

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Rocky Mountain Care - the Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 544 East 1200 South Heber City, UT 84032	

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)
<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>50494</p> <p>Based on record review, interviews, and facility document and policy review, the facility failed to adequately address a grievance filed by a family member of 1 (Resident #328) of 1 sampled resident reviewed for neglect. Specifically, Resident #328's family member filed a grievance related to finding the resident lying in bowel movement and urine on the morning of 10/16/2023, and the facility was unable to provide documentation of the steps taken to investigate the concern or information regarding whether the facility was able to confirm the concern.</p> <p>Findings included:</p> <p>(continued on next page)</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility policy titled, Resident and Family Grievances, revised in June 2023, revealed, The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations. The policy specified, 10. Procedure: a. This facility will not retaliate or discriminate against anyone who files a grievance or participates in the investigation of a grievance. b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form, or assist the resident or family member to complete the form. i. Take any immediate actions needed to prevent further potential violations of any resident right. ii. Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property immediately to the administrator and follow procedures for those allegations. c. Forward the grievance form to the Grievance Official as soon as practicable. d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. i. Steps to resolve the grievance may involve forwarding the grievance to the appropriate department manager for follow up. ii. All staff involved in the grievance investigation or resolution should make prompt efforts to resolve the grievance and return the grievance form to the Grievance Official. Prompt efforts include acknowledgment of complaint/grievances and actively working toward a resolution of that complaint/grievance. iii. All staff involved in the grievance investigation or resolution will take steps to preserve the confidentiality of files and records relating to grievances, and will share them only with those who have a need to know. e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. f. The facility will take appropriate action in accordance with State law if an alleged violation of resident's rights is confirmed by the facility or an outside entity, such as State Survey Agency, Quality Improvement Organization, or local law enforcement agency. g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum: i. The date the grievance was received. ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concern(s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility as a result of the grievance. vi. The date the written decision was issued. The policy identified the Social Services Director (SSD) as the Grievance Official.</p> <p>A review of Resident #328's Resident Face Sheet revealed the facility admitted the resident on 09/07/2023 with diagnoses that included type two diabetes mellitus, unspecified dementia, muscle weakness, unspecified lack of coordination, and need for assistance with personal care. According to the Resident Face Sheet, Resident #328 was discharged from the facility on 11/10/2023.</p> <p>A review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/10/2023, revealed Resident #328 had a Brief Interview for Mental Status (BIMS) score of 9, indicating the resident had moderate cognitive impairment. According to the MDS, the resident did not reject care in the seven days prior to the assessment, was dependent on staff for toileting hygiene, and was always incontinent of urine and bowel movement.</p> <p>A review of Resident #328's Care Plan revealed a Problem area, with a start date of 09/09/2023, that indicated the resident was incontinent. Interventions directed staff to keep the call light in reach, assist with toileting, and to provide incontinence care after each episode of incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's October 2023 Concern Log revealed that on 10/16/2023, Resident #328's family member found them in bed in urine. Per the Concern Log, the concern was filed by the SSD, and the concern was resolved.</p> <p>A review of a Concern Form, dated 10/16/2023 at 1:45 PM, revealed Resident #328's family member reported that they found the resident lying in bowel movement and urine on the morning of 10/16/2023. The Concern Form indicated the form was filled out and turned into the facility's Executive Director (ED). The section of the Concern Form addressing Concern Investigation indicated the concern was reported to the Director of Nursing (DON)/Unit Manager, and staff were educated on call light responsiveness and frequent checks. The Concern Form did not reflect any steps taken by the facility to investigate the concern and did not indicate if the concern was determined to be confirmed or not confirmed. The Complaint Form was signed by the SSD and ED on 10/17/2023.</p> <p>During an interview on 03/27/2024 at 05:37 PM, the ED stated that the grievance regarding Resident #328 was not fully investigated. The ED further stated the facility had not determined who the aide was assigned to care for the resident at the time of the concern and indicated it was not clear if the resident had been provided incontinence care. The ED said the concern was reported to the SSD, the SSD turned it into the ED, and the ED immediately provided in-servicing to staff. The ED acknowledged that the grievance should have been better investigated.</p> <p>During an interview on 03/28/2024 at 4:08 PM, the SSD stated that the grievance regarding Resident #328 was given to the ED, and the ED should have addressed the grievance with the related department.</p> <p>During an interview on 03/28/2024 at 6:45 PM, the DON stated if a grievance involved nursing staff, then the nursing department was supposed to be made aware so they could investigate the concern.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>36105</p> <p>Based on interviews, record reviews, and facility policy review, the facility failed to protect the residents' right to be free from physical abuse by a resident (Resident #228) for 2 (Resident #48 and Resident #42) of 5 sampled residents reviewed for abuse.</p> <p>Findings included:</p> <p>A review of a facility policy titled Abuse - Prevention, Investigating and Reporting, revised on 07/01/2019, revealed, [The facility] takes steps to prevent abuse of residents. This includes abuse from staff, other residents, families or any person having contact with the resident. Every resident has the right to be free from verbal, sexual, physical and mental abuse including abuse facilitated or enabled through the use of technology, corporal punishment, exploitation,</p> <p>misappropriation of resident property, neglect, use of physical or chemical restraints imposed for the purpose of discipline or convenience and involuntary seclusion.