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	11/08/2023

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 - 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** 33215 Based on observation, interview, and record review, it was determined, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 1 out of 3 sampled residents, a resident that was a quadriplegic received second degree burns on his body after being served hot water by a Certified Nursing Assistant (CNA) and the resident was not supervised while drinking the hot water. Resident identifier: 1. Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, quadriplegia, type 1 diabetes mellitus, neuromuscular dysfunction of bladder, anxiety disorder, and burn of unspecified body region. Resident's medical record was reviewed on 11/8/23. On 11/18/22, a Hot Beverage Evaluation documented that resident 1 DOES NOT demonstrate the ability to self serve hot liquids, but wishes to have hot liquids and can do so with interventions. The interventions included, Staff will assist to serve hot liquids and assist with proper positioning during hot beverage consumption. A quarterly Minimum Data Set assessment dated [DATE], documented a brief interview for mental status (BIMS) score of 15. A BIMS score of 13 to 15 would suggest cognitive intactness. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/3/23 at 11:58 PM, a Nursing Progress Note documented Date 11/3/2023 reported at 2300 [11:00 PM]: [Resident 1] sustained burns to right upper chest, right inner arm, right posterior lateral back, left groin, left hip and abdomen. CNA on PM shift reported to nurse at 2300 that [resident 1] had blisters and would I look at them. I spoke with [resident 1], he stated, his CNA filled his mug with water at approx [approximately]. 10 PM. [Resident 1] states as he was drinking his water, it was so hot that he pushed the straw from his mouth so that it would not burn him. [Resident 1] explained that when taking a drink out of his personal straw set up for his water, it is like siphoning gas, only stops when he puts his tongue back on the straw to stop it from flowing. [Resident 1] said due to it being so hot, he was not able to put his tongue on the straw to stop it. That's when the water poured out of the mug it went all over his chest & body. [Resident 1] could not feel the water as he has not [sic] feeling from the neck down. CNA's and nurse removed clothing and linens and changed to new gown and linens. Body check was completed. NP [Nurse Practitioner] [name removed] was notified; orders were given to clean burns with NS [normal saline], and apply Bacitracin, keep wounds clean and dry. Monitor patient closely for any changes or concerns. [Resident 1] denies pain at this time. temperature 98.1 [degrees Fahrenheit (F)], refused any additional vital signs. Education given, verbalizes understanding. Call light within reach. Hydration encouraged-CNA's informed to keep [resident 1] with fluids, no hot water. Staff education provided. On 11/4/23 at 12:10 AM, a Nursing Progress Note documented [Resident 1] sustained burns from hot water-order for Clean with NS, pat dry, apply bacitracin cream and protect with gauze. Monitor for infection. Do not apply cover [sic] blisters. This has been completed, nursing will continue to monitor patient condition-vital signs refused per patient, temp [temperature] 98.1 [degrees F]-No pain r/t [related to] quadriplegic-staff will be vigilant to monitor through the night-Linens, gown C/D [clean and dry]. [Resident 1] is aware of the situation, drinking well at this time. On 11/4/23 at 2:07 AM, a Nursing Progress Note documented Patient during bs [blood sugar] check dressings changed per order. Patient drinking well and urine output is good. Mucous membranes moist. VSS [vital signs stable] at this time patient is afebrile 98.4 [degrees F]. Patient pulse 88 bp [blood pressure] 103/71. Patient offered at this time to be evaluated at hospital related to surface area. Patient content with POC [plan of care]. Hydration and nutritional needs reinforced. Patient spent whole time telling pirate jokes. WCTM [will continue to monitor]. On 11/4/23 at 4:10 AM, a Nursing Progress Note documented Patient mugged [sic] filled with tap water per his request. Patient dressing changed and reinforced per order. Patient has had serous drainage from distal and posterior chest. Patient dressings otherwise intact and without irritation. Patient resting at this time. WCTM. On 11/4/23 at 6:13 AM, a Nursing Progress Note documented Patient bs 114 temp 98.5 [degrees F]. Mucous membranes moist. Patient urine is clear yellow. Patient has had no further drainage thus far. Patient dressing are intact without s/s [signs and symptoms] of irritation. Patient educated on need to continue fluids and to increase protein to promote healing. Patient educated on s/s to report. Discussed ways patient his [sic] body expresses infection ie increased bs, inability to maintain body temp, decreased intake and output. Patient content with care and progress thus far. Patient demonstrated ability to push call