STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Hunter Hollow	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 - Minimal harm or potential for 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** Based on observation, interview, and record review, it was determined that, for 1 out of 30 sampled residents, the facility failed to ensure that each resident's environment remained as free of accident hazards as possible, and received adequate supervision and assistance with devices to prevent accidents. Specifically, a resident who had significant dysphagia was coughing while eating with no staff supervision or assistance. Resident identifier: 122.Findings included:On 2/10/26 at 12:26 PM, resident 122 was observed sitting upright in his wheelchair at a table and eating lunch in the dining room, staff member 1 was sitting with him. Resident 122 had a productive wet cough while he was drinking his milk. At 12:27 PM, staff member 1 got up, walked across the large dining room, got a clothing protector, and then returned and put the clothing protector on resident 122 and sat down next to him. Resident 122 was observed to have a productive wet cough after drinking milk. He then ate a spoonful of what looked like mashed potatoes with gravy and had another productive wet cough. At 12:34 PM, resident 122 could be heard grunting and clearing his throat as he continued to have a productive wet cough. At 12:42 PM, staff member 1 left the residents side and assisted another resident with their oxygen tank with resident 122 continuing drinking milk and coughing. While coughing he was observed to be grabbing the arm of his wheelchair with his left arm and trying to sit himself up. It should be noted that resident 122's right arm had weakness and was laying on a board that was placed on the right arm of the wheelchair. While coughing, food particles were observed to be propelled out of his mouth into the air and onto his chin and chest. Resident 122 started to clear his throat, took more sips of milk and continued to cough. The resident could be heard gurgling when coughing. Resident 122 was observed attempting to sit himself up again, milk was dribbling down his chin as he continued to have a productive wet cough. No staff were present with the resident during this time. At 12:44 PM, staff member 1 said resident 122's name as she walked by and left the dining room with an oxygen tank. At 12:45 PM, staff member 2 came up to the resident while the resident was gurgling and had milk going down his face. Staff member 2 wiped his mouth and asked the resident if he was done eating. Resident 122 was coughing and gurgling while he attempted to communicate with staff member 2. Staff member 2 removed the resident's clothing protector and asked him if he was okay. Resident 122 was leaning forward at this time and continued coughing. Staff member 2 called for Registered Nurse (RN) 3, who was down the hall and told her that resident 122 had a lot of mucus and that she thought he was choking on his milk or mucus. RN 3 stated that she was going to take him to his room. RN 3 and staff member 2 took resident 122 to his room and the staff shut the door. It should be noted that there was no documentation of this event in the medical record. Resident 122's medical record was reviewed from 2/9/26 through 2/12/26. Resident 122 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, facial weakness, dysarthria, dysphagia, aphasia, muscle weakness, dementia, cognitive communication deficit, contracture right knee, and ataxia. A physician's order dated 10/3/25 indicated a mechanical soft ground texture, thin consistency, minced and moist diet. A significant change in status Minimum Data Set (MDS) assessment dated [DATE] (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 - Minimal harm or potential for actual harm Residents Affected - Few	indicated resident 122 had moderately impaired cognitive skills for daily decision making. It further indicated resident 122 had impairment to the upper extremity on one side, was provided supervision or touching assistance with eating, was provided substantial/maximal assistance to go from a lying position to a sitting position and to go from a sitting position to a standing position. It further indicated resident 122 had a loss of liquids/solids from mouth when eating or drinking, held food in mouth/cheeks or residual food in mouth after meals, and did not cough or choke during meals or when swallowing medications. The Care Plan Report with a Focus dated 10/4/25 indicated, [Resident 122] is at risk for nutritional deficits secondary to stroke, dysphagia, aphasia, ataxia, dementia, anxiety, insomnia, restless/agitation, pruritus, lupus anticoagulant syndrome, gout, afib [atrial fibrillation], dysarthria, facial weakness Diet NAS [no added salt] Regular diet, Mechanical Soft MM5 [Minced and Moist], Thins liquids Updated likes and dislikes NKFA [no known food allergies] will assist as needed or requested; with an intervention that included, Provide assistance with meals, PRN [as needed]. A provider progress note dated 1/19/26 at 11:00 AM indicated, .Patient experienced clinical deterioration since