</p> <p>A review of Resident #228's Face Sheet revealed the facility admitted the resident on 07/17/2021 with diagnoses that included Wernicke's encephalopathy (a neurological disease), alcohol dependence with alcohol-induced persisting dementia, and mood disorder due to known physiological condition. Further review revealed the facility discharged the resident on 11/21/2023.</p> <p>A review of Resident #228's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/23/2023, revealed Resident #228 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had physical and verbal behaviors directed toward others for one to three days during the seven-day assessment period. The MDS revealed the resident rejected care or evaluations for one to three days during the seven-day assessment period. The MDS indicated the resident used a wheelchair. The MDS revealed the resident received antidepressant medication seven days during the seven-day assessment period.</p> <p>A review of Resident #228's Care Plan History revealed a Problem area, with a start date of 04/24/2023, that indicated the resident had the behavior of wandering. Interventions directed staff to remove the resident from other resident's rooms and provide comfort measures. The Care Plan History revealed a Problem area, with a start date of 02/06/2023, that indicated the resident invaded others' personal space. Interventions included staff instructions to provide one-on-one supervision as needed and redirect the resident to an activity of their choice or have a conversation of their choice. Further review revealed a Problem area, with a start date of 08/20/2021, that indicated the resident had been combative toward staff. Interventions included staff instructions to avoid overstimulation, including other physically aggressive residents.</p> <p>1. A review of Resident #48's Face Sheet revealed the facility admitted the resident on 04/14/2023 with diagnoses that included vascular dementia of unspecified severity with psychotic disturbance, alcohol dependence with alcohol-induced persisting dementia, anxiety disorder due to known physiological condition, and mood disorder due to known physiological condition with depressive features.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #48's quarterly MDS, with an ARD of 05/04/2023, revealed Resident #48 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had verbal behaviors directed toward others for one to three days during the seven-day assessment period. The MDS indicated that the resident walked once or twice during the assessment period and used a wheelchair. The MDS indicated the resident received antipsychotic, antidepressant, and anti-anxiety medications seven days during the seven-day assessment period.</p> <p>A review of Resident #48's Care Plan revealed a Problem area, with a start date of 02/28/2023, that indicated the resident had a history of wandering. Interventions included staff instructions to redirect the resident to a conversation or an activity and to remove the resident from other resident's rooms and unsafe situations. The Care Plan revealed a Problem area, with a start date of 02/28/2023, that indicated the resident had verbal behavioral symptoms directed toward others, and at times not directed toward anyone. Interventions included staff instructions to follow familiar routines. The Care Plan revealed a problem area, with a start date of 02/28/2023, that indicated the resident had physical behavior symptoms directed at others. Interventions included staff instructions to avoid power struggles with the resident and to provide one-on-one sessions as needed. Further review revealed a Problem area, with a start date of 02/28/2023, that indicated the resident had increased moods and irritation, refused care from staff, and made accusations of staff. Interventions included staff instructions to attempt to educate the resident, provide care, and document refusals.</p> <p>A review of an Initial Report, dated 06/14/2023, revealed nurses on the 100 hall witnessed a resident-to-resident physical abuse incident. The report indicated that Resident #228 pulled Resident #48's arm, causing Resident #48 to fall out of their wheelchair, resulting in skin tears on Resident #48's elbow and shoulder.</p> <p>A review of the Follow-up Investigation Report, dated 06/20/2023, revealed that video footage of the incident was reviewed and indicated that Resident #228 was seen walking with Resident Advocate (RA)/Receptionist #30, a former employee, and waved their hand at Resident #48. The report indicated that RA/Receptionist #30 got in between the two residents. The report indicated that Resident #228 started hitting and grabbing RA/Receptionist #30, who lost their balance, which appeared to cause Resident #48 to roll out of their wheelchair. The report indicated that RA/Receptionist #30 stated that when she was walking down the hall with Resident #228, the resident was talking loudly, and Resident #48 told them to shut up and made a gesture towards Resident #228. The report indicated that RA/Receptionist #30 stated that Resident #228 pulled and pushed her trying to get to Resident #48; she thought either Resident #48 was bumped out of their wheelchair or Resident #228 pulled Resident #48's arm but was not sure. The report indicated that Registered Nurse (RN) #8 witnessed the incident.</p> <p>During a telephone interview on 03/26/2024 at 7:23 PM, RN #8 stated she remembered the incident but did not see the incident; she heard a commotion. She stated that no one was yelling, but she heard excited, louder voices. She stated she did not write out a witness statement and could not remember if the previous Executive Director had interviewed her. RN #8 stated that RA/Receptionist #30 was in the middle of the incident, and no other staff were in the area. She stated that the staff did not allow Resident #228 and Resident #48 to be next to one another, and she did not know why they were together at the time of the incident. She stated that a resident-to-resident altercation between residents with dementia was considered abuse. She stated verbal behaviors between Resident #228 and Resident #48 seemed to have happened before and stated that they lived on the same hall at the time of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 03/27/2024 at 7:13 PM, RA/Receptionist #30 stated she witnessed the incident on 06/14/2023. She stated she was at the nurse's station on the 100 Hall, and Resident #228 approached her in their wheelchair to request help looking for their glasses. She stated that she and Resident #228 looked in the resident's room but could not find them, then she went to the nurse's station, and Resident #228 wheeled themselves next to RA/Receptionist #30, and at the same time, Resident #48 was next to RA/Receptionist #30, in their wheelchair. She stated that both residents were easily agitated, and Resident #228 yelled, That's mine, that's mine. She stated Resident #48 started to yell, and Resident #228 pushed the RA/Receptionist #30 out of the way and hit her hand. She stated she lost her balance but did not fall. Per RA/Receptionist #30, Resident #228 grabbed Resident #48 by the hair and pulled them out of their wheelchair and to the floor. RA/Receptionist #30 stated both residents had yelled at each other on other occasions but had never touched one another before the incident. She stated that the previous Executive Director had interviewed her about the incident but did not think she had written a statement.