light. WCTM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/4/23 at 9:29 AM, a Hot Beverage Evaluation documented that resident 1 was able to drink lukewarm beverages with straw. DOES NOT demonstrate the ability to self serve hot liquids, but wishes to have hot liquids and can do so with interventions. The interventions included, Staff will assist to serve hot liquids and assist with proper positioning during hot beverage consumption. Provide cups with lids, Use only mugs appropriate for hot liquids, DO NOT refill resident's cup while they are holding it, Educated on safe handling techniques, and Other - only lukewarm beverages, per pt [patient]. On 11/4/23 at 10:37 AM, a Nursing Progress Note documented new order per NP to Clean burns with chlorohexidine (NO ALCHOLOL [sic]), Apply silvadene to red and blistered areas BID [twice daily], Cover with Adaptic or xeroform, then place non adherent pad on top and wrap with kerlix, and secure with dry dressing on the unable to wrap areas of the body BID and PRN [as needed] and to have wound team evaluate for further treatment and monitoring. Res [Resident] aware. On 11/4/23 at 11:04 AM, a Nursing Progress Note documented Skin assessment done with wound nurse. Resident with second degree burns d/t [due to] scalding from hot liquid R [right] inner arm measurements 14x7 [centimeters (cm)] R back side posterior lateral measurements 22x18 [cm] Chest measurements 20x20 [cm] Abdomen 20x32 [cm] with a large blister on R side measuring 8.0x7.0 [cm] L [left] groin multiple small blisters measuring 3.0x13.0 [cm] L hip blister 1.0x1.5 [cm] All scaled areas are red with some denuded areas, and multiple blisters. Wound team and NP notified. New orders in place. On 11/4/23 at 11:49 AM, a Nursing Progress Note documented Resident in good mood this morning. Temperature check this morning 98.0 [degrees F]. Resident denies any pain. Repositioned for comfort. Offered prn pain medications resident refused. Skin treatment done. Continue monitoring for any changes. Continue staff education about hot beverages to be mindful and careful of the temperature when assisting a resident with food or drinks. For [resident 1] serve only lukewater per [resident 1] request. On 11/4/23 at 12:06 PM, a Nursing Progress Note documented Follow up with resident related to burns sustained from warm water and ask resident if he wants to go to the hospital. Resident refused, stating he wants to be treated here in facility, agrees with skin treatment order. Resident stated that he feel [sic] safe in facility, and that nobody hurt or abuse him, and complimented staff for prompt action and providing exceptional care. On 11/4/23 at 12:41 PM, a Nursing Progress Note documented New order received from NP to monitor and encourage hydration, monitor vitals and notify provider with any concerns. Resident notified. Fluids encouraged as tolerated. On 11/4/23 at 4:46 PM, a Nursing Progress Note documented [Resident 1] burn wounds changed per order/[resident 1] states he feels a little weak/Midodrine given prn as ordered to elevate BP of 60's-next BP 79 systolic-after second dosing of Midodrine, BP > [greater than] 130. [Resident 1] is increasing his fluids. Tylenol for general well being-no temp at this time/call light within reach. On 11/4/23 at 9:10 PM, a Nursing Progress Note documented [Resident 1] states he is a little cold-some mild shivering-no temperature,vss. NP [name removed] notified of BP improving with Midodrine and increaseing [sic] fluids as well as his overal [sic] fatigue. Dressings to burns C/D/I [clean, dry, and intact] call light within reach-repositioned as requested. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/5/23 at 3:15 PM, a Nursing Progress Note documented Resident received Tx [treatment] for burn on torso, front/inner lateral, right arm, right posterior lateral back, left groin and L hip per order BID wound care. Not [sic] c/o [complaints of] pain or discomfort noted. Fluids intake as tolerated. Recorded as Late Entry on 11/5/23 at 9:17 PM. On 11/5/23 at 9:00 PM, a Nursing Progress Note documented Resident's burn dressing change BID. Not [sic] c/o pain at this time. Resident is encourage to drinks fluids. Reposition done. assist with feeding, appetite is fair to good. Not [sic] fever noted. WCM [will continue monitor]. Recorded as Late Entry on 11/6/23 at 6:02 PM. On 11/6/23 at 5:03 PM, a Nursing Progress Note documented Resident received partial bed bath. Burn dressing changed. Not [sic] s/s of infection. Not [sic] c/o pain noted. Fluids [sic] intakes is tolerated well. Supra Foley in place DD [down drain] well. Resident participated in therapy session . Appetite is good. WCM. Recorded as Late Entry on 11/6/23 at 6:06 PM. On 11/6/23 at 9:55 PM, a Nursing Progress Note documented Dressings changed to burns this evening. Tolerated well. No s/s of infection noted. All needs met at this time. Call light within reach. On 11/7/23 at 12:15 PM, a Nursing Progress Note documented New order received from wound team and approved by NP: Silvadene (silver sulfadiazine) cream; 1 %; amt [amount]: 1 application; topical