

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465075	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2025
NAME OF PROVIDER OR SUPPLIER Rocky Mountain Care - Hunter Hollow		STREET ADDRESS, CITY, STATE, ZIP CODE 4090 West Pioneer Parkway West Valley City, UT 84120	

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 11 sampled residents, that the facility did not provide each resident adequate supervision to prevent accidents. Specifically, a resident was not provided two person assistance during a brief change, which led to a fall and subsequent fractures. This resulted in a finding of harm for resident 5. Resident identifiers: 5. Findings included: Resident 5 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included multiple sclerosis, wedge compression fracture of third lumbar vertebra, paraplegia, and neuromuscular dysfunction of bladder. Resident 5's medical record was reviewed on 12/22/25. A progress note dated 11/15/25 at 12:12 PM stated Aide came to nurse stating that [resident 5] was on the floor, nurse found her on her side next to her bed. She stated she rolled to be changed and was rolled too far and rolled off the bed. Scratches on face from metal side rail seen on face. When this nurse said she would assess she said 'No, I just want to be sent to the hospital; I know what I need' she also refused staff help from getting her off the floor and said she would wait for [ambulance service]. Notified NP [Nurse Practitioner], DON [Director of Nursing], and admin [Administrator], sent with [ambulance service]. A progress note dated 11/15/25 at 8:52 PM documented that the hospital intended to admit resident 5 due to bilateral femur fractures. On 11/15/2025 at 9:21 pm, the facility reported the incident to the State Survey Agency. The facility investigation, reviewed on 12/22/25, contained the following statement: [Resident 5] was interviewed about the incident before she left for the [local hospital] on 11/15/2025 and she was interviewed further at the hospital on [DATE]. [Resident 5] stated that she was being changed by her CNA [Certified Nursing Assistant] and she was rolling to her left side. [Resident 5] states she was holding on to the positioning bar but let go of the positioning bar to grab her catheter, then lost control sliding off the bed. Her lower body fell off the bed first, then her face scraped the position bar. [Resident 5] was asked if she was to [sic] close to the edge of the bed and she said she could have been. The facility investigation contained the following interview with CNA 1: I was changing [Resident 5's] brief and when she rolled over I helped her hold her leg, but she let go of the bed rail to grab her catheter and that's when she lost control and fell from her side. I tried to hold her but she had lost control from her hips down. The facility investigation contained the following statements: [DON] was interviewed about the allegation and stated that [Resident 5] was at risk of falling due to having Multiple Sclerosis, past falls, depression, and opioid use. [Resident 5] was also on an air mattress and had bilateral side rails to help with bed mobility. [Resident 5] had a care plan for 2 person assist for transferring due to being at risk of falling. [Resident 5] did not have a care plan for 2-person bed mobility, and she should have had one because she was using a [sic] air mattress. The conclusion of the facility investigation was verified due to Resident 5 being on an air mattress but not having a care plan for 2 person assist for bed mobility. As a result of the verified investigation the facility listed the following corrective actions taken: The facility has completed a building audit on all residents that are on an air mattress on 11/17/2025 and an in-service has been done with CNA's to educate them on all residents that are on an air mattress need to be 2 person assist for bed mobility. Observe 5 staff during care (bed mobility, transfer, repositioning) weekly X4 weeks; then 5 staff monthly X2 months. Any resident that is on an air mattress will have a care plan for a 2 person assist for bed mobility. On 10/10/25, resident 5's provider ordered an air mattress. A care plan intervention dated 5/2/25 initiated the intervention: Hoyer lift for transferring with two person total assist. A care plan intervention dated 11/15/25 initiated the intervention: [Resident 5] has Air Mattress, needs two person assisted cares. On 12/22/25 at 2:57 PM, an interview was conducted with Nursing Assistant (NA) 1. NA 1 stated that she was notified of residents requiring a two person assist when she received report at shift change. NA 1 was unaware of any changes in care for residents with an air mattress, noting that the only resident she cared for who had an air mattress required a one person assist. On 12/22/25 at 3:06 PM, an interview was conducted with CNA 2. CNA 2 stated that she knew resident requirements for a two person assist from the shift change report or based on her observations of the resident. CNA 2 stated if a resident was unable to hold themselves up during care that she would request help from another CNA. CNA 2 stated that a resident on an air mattress could require a one- or two-person assist, depending on their individual ability to help with positioning. CNA 2 stated that she cared for a resident who used an air mattress and required a one person assist because he could roll over and support himself. On 12/22/25 at 2:00 PM, an interview was conducted with the DON. The DON stated that because resident 5 was on an air mattress she should have been a two person assist at the</p>		