</p> <p>2. A review of Resident #42's Face Sheet revealed the facility admitted the resident on 04/25/2023 with diagnoses that included unspecified personality disorder, cognitive communication deficit, and benign neoplasm of meninges.</p> <p>A review of Resident #42's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/20/2023, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had verbal behavioral symptoms toward others on one to three days during the seven-day assessment period and rejected evaluations or care every day during the seven-day assessment period.</p> <p>A review of Resident #42's Care Plan revealed a Problem area, with a start date of 06/16/2023, that indicated the resident resisted care provided by staff. Interventions included staff instructions to Allow resident to choose options and have control over situations when possible and to reiterate the purpose and advantages of treatment. The Care Plan revealed a Problem area, with a start date of 06/16/2023, that indicated the resident had verbal and physical behavioral symptoms directed toward others. Interventions included staff instructions to administer medications as ordered, assess whether the behavior endangered the resident or others, and avoid over-stimulation such as noise, crowding, or other physically aggressive residents.</p> <p>A review of a Follow-Up Investigation Report, dated 11/8/2023, revealed that on 11/02/2023 at around 11:35 AM, Resident #228 and Resident #42 got into an argument. The report indicated that Resident #228 requested to go into Resident #42's room, who denied the request. The report indicated that Resident #228 slapped Resident #42 in the face two times. The report indicated that Assistant Director of Nursing (ADON) #2 and Certified Nursing Assistant (CNA) Coordinator heard the commotion and removed the residents from the situation immediately. The report indicated that there were no injuries. The report indicated that ADON #2 and the CNA Coordinator were both interviewed, and both stated that Resident #228 pulled Resident #42's hair and slapped Resident #42 twice.</p> <p>A Review of Resident #228's Resident Progress Notes, dated 11/02/2023, indicated that ADON #2 witnessed Resident #228 hit Resident #42 twice in the side of the head and pulled Resident #42's hair.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/28/2024 at 8:14 AM, ADON #2 stated she intervened during the 11/02/2023 resident-to-resident incident. She stated she heard the residents yelling at each other, and she came out of her office and into the hallway and saw Resident #228 pulling Resident #42's hair. She stated she removed Resident #228 from the area, and a CNA took the resident back to their room. ADON #2 stated she instructed staff to monitor them and make sure they were not in the same place at the same time. ADON #2 stated the process was to separate the residents and complete an event report, which triggered nurse monitoring on the Medication Administration Record for the nurses to monitor behaviors. She stated she reported the incident and wrote a progress note.</p> <p>During an interview on 03/28/2024 at 10:35 AM, the CNA Coordinator stated that a physical altercation between two residents with dementia was considered abuse. She stated that the staff reported abuse to the Executive Director, and he completed the investigation. She stated Resident #228 had behaviors and they changed quickly. She stated Resident #42 was not social and stayed in their room most of the time. The CNA Coordinator stated the incident on 11/02/2023 happened outside of her office door. She stated she heard the residents yelling, and she went out to the hall. She stated Resident #228 wanted to go into Resident #42's room, who refused the request. She stated Resident #228 became agitated and thought Resident #228 pulled Resident #42's hair. She stated she did not witness what happened visually but heard it. She stated she and ADON #2 came out of their offices at the same time. The CNA Coordinator stated that she spoke to the Director of Nursing (DON) about the incident.</p> <p>During an interview on 03/27/2024 at 9:08 AM, the Executive Director stated he had not been able to retrieve the requested video footage of the resident-to-resident incidents because the company that managed it had not been able to find the videos.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>36105</p> <p>Based on interview and facility document and policy review, the facility failed to conduct a criminal background check for 1 (Certified Nursing Assistant [CNA] #3) of 6 nursing department staff prior to employment at the facility.</p> <p>Findings included:</p> <p>Review of a facility policy titled, Abuse - Prevention, Investigating and Reporting, last revised on 07/01/2019, revealed under a Screening section, New Employees and Direct Care Volunteers: All potential employees and direct care volunteers will be screened for a history of abuse, neglect or mistreating residents by the following methods: including A criminal background check will be performed on all new employees and direct care volunteers. The policy further revealed Continued employment is contingent upon the Criminal Background investigation and If anything in the employee screening process indicates a history of abuse, the individual will not be hired.</p> <p>Review of a facility Employees list, dated 03/28/2024, indicated the facility hired CNA #3 on 12/20/2023.</p> <p>A review of CNA #3's employee personnel records did not reveal a criminal background check.</p> <p>During an interview on 03/29/2024 at 5:40 PM, the Executive Director (ED) stated the corporate office completed the criminal background checks for new employees.</p> <p>During an interview on 03/29/2024 at 2:27 PM, the Director of Nursing (DON) stated the facility lacked a criminal background check for CNA #3, noting the corporate office did not find it.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47914</p> <p>Based on observations, interviews, record review, and facility document and policy review, the facility failed to provide supervision to prevent accidents related to elopement for 2 (Resident #59 and Resident #38) of 3 residents reviewed for elopement. Specifically, Resident #59 eloped from the facility on 02/24/2024 and was pushing their wheelchair when it was hit by a car.</p> <p>It was determined the facility's noncompliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J.</p> <p>The IJ began on 02/24/2024 at approximately 8:00 PM when Resident #59 eloped from the facility. On 03/28/2024 at 3:34 PM, the facility Executive Director (ED) was provided with the completed IJ template and notified of the existence of an IJ for accidents. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency (SSA) on 03/29/2024 at 7:13 PM. The IJ was removed on 03/29/2024 at 8:15 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower scope and severity of D, which was not immediate jeopardy for F689.