Special Instructions: Clean burns with chlorohexidine (NO ALCHOLOL), Apply silvadene to red and blistered areas daily, Cover with Adaptic, then place non adherent pad on top and wrap with kerlix, and secure with dry dressing on the unable to wrap areas of the body daily and PRN. Avoid areas drying out. Resident made aware. Wound burn dressing done by wound team. Resident tolerated dressing change well. Recorded as Late Entry on 11/8/23 at 9:16 AM. On 11/7/23 at 4:37 PM, a Nursing Progress Note documented Resident remain in bed. Wound burn dressing changed. Not [sic] c/o pain at this time. Resident is encourage to drink fluids. Foley Cath [catheter] in place DD well. Encourage to use call light within to reach. WCM. Recorded as Late Entry on 11/7/23 at 6:38 PM. On 11/7/23 at 11:43 PM, a Nursing Progress Note documented Resident resting in bed this shift. He is A&O [alert and oriented] at his baseline. Compliant with medication administration and cares offered. Dressing in place, CDI. He has no c/o pain. Resident encouraged to use call light. Within reach. Will continue with current plan of care. On 11/8/23 at 9:16 AM, a Nursing Progress Note documented Spoke with resident this morning. Resident is in good spirit and making jokes and laughing. Wound burn dressing in place, intact. Resident denies any pain or discomfort. Encouraged fluids as tolerated. Educated resident to use call light and ask for help if needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/8/23 at 10:35 AM, an interview was conducted with CNA 1. CNA 1 stated that resident 1 asked for the hot water and not thinking any thing of it CNA 1 gave resident 1 the hot water and the straw. CNA 1 stated that she came back later and resident 1 stated that the water was to hot. CNA 1 stated that she had noticed the blisters on resident 1 and told the nurse. CNA 1 stated that she was doing cares for resident 1 when she noticed the blisters. CNA 1 stated the Creamery was where she usually got the hot water for residents. CNA 1 stated there was a tap by the hot chocolate machine labeled Hot Water. CNA 1 stated that she had put the hot water in resident 1's water mug and could not remember if there was a lid for the mug. CNA 1 stated that resident 1 had a personal drinking straw that was hooked up to suction. CNA 1 stated the suction helped resident 1 to drink from the straw. CNA 1 stated that she had given resident 1 hot water in the past. CNA 1 stated she did not know if the protocol was to temp the water prior to giving the hot water to a resident. CNA 1 stated she did not temp the hot water prior to giving the mug to resident 1. On 11/8/23 at 10:47 AM, an interview was conducted with resident 1. Resident 1 stated that suction had nothing to do with the drinking straw. An observation was conducted of resident 1's water mug. A long straw that appeared to be suction tubing came out of the water mug and was attached to a arm device that resident 1 could reach with his mouth. The suction canister tubing was observed to be attached to the same arm device but separate from the drinking straw. Resident 1 stated that he would request warm water when he was cold. Resident 1 stated that he was a quadriplegic and when he got cold the warm water would warm him up. Resident 1 stated the other CNAs would get the hot water from the nurses station and would fill his water mug with half hot water and half cold water. Resident 1 stated that CNA 1 was his CNA the night he got burned. Resident 1 stated he did not specify on the water and when he got a drink it was burning hot water. Resident 1 stated that he tried to blow the water back in the straw but the water was to hot and it came out of the straw and he felt the hot water on his chest. Resident 1 stated that he thought the water was only on the blanket but it had poured onto his skin. Resident 1 stated the water had burned under the side of his right arm, right side of his genitals, and along side the right of his hip. Resident 1 stated that he had blistered and the blisters bursted for two nights. Resident 1 stated the NP which was the wound nurse seen him once a week. Resident 1 stated he had a racking headache over the weekend after the incident. Resident 1 stated that he was not sure if the headache was a response to the pain. Resident 1 stated by Monday he was feeling better and yesterday the NP described the wound areas were looking much better. Resident 1 stated the NP had prescribed saline and silvadene cream for the burns and to cover the burns with protective pads. Resident 1 stated that yesterday the NP changed the dressing order to once a day. Resident 1 stated that he has not had a headache for two days. Resident 1 stated that he had received compassionate and effective care from the facility since the hot water incident. Resident 1 stated that CNA 1 had not brought him hot water before. Resident 1 stated that though it was a mistake it was out of ignorance or lack of communication. Resident 1 stated that the hot water was not out of negligence. On 11/8/23 at 11:24 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that