last visit on 01/13/2026 with development of acute respiratory symptoms.Given patient's documented dysphagia and high risk for aspiration pneumonia maintained on mechanical soft ground texture diet, clinical presentation is most consistent with aspiration pneumonia.Patient continues with significant dysphagia as a direct result of cerebral infarction, placing him at high risk for aspiration pneumonia. Maintaining aspiration precautions during all meals. Patient is maintained on mechanical soft ground texture diet for safety. Continuing speech therapy for swallowing exercises and techniques.Current acute pneumonia presentation is consistent with aspiration event given documented dysphagia and aspiration risk. Will continue strict aspiration precautions and dietary modifications .Speech therapy continues to work with patient on swallowing exercises and techniques to improve oropharyngeal function. Maintaining aspiration precautions during all meals with mechanical soft ground texture diet. Patient demonstrated ability to feed himself with left hand during today's visit without difficulty, though significant dysphagia persists. It should be noted that resident 122 was discharged from SLP (Speech-Language Pathology) services on 11/10/25 and had an evaluation completed on 12/22/25 which indicated that no skilled SLP services were warranted at that time. No other speech therapy treatment documents were provided. A provider progress note dated 2/3/26 at 1:00 PM indicated, .Significant post-stroke dysphagia with high aspiration risk. Recent aspiration pneumonia on 01/19/2026 treated with levofloxacin, completed 01/25/2026 with resolution. Now presents with acute bronchitis on 02/03/2026 likely related to aspiration risk. Maintained on mechanical soft ground texture diet with aspiration precautions during all meals. Patient feeds himself with left hand. Continue speech therapy for swallowing exercises. Monitor closely for recurrent aspiration events. A provider progress note dated 2/5/25 at 8:30 AM indicated, The patient is currently on doxycycline 100 mg [milligrams] PO [by mouth] twice daily for presumed pneumonia following significant symptoms of fever, coughing, and malaise a couple of days ago concerning for aspiration pneumonia. The patient has a well-documented history of aspiration pneumonia due to significant dysphagia and is unable to follow directions for meals, frequently not sitting up properly during eating. A provider progress note dated 2/9/26 at 1:15 PM indicated, .The patient's significant aspiration risk secondary to dysphagia from cerebrovascular accident continues to require close monitoring with maintenance of mechanical soft ground texture diet and strict aspiration precautions during all meals. On 2/11/26 at 1:12 PM, an interview was conducted with the MDS Coordinator. The MDS Coordinator stated she was over the RNA (Restorative Nursing Assistant) program and that if a resident was supposed to be supervised while eating they were supposed to be in the dining area during meal times and that one staff member needed to be in the room. The MDS Coordinator stated that there was a document that listed residents who received physical and occupational therapy recommendations for the RNAs to follow but was not sure if that included speech therapy recommendations because those did not usually come through the signed paperwork. On 2/12/26 at 11:00 AM, an interview was conducted with RNA 1 and she stated that as an RNA she (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	watched dining and passed out food trays. RNA 1 stated that they used to have a table in the dining room where residents who needed assistance to eat would sit at but that they were not doing that anymore. On 2/12/26 at 11:05 AM, an interview was conducted with RNA 2 and she stated that MDS provided a list of residents who needed supervision or assistance with eating but that resident 122 was not on her list. RNA 2 stated the resident needed to be watched but he was not on the list. RNA 2 stated resident 122 coughed up food a lot, everyday, and that RNA 2 noticed it was getting worse last week and that she notified the nurse last week. RNA 2 stated that before last week resident 122 was eating fine. On 2/12/26 at 11:21 AM, an interview was conducted with the Director of Rehabilitation (DOR) and she stated that resident 122 was not currently receiving speech therapy services. The DOR stated that nursing should have notified them if the resident had any changes of condition, and then speech therapy would evaluate them and do their own assessment. The DOR stated she would have expected staff to watch him eat. The DOR stated RNAs have a designated restorative dining table where residents who needed an additional level of support for eating, like strict aspiration precautions, would sit and had staff there to supervise and assist them. The DOR stated she recently heard that the restorative dining table was not being used anymore but that she recently confirmed with the Administrator that it was still being used. The DOR stated if a resident needed strict aspiration precautions staff should have been ensuring the resident was awake and