</p> <p>In addition, based on observations, interviews, record review, and facility document and policy review, the facility failed to provide supervision for Resident #38. Resident #38 eloped from the facility on 06/20/2023, around 8:30 PM, when nursing staff discovered the resident was not in their room. Resident #38 was found by emergency services and brought back to the facility around 11:40 PM.</p> <p>Findings included:</p> <p>A review of a facility policy titled Elopements and Wandering Residents, revised in June 2023, revealed, This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The policy further indicated, 1. The facility is equipped with door locks/alarms to help avoid elopements. 2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner.</p> <p>1. A review of Resident #59's Face Sheet revealed the facility admitted the resident on 12/11/2023 with diagnoses that included cerebral infarction (stroke), aphasia (difficulty with speech), dysphagia (difficulty understanding language), and Wernicke's encephalopathy (a neurological disorder).</p> <p>A review of Resident #59's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/15/2023, revealed Resident #59 did not have a Brief Interview for Mental Status (BIMS) or a Staff Assessment for Mental Status completed. The MDS indicated disorganized thinking was present continuously. The MDS indicated Resident #59 did not exhibit any wandering behavior, ambulated with a walker or wheelchair, and required supervision or touching assistance with walking. The MDS revealed no wandering/elopement alarm was used.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of Resident #59's Care Plan revealed a Problem area with a start date of 02/20/2024, which indicated the resident was at risk for elopement related to Wernicke's encephalopathy. The Care Plan indicated the resident had exit-seeking behaviors and would kick the door off the tracks to get it open. Interventions included to ensure the departure alert system was in place and functioning properly and indicated the resident had two departure alert system devices, one on the inside of an article of clothing and one on the back of the resident's wheelchair. Further review of the interventions revealed that company vans had been moved to the back of the facility (out of sight) after an elopement attempt on 02/20/2024, elopement monitoring every 30 minutes for an elopement attempt on 02/21/2024, and one-on-one supervision for an actual elopement on 02/24/2024.</p> <p>A review of Resident #59's nursing Progress Notes, dated 12/17/2023 at 9:25 AM, revealed Resident #59 was found in a facility van outside the facility, and a departure alert system device was placed on the resident.</p> <p>A review of Resident #59's physician's Progress Notes, dated 01/09/2024 at 3:37 PM, revealed Resident #59 was severely agitated and attempting to escape from the building.</p> <p>A review of Resident #59's nursing Progress Notes, dated 02/20/2024 at 10:48 AM, revealed the departure alert system alerted a nurse to check outside the facility. The note revealed the front door was pushed open off the track, and Resident #59 was found attempting to get inside the facility transport vehicle. The note revealed two staff members safely brought the resident back into the facility, and all company vehicles were moved to the back of the building as an intervention.</p> <p>A review of Resident #59's nursing Progress Notes, dated 02/20/2024 at 1:57 PM, revealed Resident #59 attempted to leave the facility twice on that shift. The note revealed that the first time, the resident was able to be redirected at the front door; about thirty minutes later, the resident was found outside the facility. The note revealed the resident had on a departure alert system device that locked the doors, but the resident had forced the doors open.</p> <p>A review of Resident #59's physician's Progress Notes, dated 02/20/2024 at 3:27 PM, revealed the Medical Director (MD) found the resident outside in the cold parking lot. The MD indicated that he felt Resident #59 required a locked memory care unit for safety.</p> <p>A review of Resident #59's nursing Progress Notes, dated 02/24/2024 at 3:20 PM, revealed that on this date, Resident #59 had attempted to elope multiple times.</p> <p>A review of Resident #59's nursing Progress Notes, dated 02/24/2024 at 8:15 PM, revealed that during the night shift, Resident #59 left their room, crossed the road, and a car collided with the resident in their wheelchair. The note revealed Resident #59 was taken to the hospital, evaluated, and returned to the facility about an hour later. The note revealed that after 30 minutes, Resident #59 attempted to leave the facility again, and staff followed the resident to the front door. The note revealed the resident became very combative, but staff were able to redirect the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of a document titled Follow-Up Investigation Report, dated as submitted by the ED on 02/28/2024 at 7:15 PM, revealed camera footage was reviewed, and Resident #59 had pushed through the front door at 7:46 PM, exited the building, and walked down the parking lot. The report revealed that at 7:52 PM, the resident was pushing a wheelchair ahead of them, and the wheelchair was struck by a car. The Follow-Up Investigation Report further revealed Resident #59 had minor cuts and scrapes to their hands, with blood visible on their fingers. The report revealed the resident was sent to the local emergency room (ER) for further evaluation, and no additional injuries were identified. The report revealed the resident was placed on one-to-one continuous staff supervision upon return to the facility.</p> <p>During an interview on 03/26/2024 at 7:42 PM, Registered Nurse (RN) #19 stated staff needed to always keep their eyes on an elopement risk resident. RN #19 said elopement risk residents had a departure alert system device on their wrist or ankle, and some also had a device on their wheelchair. RN #19 stated that usually, when the resident would get close to the front door, an alarm would sound, and the doors would lock. She stated if any of the side doors were opened, an alarm would sound. She stated when the door alarms sounded, staff were not able to hear them. RN #19 said that on the day of the elopement, upon arrival at work, she was made aware that Resident #59 had tried to elope earlier in the day. RN #19 stated that on the night of the elopement, a certified nursing assistant (CNA) had taken Resident #59 to the bathroom, and RN #19 had gone to administer medication to another resident. RN #19 stated that when she came out of the other resident's room, she noticed Resident #59's door was open, which was unusual. RN #19 stated that she asked the aides if they had seen Resident #59, and they all said no. RN #19 stated that the aides went running down the hallway. RN #19 stated she heard the alarm, went running towards the front door, and saw police cars. RN #19 said Resident #59 had a departure alert system device placed on their wrist or ankle and on their wheelchair. RN #19 indicated Resident #59 had kicked open the front door and walked across the street, and their wheelchair was hit by a car. RN #19 stated she went out to speak with the police to give them all the information about the resident. She stated Resident #59 was taken to the hospital. RN #19 stated that after the 02/24/2024 event, there was a booklet on elopements that staff had to read and sign that explained what to do if a resident tried to elope. RN #19 said new alarms were also put in place but did not ring overhead and were still unable to be heard. RN #19 said the alarm only sounded on the 400 hall. She further stated the two-way radio walkie-talkies only said wanderer. RN #19 stated she did not think the alarms were what alerted staff that the resident was out of the building. RN #19 stated she thought when staff first realized the resident was missing, they went to the front door and realized the alarm was sounding and the resident was out of the building.