resident 1 was a quadriplegic. RN 1 stated that resident 1 had been at the facility for four years. RN 1 stated that resident 1 was respectful but sarcastic and very specific with cares. RN 1 stated that resident 1 did not like ice water and the CNAs have told RN 1 that resident 1 would ask for hot water. RN 1 stated that the CNAs have told RN 1 that they would mix hot and cold water so the water was warm. RN 1 stated that resident 1's suction was for congestion and respiratory would see resident 1 twice a day and empty the canister if needed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/8/23 at 11:29 AM, resident 1's wound dressing change was observed with RN 2. RN 2 was observed to remove the dressings from the right lower back and right side. RN 2 stated she would clean the wounds in sections. The edges of the burns were observed to be bright red and the center was a creamy off-white color. RN 2 cleansed the burn areas with Hibiclens. A silver dollar sized area of skin came off near the lower back during the cleaning. RN 2 applied silvadene, covered the area with oil emulsion dressings, abdomen pads, and tapped the pads to resident 1's skin. Resident 1's right arm was observed to have some drainage on the bandage. The burn on resident 1's right side was observed to cover half way down the right side to the hip area and angled towards the middle of resident 1's back. RN 2 was observed to remove the dressings from the chest area and abdomen. The burn was observed to cover resident 1's chest and down toward resident 1's left side around the colostomy site. The burn was observed in the left hip crease area and towards the top of the pelvic area. The edges of the burns were observed to be bright red and the centers were a creamy off-white color. Blisters were observed on resident 1's left side near resident 1's ostomy. Resident 1's belly button was observed to be red. RN 2 was observed to remove the dressings from resident 1's right arm. The burn area covered under the bicep from the elbow to half way up the arm. RN 2 stated that the skin was starting to come off. On 11/8/23 at 12:50 PM, an observation of the hot water was conducted. In the Creamery the hot water tap was observed to be connected to the coffee machine. A resident coffee mug was filled with hot water. The temperature was obtained with a digital thermometer and read 158.7 F. On 11/8/23 at 12:54 PM, an interview was conducted with CNA 2. CNA 2 stated if a resident requested hot water she could get the hot water at the nurses station or the Creamery. CNA 2 stated that she would get the resident a new cup and a new straw. CNA 2 stated that she never used the hot water in the Creamery. CNA 2 stated if the resident was coherent she would remind them that the water was hot. CNA 2 stated if the resident was not coherent or oriented she would dilute the hot water. On 11/8/23 at 1:00 PM, an interview was conducted with CNA 3. CNA 3 was observed in the main dining area near the Creamery. CNA 3 stated that when dining was finished there was a chain that was put up so the residents were not able to access the Creamery. CNA 3 stated that during dining a staff member would be present and the residents would ask for what they needed. A resident was observed to wander into the Creamery and filled her water mug with ice. CNA 3 was observed to assist the resident and escorted her out of the Creamery. On 11/8/23 at 1:12 PM, an interview was conducted with the Administrator (Admin). The Admin stated that he had tested the hot water on Saturday and it was coming out at 176 F. The Admin stated the company that owns the coffee machine came to the facility on Monday and the coffee machine was set at 196 F. The Admin stated he was told by the company that the coffee machine needed to be set in the 180's to be able to make coffee. The Admin stated the company made adjustments on the coffee machine for 180 F. The Admin stated the kitchen staff were temping the coffee mugs before the mugs went to the residents and monitoring was conducted once a day. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/8/23 at 1:39 PM, an interview was conducted with the Director of Nursing (DON). The DON stated there had not been any other burns in the facility. The DON stated the residents usually rarely ask for hot water, but the residents would usually ask for tea or coffee. The DON stated the staff were to pour the water and if the water was hot the staff would put cold water or ice in the cup. The DON stated the staff should make sure the temperature was good and the water was in a proper cup with a lid. The DON stated when the staff bring the warm water to the resident room the staff need to reposition the residents and ask the resident how they would like to drink. The DON stated the staff need to supervise the resident. The DON stated that resident 1 was the only resident that would ask for hot water. The DON stated she did education for the entire facility regarding hot water. The DON stated that resident 1 at this moment has requested luke warm water and the care plan had been updated.