insomnia, hypokalemia, pain, acute recurrent sinusitis, personal history of UTIs, neuralgia, morbid obesity, major depressive disorder, sleep apnea, pure hypercholesterolemia, constipation, pain, erythematous, hypomagnesemia, gout, muscle weakness, hypokalemia, atypical femoral fracture, pain, long term use of anticoagulants, constipation, and bradycardia. On 6/12/23 at 10:13 AM, an interview with resident 11 was conducted. Resident 11 stated that she was tested for a UTI a while ago and was still waiting for the results. Resident 11 stated that the staff have collected multiple urinary samples for a urinalysis (UA) but resident 11 had not received any results. Resident 11 stated that she did have mild symptoms of a UTI including urinary retention and the urge to urinate frequently. Resident 11's medical record was reviewed. A progress note dated 5/24/23 at 3:25 PM, revealed [Resident 11] has reported pain during urination. MD [Medical Director] notified. Waiting for further orders. A progress note dated 5/24/34 at 8:22 PM, revealed Straight cath [catheter] performed in a sterile manner. 300mL [milliliters] urine output. Patient tolerated well. Called . for lab pick up. A progress note dated 5/31/23 at 5:50 PM, revealed Urinalysis C/S [culture and sensitivity] was obtained by the nurse and . lab was called for pick up. A lab result with the date of the sample collected being 5/24/23, was reported back to the facility on [DATE]. The results stated, No tests indicated. A urine was received with no test indicated. A urine culture transport was received with no test indicated . A lab result with the date of the sample collected being 5/23/23, was reported back to the facility on [DATE]. The results stated, Request problem. Request for additional testing has been received, however, we are unable to add on the test requested. The following tests were not performed: UA/M w/rflx [urinalysis with microscopic with reflex] culture, routine . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465125	A. Building B. Wing	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Cottage on Vine	835 East Vine Street Murray, UT 84107

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 6/8/23 at 3:15 PM, revealed Received new order to collect UA for culture and sensitivity by MD. Sample collected, waiting for [name of lab] to pickup specimen. Sample collected via straight catch/hat. A lab result with the date of the sample collected being 6/8/23, was reported back to the facility on [DATE]. The results stated, greater than 2 organisms recovered, none predominate. Please submit another sample if clinically indicated. A lab result with the date of the sample collected being 6/10/23, was reported back to the facility on [DATE]. The results stated, no tests indicated. A urine was received with no test indicated. Dear Doctor, the requisition we received for the above patient has no test indicated on the request form for one or more of the specimens submitted. The US [United States] code of regulations requires a written and signed request to be forwarded to the testing laboratory following the verbal order of a laboratory test. On 6/14/23 at 10:07 AM, an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON stated that they facility has had issues with getting lab results back in a timely manner. The ADON stated that the most resent issue with resident 11's lab results were due to the lab reported that the necessary forms required by the lab were not filled out correctly by the facility. The ADON stated that the forms were filled out correctly and she called the lab on 6/13/23, to request that the urine sample be tested for a UTI. The ADON stated that the most recent lab results which were reported back on 6/14/23, revealed that resident 11 did not have a UTI. It should be noted that, due to multiple issues with the testing of the urine, it took 22 days after resident 11 reported symptoms of a UTI to receive the results from the laboratory. On 6/14/23 at 10:14 AM, an interview with Registered Nurse (RN) 2 was conducted. RN 2 stated if the staff did not hear back from the lab regarding UA and C/S results after five days, the staff would call the lab to find out why there were no results. 46232 2. Resident 26 was admitted to the facility on [DATE] with the following diagnosis that included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, post-traumatic stress disorder, mood disorder with depressive features, sleep disorder, and essential hypertension. Resident 26's medical record was reviewed on 6/13/23. A care plan developed on 1/5/21, stated resident 26 was at risk for adverse side effects secondary to Psychotropic medication use. A documented approach was to monitor labs as prescribed. Resident 26's physician lab orders were reviewed and documented, CBC [complete blood cell count]; CMP [complete metabolic panel]; Once a day on the 16th of Every 3rd month. This order had a start date of 2/22/22. Resident 26's lab results were reviewed. There were no lab results for the CBC and CMP ordered in November of 2022. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 26's progress notes were reviewed and no documentation was located to indicate blood work was obtained in November of 2022. A review of the Medication Administration Record (MAR) and Treatment Administration Record for November 2022 documented a lab order dated November 16. The lab was documented as not administered and the comment stated unable to verify as complete. On 6/13/23 at 2:29 PM, an interview was conducted with the ADON. The ADON stated they were unable to locate any blood work results for November of 2022 in resident 26's medical record. The ADON stated when blood work was not done, it was communicated to the provider. The ADON stated the nurse should have wrote a progress note about resident 26's blood work. The ADON stated it was tough to say if the blood work was done for November of 2022 but stated they did not have the results for it. On 6/15/23 at 11:41 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated the facility had a lab company that came in to draw blood. LPN 2 stated if the nurse was skilled enough to obtain the blood work, they would do it but normally they just waited for the company to come in and get the blood work. LPN 2 stated if a resident had an order for blood work, it popped up in the MAR and they checked it off when it was done. LPN 2 was unable to locate any blood work results for November of 2022 for resident 26. The facility policy regarding Laboratory Services and Reporting was reviewed. Policy: The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. Policy Explanation and Compliance Guidelines: 1. The facility must provide and obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services. 3. Should the facility provide its own laboratory services, the services must meet the applicable requirement for laboratories. 4. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements. 5. Assist the resident in making transportation arrangements to and from the laboratory if necessary. 6. All laboratory reports will be dated and contain the name and address of the testing laboratory and will be filed in the resident's clinical record. 7. Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46232 Based on interview and record review, it was determined, the facility did not ensure that each resident's medical record included documentation that indicated that the resident or resident's representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization; and that the resident either received the pneumococcal immunizations or did not receive the pneumococcal immunizations due to medical contraindications or refusal. Specifically, for 2 out of 29 sampled residents, the facility did not keep documentation within the residents' medical record regarding the residents' pneumococcal consent status or education of the benefits and potential risks associated with the immunization. Resident identifiers: 24 and 32. Findings included: 1. Resident 24 was admitted to the facility on [DATE] with diagnoses the included, but were not limited to, posterior reversible encephalopathy syndrome, epilepsy, chronic systolic congestive heart failure, depression, type 2 diabetes mellitus, and respiratory failure. On 6/14/23, Resident 24's medical record was reviewed. A review of the vaccination record in the preventative health section of the medial record revealed, resident 24 had received the pneumococcal vaccine outside of their current care setting. It did not specify the date and the type of vaccine the resident had received before they had arrived at the facility on 5/2022. [Note: Resident 24 was offered and given another pneumococcal vaccine on 6/14/23.] A consent/refusal form and education regarding the pneumococcal immunization was not provided or located in resident 24's medical record. 2. Resident 32 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction, Alzheimer's disease, and adult failure to thrive. On 6/14/23, Resident 32's medical record was reviewed. A review of the vaccination record in the preventative health section of the medial record revealed, resident 32 had refused the pneumococcal vaccine and the documented reason was because of a conscientious objection. A consent/refusal form and education regarding the pneumococcal immunization was not provided or located in resident 32's medical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/14/23 at 10:21 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the influenza and pneumococcal vaccines were offered to residents upon admission and consent/refusal forms were signed by the residents. The ADON stated they expected the nurse to verbally educate the residents on the risk versus benefits of the vaccines. The ADON was unable to provide documented education regarding the pneumococcal vaccine. The ADON stated when a resident received their vaccines outside of the care facility, they had to rely on hospital records, Utah Statewide Immunization Information System, or residents' self-reporting their vaccines. The ADON stated in regards to resident 24, they should be offered another pneumococcal vaccine since they had been at the facility for over a year and they were unsure when they had received their last pneumococcal vaccine. On 6/14/23 at 10:43 AM, a follow-up interview was conducted with the ADON. The ADON stated before today, residents were not given documented education on the pneumococcal vaccine. The ADON stated the cooperate nurse was able to provide them with education they could hand out to residents about the pneumococcal vaccine. The ADON stated from now on they would be providing the documented education to all the residents.