</p> <p>During an interview on 03/26/2024 at 8:07 PM, Certified Nursing Assistant (CNA) #21 stated she was present on the night Resident #59 eloped. CNA #21 stated that she did not recall hearing any alarms sounding because she and another CNA were in resident rooms and too far from the front door. CNA #21 said after the incident on 02/24/2024, walkie-talkie radios were put in place, and Resident #59 was put on one-to-one continuous staff supervision. CNA #21 said Resident #59 already had a departure alert device in place but discovered how to push the door open. She stated that after the incident, a booklet with information on elopement was passed out for staff to read and sign.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/27/2024 at 8:18 AM, the CNA Coordinator stated she worked the day Resident #59 eloped. The CNA Coordinator said she was assigned one-on-one with Resident #59, and the resident spent a lot of time with her. The CNA Coordinator stated that on the day of the incident, she was off work but came to the facility due to the resident being very agitated. The CNA Coordinator stated she came in around 11:30 AM and was with the resident until around 3:30 PM. She stated Resident #59 was completely fine when she left for the day. The CNA Coordinator said she never witnessed the resident make it outside. She stated Resident #59 was always in the hall when the alarm would sound, and she would redirect the resident and spend time with the resident.</p> <p>During an interview on 03/26/2024 at 12:49 PM, CNA #11 stated she was not working on the day Resident #59 eloped but said the resident would take their wheelchair, put it against the door, and open the door. CNA #11 said Resident #59 had a departure alert system device, but she was not sure where it was placed.</p> <p>During an interview on 03/26/2024 at 1:13 PM, CNA #5 indicated if a resident was trying to elope, she would try to redirect them. CNA #5 stated if that did not work, she would try to approach the resident in a different way. CNA #5 stated that all residents who were at an elopement risk wore a departure alert system device. CNA #5 stated the device would be attached to an ankle or wheelchair. CNA #5 stated she checked residents for placement of the device to ensure there was no dangerous situation of the resident going into the street or something.</p> <p>During an interview on 03/26/2024 at 1:26 PM, CNA #13 stated if a resident had on a departure alert system device and got too close to the front door, an alarm would sound in the whole building. CNA #13 said she worked as a one-on-one staff member with Resident #59 for about two weeks. CNA #13 said after the elopement incident, Resident #59 had a departure alert system device attached to their clothing because the resident hated the device being on their body. CNA #13 said walkie-talkies at the nursing stations were also alarmed when one of the residents got near the door.</p> <p>During an interview on 03/26/2024 at 2:27 PM, Licensed Practical Nurse (LPN) #14 stated a resident that was an elopement risk would have a departure alert system device on the resident so when they got close to an exit door, the door would automatically lock. LPN #14 said that staff now had walkie-talkies that would sound since residents in the past had been able to push the doors open once they were locked. LPN #14 said they were not at work when Resident #59 eloped. LPN #14 stated Resident #59 tended to wander a lot and got frustrated because the staff could not really understand the resident. LPN #14 said Resident #59 was the reason a special alarm was put in place for when the front door got knocked off the hinges. LPN #14 stated that prior to the walkie-talkies, there was a faint alarm that staff could barely hear.</p> <p>During an interview on 03/26/2024 at 2:38 PM, CNA #15 stated she could not hear the front door alarm at all.</p> <p>During a follow-up interview on 03/26/2024 at 3:29 PM, CNA #15 stated there had only been one resident to elope since she had been at the facility. She said newly hired staff had not been told what to do when a resident eloped. CNA #15 stated the front door alarm was faint, and she had never heard the walkie-talkie sound. CNA #15 stated she was not in the facility when Resident #59 eloped.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/26/2024 at 2:42 PM, CNA #17 stated that elopement risk residents had a departure alert system device, and staff checked on them every two hours to make sure the device was in place. CNA #17 said if an alarm sounded at the front door, the doors would lock, and that would cue staff to check the doors and find the residents. CNA #17 stated the alarm could be heard from everywhere in the building. CNA #17 stated walkie-talkies were implemented at each nurse's station after Resident #59 eloped and said the walkie-talkies would transmit a message. CNA #17 said after the elopement, staff had to read a packet on preventive measures and other interventions for elopement.</p> <p>During an interview on 03/26/2024 at 3:11 PM, the Business Office Manager (BOM) stated she would hear the alarm sounding. She stated the alarm would be very loud, and she would hear it in her office and the conference room. The BOM stated she was not working during the elopement event for Resident #59 because it was on a weekend.</p> <p>During an interview on 03/26/2024 at 3:34 PM, CNA #16 stated the walkie-talkies' volumes were turned down at the nurses' station due to them being too loud when staff were on the phone. CNA #16 stated the walkie-talkies notified of call light activations and an elopement.</p> <p>During an interview on 03/26/2024 at 7:22 PM, CNA #18 stated for an elopement risk resident, she tried to distract the resident, tried to get them to go back to their room, and keep them from the doors, and completed a safety check every two hours. CNA #18 stated if a resident with a departure alert system device went to the front door, there was an alarm that sounded, and the door locked. CNA #18 said walkie-talkies were also at the nurse's station. CNA #18 said she could hear the alarms if she was at the nurse station but not if she was in a resident room. CNA #18 said she was at work the night Resident #59 eloped but was not aware of the incident until her coworkers told her about it and she saw the police.