alert, swallowing before taking another bite, making sure the resident was sitting upright, and watching for any overt signs of aspiration. The DOR stated resident 122 had zero awareness of his abilities. The DOR stated that nobody had reported to her that resident 122 was coughing more while eating or had aspiration pneumonia and that if they had they would have reevaluated him. On 2/12/26 at 11:39 AM, an interview was conducted with Registered Nurse (RN) 2 and she stated resident 122 was to receive supervision when eating but that he would feed himself. RN 2 stated he usually went to the dining area to eat, but no CNA (Certified Nursing Assistant) or RNA was designated to watch him. RN 2 stated he coughed off and on when he ate and that he was put on antibiotics for possible pneumonia or bronchitis. RN 1 stated nobody had reported to her that resident 122 was choking or coughing more than normal lately. On 2/12/26 at 11:46 AM, an interview was conducted with the Nurse Practitioner (NP). The NP stated she was notified by a nurse last week that resident 122 was having increased difficulty eating and spitting out food and that she was planning on calling his daughter. The NP stated resident 122 had two strokes and was likely to aspirate and that there was nothing to do with him. When asked what strict aspiration precautions from her charting meant, she stated that it was put in by AI (Artificial Intelligence) and that staff were to follow what the facility protocol was. On 2/12/26 at 12:13 PM, an interview was conducted with MDS Support and she stated that there were no directions for resident 122 to be watched and that he was not on dining observations but he should have been. On 2/12/26 at 12:20 PM, an interview was conducted with the Director of Nursing (DON) and she stated resident 122 had intermittent confusion and dysphagia so he was on a mechanical soft diet to help him with swallowing. The DON stated they usually had staff in the dining room and they oversaw everyone in the dining room. The DON stated staff watched him for coughing and choking while eating. The DON stated that they were going to have speech therapy reevaluate him and update the care plan with interventions for what staff needed to do to assist him with eating.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 1 out of 30 residents receiving a tube feeding received appropriate treatment and services to prevent complications. Specifically, observations revealed the tube feeding was not infusing at the rate prescribed by the provider. Resident identifier: 90 Findings included: Resident 90 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, spastic quadripalegic cerebral palsy, epilepsy, gastrostomy and dysphagia. Resident 90 was NPO (nothing by mouth).A physician order dated 9/19/25 documented, Isosource 1.5 CAL (calorie) 0.07 G (gram) - 1.5 Liquid. Give 40 ml/hr (milliliter/hour) via G-Tube [gastrostomy tube] two times a day for Nutrition Tube Feed to run continuously X (times) 22 hrs (hours)/day with water flushes of 45mL/hr x 22 hours.On 2/9/26 at 8:50 AM, an observation was made of the tube feeding at resident 90's bedside. The tube feeding pump was infusing at 34 ml/hr. A sticker was observed on the bag that documented the feeding was started on 2/8/26 at 2:15, no initials and no information of the type of feeding that was in the bag were observed. A bag of fluid was also observed with a date of 2/8/26, no indication of what the fluid was, the time it was hung, or initials were observed. On 2/10/26 at 9:28 AM, an observation was made of the tube feeding at resident 90's bedside. The tube feeding was observed to be infusing at 34 ml/hr. There was a sticker on the bag that documented the feeding was started on 2/9/26 at 2:19, AM or PM was not documented on the bag, no initials and no information of the type of feeding that was in the bag were observed. A bag of fluid was also observed with a date of 2/9/26; no indication of what the fluid was, the time it was hung, or initials were observed. On 2/10/26 at 2:45 PM, resident 90's feeding tube was observed to be infusing at 34ml/hr. The label on the feeding bag did not indicate what type of feeding was in the bag. On 2/11/26 at 10:20 AM, an interview was conducted with Registered Nurse (RN) 1 who stated the tube feeding for resident 90 was supposed to be running Isosource at 34-36 ml/hr. RN 1 stated that she had just changed resident 90's tube feeding bag. RN 1 stated the nurses were supposed to look in the orders for the feeding rate. An observation was made of RN 1 looking in resident 90's medical record orders and stated the feeding should be infused at 40ml/hr with a 45ml/hr flush. RN 1 and this surveyor entered resident 90's room and the tube feeding was observed to be infusing at 34ml/hr. RN 1 stated the feeding rate was wrong and should have been 40ml/hr. RN 1 stated the staff should put the name of the feeding, the date and time and who hung the feeding on the sticker of the bag. RN 1 was observed to change the rate of the feeding to 40ml/hr. She stated she did not know how long the resident had only been getting 34ml/hr instead of 40ml/hr.On 2/11/26 at 10:37 AM, an interview was conducted with the Director of Nursing (DON) who stated the staff should always follow the rate the provider prescribed for the tube feeding. The DON stated resident 90's feeding rate should have been running at 40ml/hr, flushed with 45ml and to run for 22 hours. The DON stated the staff should label the tube feeding with the date, formula/flush, rate of the feeding, rate of flush, and their initials. The DON stated she would do staff education again.Review of a facility policy titled, Care and Treatment of Feeding Tubes with a revision date of April 2025, revealed .1. Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush. 9. Direction for staff regarding nutritional products and meeting the resident's nutritional needs will be provided: . e. Ensuring that the administration of enteral nutrition is consistent with and follows the practitioner's orders.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, for 1 out of 30 sampled residents, a resident who received medication for diabetes mellitus did not have those medications available from the pharmacy for administration. Resident identifier: 97. Findings included: On 2/9/26 at 9:38 AM, an interview was conducted with resident 97 and he stated that he had not received his GLP1 (glucon-like peptide-1) shot (a medication for diabetes) that was due three days ago. Resident 97 stated he was told by staff that it was always given late because the pharmacy did not deliver it.Resident 97's medical record was reviewed from 2/9/26 through 2/12/26.Resident 97 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus with diabetic neuropathy and chronic kidney disease.The current physician's order dated 2/9/26 at 2:43 AM indicated, Tirzepatide Subcutaneous Solution Auto-injector 10 MG [milligrams]/0.5ML [milliliters] (Tirzepatide) Inject 10 mg subcutaneously at bedtime every Mon [Monday] for Diabetes.The Medication Administration Record (MAR) indicated resident 97 was administered Tirzepatide late 3 times between 9/1/25 through 2/11/26 and missed doses for the weeks of 1/1/26 and 1/31/26.Orders- Administration Notes were reviewed from 9/18/25 through 2/8/26 with multiple notes that indicated Tirzepatide was not given due to it not being available.On 2/12/26 at 10:53 AM, an interview was conducted with Registered Nurse (RN) 2 who stated that Tirzepatide was hard to get from the pharmacy because it needed insurance to approve of it. RN 2 stated it should have been administered weekly and usually on Fridays but the pharmacy did not send it on time. RN 2 stated when medications get close to running low they were supposed to reorder it from the pharmacy before it ran out.On 2/12/26 at 12:36 PM, an interview was conducted with the Director of Nursing (DON) who stated that the nurses needed to contact the pharmacy to order the medication and that the residents should be getting their medications on time, and if it was not, the nurses should have notified the doctor.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that, for 1 out of 30 sampled residents, the facility failed to provide the required specialized rehabilitation services, speech-language pathology. Specifically, one resident experienced a change in his eating abilities and speech therapy was not notified. Resident identifier: 122. Findings included: On 2/10/26 at 12:26 PM, resident 122 was observed sitting upright in his wheelchair at a table and eating lunch in the dining room, staff member 1 was sitting with him. Resident 122 had a productive wet cough while he was drinking his milk. At 12:27 PM, staff member 1 got up, walked across the large dining room, got a clothing protector, and then returned and put the clothing protector on resident 122 and sat down next to him. Resident 122 was observed to have a productive wet cough after drinking milk. Resident 122 then ate a spoonful of what looked like mashed potatoes with gravy and had another productive wet cough. At 12:34 PM, resident 122 could be heard grunting and clearing his throat as he continued to have a productive wet cough. At 12:42 PM, staff member 1 left the residents side and assisted another resident with their oxygen tank; resident 122 continued drinking milk and coughing. While coughing he was observed to be grabbing the arm of his wheelchair with his left arm and trying to sit himself up. It should be noted that resident 122's right arm had weakness and was laying on a board that was placed on the right arm of the wheelchair. While coughing, food particles were observed to be propelled out of his mouth into the air and onto his chin and chest. Resident 122 started to clear his throat, took more sips of milk and continued to cough. The resident could be heard gurgling when coughing. Resident 122 was observed attempting to sit himself up again, milk was dribbling down his chin as he continued to have a productive wet cough. No staff were present with the resident during this time. At 12:44 PM, staff member 1 said the resident's name as she walked by and left the dining room with an oxygen tank. At 12:45 PM, staff member 2 came up to the resident while the resident was gurgling and had milk going down his face. Staff member 2 wiped the