

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

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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 06/04/2026
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)		
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Specifically, for 4 of 36 sampled residents, a resident's skin condition was not evaluated and treated, a resident had wound care provided without orders, a resident was hospitalized and no documentation was found of the resident's change in condition, and a resident expired at the facility and no documentation could be found of the resident's change in condition. Resident identifiers: 9, 59, 61, and 62. Findings included: 1. Resident 9 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis, cerebral infarction, morbid obesity, type 2 diabetes mellitus, fracture of right toe and non-pressure injury of left foot. On [DATE] at 1:09 PM, an interview was conducted with resident 9. Resident 9 stated that he skinned his toes. Resident 9 stated that sometimes the staff wrapped the toes when they bled and put salve on the wounds, and this was approximately every 3-4 days. Resident 9 stated that the wounds had never healed. Resident 9's bilateral feet were observed with open wounds on the second toe of each foot. Both toes were observed with dried blood on the wounds. Resident 9 had a physician order for WOUND CARE: Abrasion to Left Second Toe: Remove dressing. Cleanse wound. Apply skin prep to periwound. Apply hydrogel to wound bed. Cover with border dressing one time a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for Wound care AND as needed for Wound Care. The order was initiated on [DATE]. Resident 9's progress notes revealed the following: a. On [DATE] at 11:40 PM, the Skin Check documented, . New skin Issue. Location: Right Dorsum 2nd Digit (Second toe) Issue type: Laceration. Progress: New: new wound. Wound acquired in-house. Wound is new. Incision approximated: Yes. Closure method: Sutures. # of Sutures: 4 . Measurements not documented as part of this assessment. Reason measurements not documented as part of this assessment: unable to measure, wrapped from ER [emergency room]. b. On [DATE] at 2:31 PM, the Skin Check documented, Skin issue has not been evaluated. Location: Right Dorsum 2nd Digit (Second toe) Issue type: Laceration. Wound acquired in-house. Wound is new. c. On [DATE] at 2:46 PM, the Skin check documented, Skin issue has not been evaluated. Location: Right Dorsum 2nd Digit (Second toe) Issue type: Laceration. Wound acquired in-house. Wound is new. d. On [DATE] at 11:15 AM, the Skin Check documented, Skin issue is resolved. Location: Right Dorsum 2nd Digit (Second toe) Progress: Resolved: Wound healed and / or closed. e. On [DATE] at 12:25 PM, the Skin Check documented, New skin Issue. Location: Left Dorsum 2nd Digit (Toe). Issue type: Abrasion. Progress: Improving: overall wound characteristics improved. Wound acquired in-house. f. On [DATE] at 2:34 PM, the Nurse Note documented, Right toe assessed with purulent drainage present. Resident unsure when condition began. Wound cleansed and antiseptic applied per protocol. Provider notified; podiatry referral requested for further evaluation. g. On [DATE] at 2:37 PM, the Skin Check documented, New skin Issue. Location: Right Dorsum 1st Digit (Hallux). Issue type: Open lesion. Progress: New: new wound. Wound acquired in-house. It is unknown how long the wound has been present. Signs and symptoms of infection: Erythema/edema. Signs and symptoms of infection: Red and bleeding surface or granulation tissue. h. On [DATE] at 5:40 PM the Skin Check documented, Skin issue has not been (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 465147	Facility ID: 465147 If continuation sheet Page 1 of 4