</p> <p>During an interview on 03/26/2024 at 8:19 PM, RN #22 stated he was not working the night Resident #59 eloped. RN #22 said the alarms were soft and could not be heard, so a louder alarm had been put in place. RN #22 also said the walkie-talkie was connected to the call light system and was supposed to alert staff to both the departure alarm system and the call lights. RN #22 indicated it worked for call light notification, but he was not sure if it was working to alert for the departure alert system.</p> <p>During an interview on 03/27/2024 at 8:55 AM, RN #23 stated they were not at work when Resident #59 eloped, but for elopement risk residents wearing a departure alert system device, an alarm should have sounded when the resident got close to the door. RN #23 said sometimes the alarms did not work. RN #23 stated the front door alarm could not be heard on the 600 hall.</p> <p>During an interview on 03/27/2024 at 10:34 AM, the Social Services Director (SSD) stated she had witnessed Resident #59 exit the building once prior to the elopement on 02/24/2024. The SSD stated that when she tried to get Resident #59 to come back into the building, the resident grabbed her by the neck. The SSD said Resident #59 stopped once she told the resident they were hurting her. The SSD said she had heard the alarm sound when the residents approached the doors.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/27/2024 at 12:00 PM, the MD stated Resident #59 was a severe alcoholic and was found at home after suffering a stroke. The MD said he felt Resident #59 was admitted to the facility prematurely due to the resident being severely encephalopathic and having behaviors that were out of control. The MD recalled seeing Resident #59 right outside the front door one day. He stated when he attempted to get the resident to come back inside, the resident turned around and hit him. The MD said his approach was to get the resident on medications that could stabilize the resident's moods until the resident could be moved to a more appropriate level of care. The MD stated that on the day of the elopement, the recommendation had already been made for the resident to be transferred to another facility.</p> <p>During an interview on 03/27/2024 at 4:23 PM, the ED stated Resident #59 came to the facility for rehabilitation but was switched to long-term care. The ED stated that sometime in January, it was apparent the resident was a wander risk. The ED stated in February, the resident started showing signs of exit-seeking. The ED stated that Resident #59 went out the door a few times. The ED stated that the staff would see the resident but had a hard time redirecting the resident. The ED stated the resident would go toward the facility vans, so as an intervention, the vans were moved to the back of the facility. He stated that the intervention worked for a few days, but then the resident tried again, and it was at that point that communication started with a memory care facility. He stated that the resident displayed more exit-seeking behaviors on the day of the 02/24/2024 incident. The ED stated the resident had gone out to the parking lot, but staff were able to get the resident in. The ED said he was not notified of the initial exiting attempts the resident had on 02/24/2024. The ED said he wished staff would have notified him so that interventions could have been put in place and the entire incident could have been avoided. The ED said the Quality Assurance and Performance Improvement (QAPI) committee initiated a four-step plan to address elopement and how it should be reported. The ED stated he felt there should have been some interventions put in place sooner based on the number of times the resident attempted to elope. The ED said there were a few times that both he and the CNA Coordinator took Resident #59 outside, and the resident never attempted to go to the road. The ED stated the CNA Coordinator was notified on the day of the incident and came in to help calm the resident down. The ED said the departure alert system was tested routinely. The ED stated he installed a new alarm to the front doors on 02/27/2024 that sounded if the doors were pushed off the hinges. He stated that when the alarm was installed, he tested it with and without a departure alert system trigger to ensure the alarm worked appropriately. The ED stated he did not do any testing with the volume of the alarms. He said the walkie-talkies were installed around the same time, maybe the same day, and were connected to the call light system. He stated when they were installed, he tested them to ensure they were functioning and sending out notifications. He stated he went to the front, activated the alarm, and then went to the nurse's station to hear it sound the wanderer alert. The ED stated he made sure the volume was turned all the way up. The ED said no staff had ever mentioned they could not hear the alarms or the walkie-talkie alerts.</p> <p>During an interview on 03/28/2024 at 8:47 AM, the Maintenance Director stated he tested the departure alert system alarms weekly by removing a departure alert system device from the package and taking it to the door to make sure the alarm sounded and the door locked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/28/2024 at 8:58 AM, the Director of Nursing (DON) stated her expectation was for staff to let her know immediately if an elopement occurred. The DON said if staff were not able to find the resident, the police would be called. She stated once the resident was found, a full assessment would be completed, and if needed, the resident would be sent to the ER. The DON stated the MD would also be notified. The DON stated the staff would then meet as a team to discuss what interventions could be put in place to prevent an elopement from happening again. The DON said all of this would be done after the immediate needs of the resident were taken care of. The DON said she was working on the day Resident #59 eloped. She said the resident had gone out the door earlier in the day, and a CNA was able to get the resident to come back into the facility. The DON stated the CNA Coordinator came in to calm the resident and stayed for a few hours. The DON said when the incident occurred, Resident #59 was taken to the emergency room, and when the resident returned to the facility, they were immediately placed on one-to-one continuous staff supervision. The DON stated they were working on interventions prior to the elopement incident, which included placement at another facility. She further stated once she was made aware that staff could not hear the alarms, the walkie-talkies were put in place.