resident's mouth and asked the resident if he was done eating. Resident 122 was coughing and gurgling while he attempted to communicate with staff member 2. Staff member 2 removed resident 122's clothing protector and asked him if he was okay. Resident 122 was leaning forward at this time and continued coughing. Staff member 2 called for Registered Nurse (RN) 3, who was down the hall and told RN 3 that resident 122 had a lot of mucus and that she thought the resident was choking on his milk or mucus. RN 3 stated that she was going to take the resident to his room. RN 3 and staff member 2 took resident 122 to his room and the staff shut the door.It should be noted that there was no documentation of this event in the medical record.Resident 122's medical record was reviewed from 2/9/26 through 2/12/26.Resident 122 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, facial weakness, dysarthria, dysphagia, aphasia, muscle weakness, dementia, cognitive communication deficit, contracture right knee, and ataxia.A physician's order dated 10/3/25 indicated speech therapy to evaluate and treat as needed.A significant change in status Minimum Data Set (MDS) dated [DATE] indicated resident 122 had moderately impaired cognitive skills for daily decision making. It further indicated resident 122 had impairment to the upper extremity on one side, was provided supervision or touching assistance with eating, was provided substantial/maximal assistance to go from a lying position to a sitting position and to go from a sitting position to a standing position. It further indicated resident 122 had a loss of liquids/solids from mouth when eating or drinking, held food in mouth/cheeks or residual food in mouth after meals, and did not cough or choke during meals or when swallowing medications.The Care Plan Report with a Focus dated 10/4/25 indicated, [Resident 122] is at risk for nutritional deficits secondary to stroke, dysphagia, aphasia, ataxia, dementia, anxiety, insomnia, restless/agitation, pruritus, lupus anticoagulant syndrome, gout, afib [atrial fibrillation], dysarthria, facial weakness Diet NAS [no added salt] (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regular diet, Mechanical Soft MM5 [Minced and Moist], Thins liquids Updated likes and dislikes NKFA [no known food allergies] will assist as needed or requested; with an intervention that included, Provide assistance with meals, PRN [as needed].A provider progress note dated 1/19/26 at 11:00 AM indicated, .Patient experienced clinical deterioration since last visit on 01/13/2026 with development of acute respiratory symptoms.Given patient's documented dysphagia and high risk for aspiration pneumonia maintained on mechanical soft ground texture diet, clinical presentation is most consistent with aspiration pneumonia.Patient continues with significant dysphagia as a direct result of cerebral infarction, placing him at high risk for aspiration pneumonia. Maintaining aspiration precautions during all meals. Patient is maintained on mechanical soft ground texture diet for safety. Continuing speech therapy for swallowing exercises and techniques.Current acute pneumonia presentation is consistent with aspiration event given documented dysphagia and aspiration risk. Will continue strict aspiration precautions and dietary modifications .Speech therapy continues to work with patient on swallowing exercises and techniques to improve oropharyngeal function. Maintaining aspiration precautions during all meals with mechanical soft ground texture diet. Patient demonstrated ability to feed himself with left hand during today's visit without difficulty, though significant dysphagia persists.It should be noted that resident 122 was discharged from SLP (Speech-Language Pathology) services on 11/10/25 and had an evaluation completed on 12/22/25 which indicated that no skilled SLP services were warranted at that time. No other speech therapy treatment documents were provided. A provider progress note dated 2/3/26 at 1:00 PM indicated, .Significant post-stroke dysphagia with high aspiration risk. Recent aspiration pneumonia on 01/19/2026 treated with levofloxacin, completed 01/25/2026 with resolution. Now presents with acute bronchitis on 02/03/2026 likely related to aspiration risk. Maintained on mechanical soft ground texture diet with aspiration precautions during all meals. Patient feeds himself with left hand. Continue speech therapy for swallowing exercises. Monitor closely for recurrent aspiration events.A provider progress note dated 2/5/25 at 8:30 AM indicated, The patient is currently on doxycycline 100 mg [milligrams] PO [by mouth] twice daily for presumed pneumonia following significant symptoms of fever, coughing, and malaise a couple of days ago concerning for aspiration pneumonia. The patient has a well-documented history of aspiration pneumonia due to significant dysphagia and is unable to follow directions for meals, frequently not sitting up properly during eating.A provider progress note dated 2/9/26 at 1:15 PM indicated, .The patient's significant aspiration risk secondary to dysphagia from cerebrovascular accident continues to require close monitoring with