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F 0684 Level of Harm - Actual harm Residents Affected - Few	evaluated. Location: Right Dorsum 1st Digit (Hallux). Issue type: Open lesion. Wound acquired in-house. It is unknown how long the wound has been present. i. On [DATE] at 10:09 AM, the Skin Check documented, Skin issue has not been evaluated. Location: Right Dorsum 1st Digit (Hallux). Issue type: Open lesion. Wound acquired in-house. It is unknown how long the wound has been present. On [DATE], the hospital history and physical records documented a laceration of the right little toe after resident 9 fell out of bed. The resident had a laceration repair conducted to the 1 centimeter laceration at the base of the right little toe. The repair included 4 sutures to close the laceration. It should be noted that the suture repair to the laceration was on the fifth metatarsal and not the second metatarsal as documented in the progress note. Resident 9's care plan focus area for at risk for alteration to skin integrity was initiated on [DATE]. The care plan had an intervention for weekly skin check per facility schedule and to notify the provider of any alterations for prompt/proper interventions. On [DATE] at 8:57 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that she was the wound care nurse. The ADON stated that nursing staff conducted weekly skin checks and she looked through those notes daily to identify any new skin issues. The ADON stated that if a concern was not on the skin check the staff would message her on tiger text and send a secure photo of the wound for her evaluation. The ADON stated that resident 9 had abrasions on his left toes and they were doing wound care with hydrogel. The ADON stated she was not aware of the right second toe's abrasion. The ADON stated that she should have been notified of the wound on the right foot so that she could evaluate it. The ADON stated that she had wound care standing orders for an abrasion and she would evaluate the wound with the provider on the next wound care day. The ADON stated that the wound on the right second toe was first identified on [DATE]. The ADON confirmed that the wound did not have wound care orders and had not been evaluated by herself or the provider. On [DATE] at 12:41 PM, a follow-up interview was conducted with the ADON. The ADON stated that she went and assessed resident 9's right foot wound. The ADON stated that she put orders in for wound care for the right foot and was waiting to hear back from the provider. The ADON stated that she assessed a wound on the second digit of resident 9's right foot. The ADON stated that she did not measure the wound, and that she typically obtained measurements but had forgotten on this occasion. The ADON stated that she cleaned the wound with wound cleaner and applied a bordered foam dressing. The ADON stated that she was waiting to hear from the provider about new orders. The ADON stated that resident 9's left foot had scattered scabbing along all of the toes of the foot. The ADON stated that she was not notified of the wound on the second toe of the right foot and she should have been informed of the wound. 2. Resident 59 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis, type 2 diabetes mellitus, acquired absence of the right and left leg above the knee, infection of left amputation stump, and chronic pain. On [DATE] at 1:02 PM, an interview was conducted with resident 59. Resident 59 stated that she had pain in the right stump and that there was a wound there. Resident 59 stated that the wound was not open and they did not do a dressing change on it. Resident 59 stated that the wound on the right stump had been present for approximately 1.5 weeks. Resident 59 had a physician order for L [left] stump: Cleanse with NS [normal saline]. Apply silver alginate to wound bed. Cover with bordered dressing. every day shift every Mon, Wed , Fri . The order was initiated on [DATE]. On [DATE] at 12:15 PM the Nurse Practitioner note documented, .Infection of amputation stump, right lower extremity *: Right AKA [above the knee amputation] surgical wound previously noted as improving. No signs of infection currently noted. Continue wound care per wound team. Will defer to hospice for all medical decision making. Continue dressings per wound team orders. On [DATE], the hospice note documented, She has a stage 2 pressure ulcer on her L buttock and another unstageable pressure ulcer on her L amputation stump. On [DATE], the hospice note documented, Wound care provided during visit and tolerated without complication. The note did not document any wound locations or characteristics. On [DATE], the hospice note documented that the patient had one or more skin conditions. The note documented the wound as a Pressure Ulcer(s)/Injuries. No (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	documentation of the location or characteristics of the wound were found. The note further documented, Patient remained focused on going outside for a smoke break and declined assessment of known wounds to her stump and buttocks despite education regarding the importance of monitoring pressure injuries. Patient verbalized refusal of wound assessment at this time. Skin is ashen and frail with irregular pigmentation. On [DATE], the hospice note documented, Patient refused wound care at this time. Notified facility nurse and stated would attempt once patient back in bed. Skin assessment reveals ashen pallor with irregular pigmentation, poor turgor, dry and warm to touch consistent with dehydration and overall decline. On [DATE], the hospice note documented, Patient decline [sic] wound care and refused to return to bed for wound assessment despite education and encouragement. On [DATE], the hospice note documented, Patient remained focused on going outside for a smoke break and declined assessment of known wounds to her stump and buttocks despite education regarding the importance of monitoring pressure injuries. Patient verbalized refusal of wound assessment at this time. Skin is ashen and frail with irregular pigmentation. On [DATE], the hospice note documented, Patient declined returning to room for wound are [sic] during visit, stating she was waiting to go smoke. Patient demonstrates poor insight and impaired judgement regarding care needs. On [DATE], the hospice note did not document any information regarding resident 59's skin condition or wounds. Resident 59's care plan for alteration to skin integrity secondary to impaired mobility was initiated on [DATE]. The care plan had an intervention for weekly skin check per facility schedule and to notify the provider of any alterations for prompt/proper interventions. On [DATE] at 11:01 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the licensed nurse should be conducting a skin check assessment and documenting it per the physician orders. The DON stated that resident 59 did not go to the wound clinic for wound care. On [DATE] at 11:50 AM, an interview was conducted with Registered Nurse (RN) 4. RN 4 stated that resident 59 had a dressing on both the left and right stump and she only had orders for the left stump. RN 4 was observed providing wound care to resident 59. Resident 59 had a bordered foam dressing on her bilateral AKA stumps. RN 4 removed the dressing from the right AKA stump and stated that it did not have any drainage on the old dressing. RN 4 cleaned the right stump with a 4 x 4 gauze pad that was soaked in normal saline. RN 4 placed a new bordered foam dressing on the right stump. RN 4 stated that the right stump was newly closed. RN 4 stated that when she cleaned the right stump wound bed a scab came off and it was closed underneath. RN 4 stated that it made her believe that the wound was barely closed or was trying to break back open. RN 4 stated that she would notify the wound nurse to assess the right stump and put a treatment order in. On [DATE] at 12:49 PM, an interview was conducted with the ADON who was the facility wound care nurse. The ADON stated that hospice was in charge of resident 59's wound care. The ADON stated that prior to resident 59 going on hospice services she provided wound care for her pressure ulcer on the left stump. The ADON stated that she stopped providing resident 59 wound care recently when she was admitted to hospice services. The ADON stated that she communicated with hospice about wound care, they wrote notes with measurements and if they changed any wound care orders. The ADON stated that she did not have any recent updates from hospice about resident 59's wounds. The ADON stated that new skin conditions should be relayed to her in writing. The ADON stated that all dressings that were applied should have an order. The ADON stated that if a new wound was identified she would expect there to be an assessment documented somewhere. 3. Resident 62 was admitted to the facility on [DATE] and passed away on [DATE] with diagnoses which included Parkinson's disease without dyskinesia, dementia, protein-calorie malnutrition, epilepsy, and adult failure to thrive. A nursing progress note dated [DATE] at 3:33 PM, revealed, Residents' hospice nurse notified of condition and most recent VS [vital signs]. Residents VS were as follows: BP [blood pressure] 184/144 HR [heart rate] 88 SPO2 [oxygen] 95% T [temperature] 97.7 RR [respiratory rate] 14. Hospice nurse said to continue to give morphine and lorazepam Q [every] 1-3 hours. Will continue to monitor resident and promote comfort for resident and family. The next nursing progress note was dated [DATE] at 4:19 PM, which (continued on next page)		

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