</p> <p>During observations and interviews on 03/26/2024 between 4:40 PM and 5:10 PM, the walkie-talkies were tested. On the 100/200 hall, LPN #14 was at the nurses' station, and the walkie-talkies were at the desk. There was poor audible notification when the call bells were pressed. The walkie-talkies were labeled Do not remove. LPN #14 stated he could not take the walkie-talkie off the base. LPN #14 said he could only hear the walkie-talkie at the nurses' station and that he would not be able to hear the walkie-talkie if he was more than 20 feet from the nurses' station. On the 500/600 hall, CNA #5 stated the walkie-talkie was not on the unit and was with CNA #11. CNA #11 said she normally did not carry the walkie-talkie but took the walkie-talkie because of the morning meeting. CNA #11 was asked to demonstrate how the walkie-talkie was used, and CNA #11 was observed raising the volume. CNA #11 stated when the call bell was pressed, or a departure alert system was breached, a notification was heard on the walkie-talkie. A call bell was then pressed, and the walkie-talkie was very audible. CNA #11 stated the volume was kept low due to the staff meeting. An observation on the 400 hall with CNA #11 revealed a grey box that had an alarm that would be triggered if there was a departure alert system breach. CNA #11 stated the alarm would be very loud on hall 400. CNA #11 stated that due to the low census, the unit was unstaffed and had mainly independent residents on the unit. CNA #11 stated she would not be able to hear the grey box sound if she were on halls 500 or 600.</p> <p>During observations on 03/27/2024, between 1:19 PM and 1:33 PM, the alarms were tested with the ED. At 1:19 PM, the departure alert system alarm was initiated and could only be heard in the lobby area. At 1:21 PM, the departure alert system alarm was initiated again, and the alarms could not be heard on the 300, 500, and 600 halls; a faint alarm could be heard while standing at the nurses' station on the 100 hall. On the 300 hall, the walkie-talkie sounded wanderer. At 1:23 PM, the front door was popped off the hinges, and the alarm could only be heard on the 100 hall. At 1:25 PM, the front door was popped off the hinges again, and the alarm was heard on the 100 hall, but there was nothing on the walkie-talkie. The alarm could not be heard on the 500 hall. At 1:29 PM, the door was popped off the hinges and the alarm was heard on the 100 hall and an unintelligible talking sound was heard on the walkie-talkie. The alarm could not be heard on the 300, 500, and 600 halls.</p> <p>2. A review of Resident #38's Face Sheet revealed the facility admitted the resident on 06/13/2023 with diagnoses which included metabolic encephalopathy, delirium due to known physiological condition, generalized anxiety disorder, and cognitive communication deficit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of Resident #38's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 06/16/2023, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #38 had delusions and had displayed wandering behavior for one to three days during the assessment period. The MDS further revealed the resident used a wander/elopement alarm daily.</p> <p>A review of Resident #38's Care Plan revealed a Problem area with a start date of 06/14/2023 that indicated the resident experienced wandering by moving with no rational purpose, seemingly oblivious to needs or safety. Interventions, with a start date of 06/14/2023, directed staff to ensure the resident had an identification band in place, follow familiar routines as much as possible, redirect to conversation or activity of choice and offer to contact loved ones and provide comfort measures for basic needs when the resident begins to wander and equip resident with a device that alarms on their left wrist. An additional intervention with a start date of 03/14/2024 indicated Resident #38 had a location device on their right wrist due to frequent elopement attempts.</p> <p>A review of Resident #38's physician's Progress Notes, dated 06/14/2023 at 6:07 PM, revealed Resident #38 was seen by the Medical Director (MD) sitting in the front foyer. The Progress Note indicated the resident was waiting on a ride home.</p> <p>A review of Resident #38's physician's Progress Notes, dated 06/19/2023 at 11:33 AM, revealed Resident #38 was seen by the MD. The Progress Note indicated the resident continued to wander around the facility, triggered the alarms often, and required heavy staff involvement to prevent the resident from eloping.</p> <p>A review of an Initial Report, dated as submitted on 06/21/2023, revealed that on 06/20/2023 at 8:30 PM Resident #59's room was checked by a nurse and found to be empty. The report revealed that a thorough search of the facility and outside was conducted. The report revealed that facility management and emergency services was notified. The report indicated that the resident was located at 11:40 PM in the local town.</p> <p>A review of a document titled Follow-Up Investigation Report dated 06/28/2023 revealed camera footage was reviewed, which revealed Resident #38 exited their room at 7:50 PM on 06/20/2023. The report revealed that a visitor was seen walking into the facility around 7:55 PM and Resident #38 was observed walking out of the facility at 7:55 PM. The report revealed Resident #38 walked to the corner of the building and walked outside of the video footage view. The report indicated that the resident had an abrasion on their head and scratches on their face.</p> <p>A review of Resident #38's physician's Progress Notes, dated 06/21/2023 at 11:35 AM, revealed Resident #38 was seen by the MD after the resident had been returned to the facility by the police in the early morning hours. The note revealed the resident had a laceration on their head, and the Director of Nursing (DON) escorted the resident to the emergency room (ER) for further evaluation. The note revealed a computerized tomography (CT) scan of the head, and x-rays were conducted due to complaints of shoulder pain. Results were documented in the Progress Notes as negative.</p> <p>A review of Resident #38's nursing Progress Notes, dated 06/22/2023 at 6:35 PM, revealed a tracking device was applied to Resident #38's shoe.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an observation on 03/26/2024 at 1:08 PM, Resident #38 was observed coming out of their room with a wheelchair and their clothes. When staff asked the resident where they were going, Resident #38 said they were going home. Staff redirected the resident back to their room, and the resident put their belongings back in their room. The resident then returned and stood at the nurses' station with staff.</p> <p>During an observation on 03/27/2024 at 4:06 PM, Certified Nursing Assistant (CNA) #10 was observed with Resident #38. The resident was sitting in a recliner across from the nursing station. Resident #38 got up and walked toward the dining room, and CNA #10 immediately followed the resident.</p> <p>During an interview on 03/26/2024 at 7:22 PM, CNA #18 stated Resident #38 wandered and was often found in other rooms or in the dining room. CNA #18 stated at times it took four to five staff members to barricade the door and redirect the resident.