maintenance of mechanical soft ground texture diet and strict aspiration precautions during all meals.On 2/12/26 at 11:05 AM, an interview was conducted with Restorative Nursing Assistant (RNA) 2 and she stated that MDS provided a list of residents who needed supervision or assistance with eating but that resident 122 was not on her list. RNA 2 stated resident 122 needed to be watched but he was not on the list of people who needed supervision or assistance with eating RNA 2 stated resident 122 coughed up food a lot, everyday, and that she noticed it was getting worse last week and that she notified the nurse last week. RNA 2 stated that before last week resident 122 was eating fine.On 2/12/26 at 11:21 AM, an interview was conducted with the Director of Rehabilitation (DOR) and she stated that resident 122 was not currently receiving speech therapy services. The DOR stated that nursing should have notified them if the resident had any changes of condition, and then speech therapy would evaluate them and do their own assessment. The DOR stated that nobody had reported to her that resident 122 was coughing more while eating or had aspiration pneumonia and that if they had they would have evaluated him.On 2/12/26 at 11:46 AM, an interview was conducted with the Nurse Practitioner (NP). The NP stated she was notified by a nurse last week that resident 122 was having increased difficulty eating and spitting out food and that she was planning on calling the resident's daughter. The NP stated resident 122 had two strokes and was likely to aspirate and that there was nothing to do with him.On 2/12/26 at 12:20 PM, an interview was conducted with the Director of Nursing (DON) and she stated resident 122 had intermittent confusion and dysphagia so he was on a mechanical soft (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diet to help him with swallowing. The DON stated staff watched the resident for coughing and choking while eating. The DON stated that they were going to have speech therapy reevaluate him and update the care plan with interventions for what staff needed to do to assist him with eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465075	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mountain Care - Hunter Hollow	4090 West Pioneer Parkway West Valley City, UT 84120

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 30 sampled residents, that the facility did not maintain medical records on each resident that were complete; accurately documented; readily accessible; and systematically organized. Specifically, blood sugar results were not recorded in the medical record for a resident who was given unprescribed insulin. Resident identifiers: 126. Findings included: Resident 126 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, hemiplegia and hemiparesis of the right dominant side, dysphagia, acute kidney failure and chronic congestive heart failure. Resident 126's medical record was reviewed on 2/11/26. A progress note dated 11/23/25 at 8:35 AM documented, Med [medication] error, Pt [patient] mistakenly given 50 units glargine insulin. Pt is t2 [type 2] diabetic. Called DON [Director of Nursing], and [medical provider]. Will hold dapagliflozin and monitor BG [blood glucose] every hour for 24 hours. Any BG under 100 to be reported to [medical provider]. A progress note dated 11/23/25 at 7:32 PM documented, Patient on alert charting r/t [related to] administration of Insulin Glargine. BS and vital signs WNL [within normal limits]. POA [Power of Attorney], [name omitted], notified of incident and encouraged to call back with any follow up questions. Patient at baseline, no c/o [complaints of] discomfort. BS continues to be monitored Q [every] hour for 24 hours. Blood glucose levels were documented in the medical record on 11/23/25 at 8:35 AM, 11:36 AM and 2:31 PM. No other blood glucose records could be located in the medical record for 11/23/25 and were not provided by the facility. On 2/12/26 at 11:39 AM, an interview was conducted with the Director of Nursing (DON) who stated she kept binders in her office of the paper items that were completed by the staff. The DON stated she kept the original copy of the blood sugars and then a copy was given to the medical records department to scan into resident 126's medical record. The DON stated she kept copies in her office in case something happened with the computer system and that she was the only one who had access to the binders. The DON stated she was unable to find the blood sugar log in the binders. On 2/12/26 at 11:45 AM, a follow up interview was conducted with the DON who stated the staff did the blood sugar checks and she remembered writing them down. The DON stated there was only one person in the medical records department who would scan the resident documents into the medical record and she was unsure if she was behind. On 2/12/26 at 11:52 AM, an interview was conducted with the Regional Nurse Consultant (RNC) who stated she had spoken to offsite staff earlier in the week who helped with scanning documents into the medical records about needing more help with scanning in records. On 2/12/26 at 11:52 AM, an interview was