

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/21/2026
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure newly ordered hospice comfort medications were promptly implemented and administered as ordered by the physician. Specifically, for 1 out of 11 sampled residents, staff failed to enter and administer newly ordered end-of-life pain and anxiety medications, resulting in multiple missed doses over a two-day period. The facility developed and implemented a correction action plan before the survey start date. The facility's correction action plan, which was developed and implemented by [DATE], included the following measures: individual education for Nurse 1, facility wide education on end-of-life care and entering physician orders, resident interview and record review to identify any other medication error concerns, daily medication error audits, and implementation of a triple-check process for entering in physician orders. Resident identifier: 4. Resident 4 was admitted on [DATE] and again on [DATE] with a diagnosis of lymphocytic leukemia. Resident 4 was admitted to hospice services on [DATE] and expired on [DATE]. A facility reported incident revealed that on [DATE], Resident 4's spouse reported that the nursing staff failed to implement newly ordered hospice comfort medications, which were ordered on [DATE]. The assigned nurse reported that they received the first order from the hospice provider in the morning, did not get a chance to enter them, and received a second set or order at approximately 1:00 pm on the same day. The nurse acknowledged they reviewed the hospice orders, but stated he interpreted the latter orders as replacing the former scheduled medication orders. On [DATE], the surveyor reviewed Resident 4's Hospice orders. The hospice orders, dated [DATE], were reviewed and documented the following, Morphine 20 mg/mL concentrate 1 milliliter orally every 4 hours for moderate pain and Lorazepam 2 mg/mL concentrate 0.5 milliliter orally every 4 hours for anxiety/restlessness. Resident 4's Medication Administration Record was reviewed and the following medication errors were identified. Morphine 20 mg/mL concentrate 1 milliliter orally every 4 hours for moderate pain was not administered on [DATE] and 3 doses on the morning of [DATE]. Lorazepam 2 mg/mL concentrate 0.5 milliliter orally every 4 hours for anxiety/restlessness was not administered on [DATE] and 3 doses on the morning of [DATE]. On [DATE], the surveyor interviewed the Director of Nursing (DON), who stated that facility policy required floor nurses to enter new resident orders into the chart. The floor nurses must then provide the order to the unit manager or the Assistant DON (ADON) to verify that it was entered correctly. The DON also noted that if a nurse questioned an order, they should call to request clarification and refrain from entering the order until they are certain of its details. The facility's Performance Improvement Plan was reviewed and had been implemented by [DATE]. The plan included the following: Individual education for Nurse 1 was conducted on [DATE]. Residents were interviewed to identify any concerns with missed medications or neglect on [DATE]. All staff education on end-of-life care was conducted between [DATE]-[DATE]. All staff education on clarification of orders was conducted between [DATE]-[DATE]. Daily medication audit (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 465075	Facility ID: 465075
		If continuation sheet Page 1 of 2

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/21/2026
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reports and order listing reports in the electronic health records. were conducted every morning to identify missed medications and ensure orders matched. Daily meetings were conducted with corporate leadership to review medication error data and that a triple-check process (floor nurse entry, manager review, and DON review) had been established.		