</p> <p>During an interview on 03/27/2024 at 8:55 AM, Registered Nurse (RN) #23 stated there had been multiple complaints to administration about Resident #38. She stated when Resident #38 was first admitted, she begged staff not to put the resident on the 400 hall due to their behaviors. RN #23 stated the resident was put on the 400 hall anyway and the next night, the resident eloped. RN #23 stated that after the elopement, Resident #38 was moved to the 600 hall. RN #23 stated for elopement risk residents wearing a departure alert system device, an alarm should sound when the resident gets close to the door. RN #23 said sometimes the alarms did not work. RN #23 stated the front door alarm could not be heard on the 600 hall.</p> <p>During an interview on 03/27/2024 at 12:00 PM, the Medical Director (MD) stated he did not know much about Resident #38's history and believed the resident had a stroke and had several mental health issues and disabilities.</p> <p>During an interview on 03/28/2024 at 8:58 AM, the DON stated Resident #38 had been at the facility long enough that staff knew what worked for the resident and what did not. She said the most current intervention in place for Resident #38 was one-to-one continuous staff supervision in the afternoon and evening hours because the resident seemed to be fine in the morning hours. The DON stated Resident #38 had a departure alert system device and a tracking device that could be used to locate the resident with a cell phone. She stated a tracker had been used previously, but Resident #38 started taking the tracker off and hiding it, so that was when a different device was used. The DON said extensive conversations had taken place about placement in another facility, but the resident's family had refused.</p> <p>During an interview on 03/29/2024 at 4:38 PM, the DON stated the expectation was for a resident who may be an elopement risk to be assessed for a departure alert system device, for the family and staff to be made aware of the wandering and the placement of the departure alert system device. She stated staff needed to respond immediately if an alarm was heard. The DON said if the staff did not see the resident, they should begin searching for the resident. The DON stated if the resident got out of the facility, the staff needed to do an extensive search and notify her and the ED. The DON stated that if the resident was repeatedly exit seeking, one-to-one continuous staff supervision would be implemented until the resi[TRUNCATED]</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Rocky Mountain Care - the Lodge		STREET ADDRESS, CITY, STATE, ZIP CODE 544 East 1200 South Heber City, UT 84032	
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)		
<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>36105</p> <p>Based on interviews, facility document review, and facility policy review, the facility failed to ensure 4 (Certified Nursing Assistant [CNA] #3, CNA #13, Nursing Assistant [NA] #26, and Licensed Practical Nurse [LPN] #27) of 6 sampled employees were provided mandatory training related to dementia management and resident abuse prevention.</p> <p>Findings included:</p> <p>A review of a Facility Assessment Tool, dated 02/17/2024 and reviewed by the Quality Assurance and Performance Improvement (QAPI) committee on 03/14/2024, revealed, Staff training/education and competencies, The following training topics will be used to provide a [sic] level and type of support and care needed for our resident population. (this is not an inclusive list): Abuse, neglect and exploitation - training that at a minimum educates staff on- (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or misappropriation of resident property; and (3) Care/management for persons with dementia and resident abuse prevention.</p> <p>A review of a facility policy titled, Training Requirements, revised in June 2023, revealed 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment. The policy further indicated, 6. Training content includes, at a minimum: g. Dementia management and care of the cognitively impaired. h. Abuse, neglect, and exploitation prevention.</p> <p>A review of an undated CNA/NA Orientation and Annual Checklist revealed Abuse Reporting and Care of cognitively impaired residents were included on the checklist as required topics. The checklist specified, ***All education topics must be completed by return demonstration to document understanding of training given prior to signing off.</p> <p>A review of an undated Licensed Nurse Annual and New Hire Checklist revealed Abuse Education and Care of cognitively impaired residents were included on the checklist as required topics. The checklist specified, ***All education topics must be completed by return demonstration to document understanding of training given prior to signing off.</p> <p>A review of a facility document titled Employees, dated 03/28/2024, revealed the following:</p> <ul style="list-style-type: none"> - CNA #3 was hired on 12/20/2023; - CNA #13 was hired on 02/08/2024; - NA #26 was hired on 01/09/2024; and - LPN #27 was hired on 12/12/2024. <p>(continued on next page)</p>		

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<p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of personnel files for CNA #3, CNA #13, NA #26, and LPN #27 did not reveal any documentation of dementia management or resident abuse prevention training.</p> <p>During an interview on 03/29/24 02:27 PM, the Director of Nursing (DON) stated the orientation checklists were not completed for CNA #3, CNA #13, NA #26, or LPN #27.</p> <p>During an interview on 03/29/24 12:49 PM, LPN #27 stated that she started working at the facility in December 2023 and had not completed a dementia management or resident abuse prevention training at the facility.</p> <p>During an interview on 03/29/2024 at 3:48 PM, the DON stated that she expected every staff member to have a training checklist completed before they were scheduled to work on their own.</p> <p>During an interview on 03/29/2024 at 4:31 PM, the Executive Director (ED) stated that staff should have been trained on dementia management and abuse prevention before being assigned to work a shift without a peer partnered with them.</p> <p>A review of the CNA/Nursing Schedule for the timeframe from 03/24/2024 to 03/30/2024 revealed CNA #3, CNA #13, NA #26, and LPN #27 were each assigned to work various shifts during the week.</p> <p>During a follow-up interview on 03/29/2024 at 5:40 PM, the ED stated that the CNA Coordinator was responsible for ensuring dementia management and resident abuse prevention training was provided. The ED stated the DON was the CNA Coordinator's supervisor.</p> <p>During a follow-up interview on 03/29/2024 at 5:45 PM, the DON stated that the CNA Coordinator was responsible for ensuring the education was provided. The DON stated she did not have a process in place to monitor or audit the education, because she was not aware that was one of her responsibilities.</p> <p>During an interview on 03/29/2024 at 5:50 PM, the CNA Coordinator stated that previously, the facility had a human resources staff member that was responsible for new employee education, but they left in the fall of 2023. The CNA Coordinator said nobody informed her that she was now responsible for ensuring staff education was completed before staff were scheduled to work independently. The CNA Coordinator stated that she did not have access to the employee education records, so she did not know if they had completed their education or not.</p>		