conducted with a Medical Records (MR) staff member who stated that she scanned everything into the computer. MR stated there was a box at every nurses station for medical records that she would check every day and scan those items into the medical record. MR stated that she was not caught up on everything and it was a lot for one person but MR did not feel like she was horribly behind. MR stated that they recently changed their system, where the DON kept the original and MR would scan a copy into the medical record. MR stated that she only scanned something if it was in the box, otherwise she did not know it needed to be scanned. MR stated there was no one offsite that helped her scan documents into the medical records, it was only her. MR stated she was unsure where the blood sugar log was located.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility did not establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. Specifically, the facility did not implement policies to address the underlying cause of the problems or identify how corrective actions were taken and monitored in regard to feeding tubes. Resident identifier: 90 Findings included: During the previous recertification survey completed on 1/11/24, Federal tag 693 was cited at a D level for feeding tube noncompliance. Resident 90 was admitted to the facility on [DATE] with diagnoses which included, but not limited to, spastic quadripalegic cerebral palsy, epilepsy, gastrostomy, and dysphagia. A physician order dated 9/19/25, documented, Isosource 1.5 CAL (calorie) 0.07 G (gram) - 1.5 Liquid. Give 40 ml/hr (milliliter/hour) via G-Tube [gastrostomy] two times a day for Nutrition Tube Feed to run continuously X (times) 22 hrs (hours)/day with water flushes of 45mL/hr x 22 hours. Resident 90's feeding tube was observed to be running at the incorrect rate of 34 ml/hr on 2/9/26 at 8:50 AM, 2/10/26 at 9:28 AM and 2:45 PM, and 2/11/26 at 10:20 AM. On 2/11/26 at 10:37 AM, an interview was conducted with the Director of Nursing (DON) who stated the staff should always follow the rate the provider prescribed for the tube feeding. The DON stated resident 90's feeding rate should have been running at 40ml/hr and flushed with 45ml and to infuse for 22 hours. The DON stated the staff should label the tube feeding with the date, formula/flush, rate of the feeding, rate of flush, and their initials. The DON stated she would do education again and she would provide the facility policy. On 2/12/26 at 1:17 PM, an interview was conducted with the Administrator (ADM) who stated he thought the feeding tube issue had been resolved in their QAPI (Quality Assurance and Performance Improvement) meetings but he was not sure. The ADM stated in February of 2024 there was a QAPI note about compliance for feeding tubes, nursing charting, and life safety. The ADM stated there was nothing in the March 2024 QAPI that referenced feeding tubes. The ADM stated he was unable to find any audits or education that was completed. The ADM stated it was definitely something the QAPI team would discuss. [Cross reference 693]

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure that an emergency call system was available and accessible in 5 out of 5 public and staff-accessible restrooms located in common areas used by residents. This failure created a risk that residents who utilized these restrooms would be unable to summon staff assistance in the event of an emergency or fall.Findings included: On 2/9/26 at 9:08 AM, an observation was made of the public restroom located in the Winder Lane hallway; the restroom was accessible to the public and a call light was not located within.On 2/9/26 at 9:09 AM, an observation was made of the public restroom located in the [NAME] Blvd (Boulevard) hallway, adjacent to the conference room; the restroom was accessible to the public and a call light was not located within.On 2/12/26 at 9:40 AM, an observation was made of the public restroom near the door labeled, About Hair; the restroom was accessible to the public and a call light was not located within.On 2/12/26 at 9:46 AM, an observation was made of the staff restroom located in the pass-through from the main common area to the Harmon's Way hallway; the restroom was accessible to the public and a call light was not located within.On 2/12/26 at 9:50 AM, an observation was made of an additional public restroom located in the [NAME] Blvd hallway, near the Director of Nursing's Office; the restroom was accessible to the public and a call light was not located within.On 2/12/26 at 10:08 AM, an interview was conducted with Unit Manager (UM) 1. UM 1 stated the residents who are more independent would utilize the public restrooms. UM 1 further recalled a past incident where a resident became stuck in a public restroom.On 2/12/26 at 1:27 PM, an interview was conducted with the Administrator (ADM). The ADM stated that these bathrooms are accessible to residents but do not contain call lights. The ADM acknowledged that residents would not be unable to call for help if needed. The ADM stated he had notified corporate ownership via email regarding this issue on 12/22/25, but it had not yet been rectified.