

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465049	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Spring Creek Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4600 South Highland Drive Salt Lake City, UT 84117	
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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents' drug regimens were free from unnecessary drugs by failing to ensure blood glucose levels were monitored as ordered by a physician for 2 out of 11 sampled residents. Specifically, the facility failed to perform ordered blood glucose checks for 2 residents receiving insulin when the residents were sleeping. The facility failed to document a blood glucose check for one resident on multiple days, and during one incident, it was documented that they ran out of testing supplies. Resident Identifiers: 2 and 4. 1. Resident 2 was admitted to the facility on [DATE], and re-admitted on [DATE], with diagnoses including type 2 diabetes mellitus. On 7/28/2026 at 12:46 PM, an interview was conducted with Resident 2, who stated the facility had run out of glucose test strips, so staff could not test her blood sugar or administer insulin to her that day. The surveyors reviewed Resident 2's medical record. Resident 2's Care Plan, initiated 4/23/2025, documented she was at risk for unstable blood glucose levels related to poor dietary choices, with a documented intervention to monitor blood glucose per orders and document trends. Resident 2 had a physician order, initiated on 6/22/26 at 4:00 PM, for Insulin Lispro Injection Solution, to be injected subcutaneously per sliding scale before meals and at bedtime (scheduled for 7:30 AM, 11:00 AM, 4:00 PM, and 9:00 PM) for diabetes, and to call the provider if levels indicated 0-79 or 421-599 mg/dL. Resident 2's July 2026 Medication Administration Record (MAR) was reviewed and documented resident sleeping 25 times as the rationale for why blood glucose was not drawn. The July 2026 MAR further indicated no glucose test strips were in the building on July 28, 2026. Additionally, no documentation was noted on the MAR to indicate Resident 2's blood glucose had been taken at 4:00 PM on July 2, 4, 5, 11, 17, and 18, 2026. 2. Resident 4 was admitted to the facility on [DATE], with diagnoses including type 2 diabetes mellitus, chronic diastolic heart failure, chronic respiratory failure, and other obesity due to excess calories. The surveyors reviewed Resident 4's medical record. Resident 4 had a physician order, initiated on 5/13/2026 at 12:00 AM, to have blood sugar checks performed every 4 hours for type 2 diabetes and increased blood sugars, with instructions to contact the provider if blood sugar exceeded 400 mg/dL. Resident 4's May 2026 MAR revealed blood glucose checks were not completed on May 13 at 12:00 AM, May 15 at 12:00 PM, and on May 16 at 12:00 AM and 4:00 AM. Additionally, no documentation was noted in the MAR or progress notes to indicate the physician was contacted when Resident 4's blood glucose levels exceeded the 400 mg/dL threshold on May 13 at 8:00 PM and May 14 at 4:00 PM. On 7/30/26, the surveyors interviewed LPN 1 and RN 1, who stated that if blood glucose test strips run low in a medication cart, staff had been instructed to check the medication room or other carts, and that extra insulin was available through the facility medication dispenser. LPN 1 and RN 1 stated the facility should not run out of strips or insulin, and confirmed the expectation that staff must wake sleeping residents to test blood glucose as ordered. On 7/30/2026 at (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:35 AM, the surveyors interviewed the DON, who stated they were responsible for ordering backup testing supplies. The DON stated the facility had previously come close to running out of strips, but received additional supplies within an hour. The DON confirmed that if a physician's order required blood glucose to be tested before meals or at set times, staff had been instructed to wake sleeping residents to complete the testing.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview and record review, it was determined the facility failed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility experienced a sewage flood, and residents were observed coming into contact with the sewage water. Resident Identifiers: 2 and 6. On 7/28/2026, the surveyor reviewed video footage recorded by a staff member during the sewage backup incident on 7/19/2026. The video showed standing sewage water covering portions of the second-floor hallway, with wet bath towels and bedsheets laid across the corridor to soak up the wastewater. The footage also demonstrated water flooding both sides of the hallway and sewage leaking down through the first-floor ceiling into a facility administrative office. On 7/28/2026, the surveyor interviewed a staff member, who stated that flooding occurred on the second floor affecting resident rooms, bathrooms, and the hallway, and was dripping down to the first floor. The staff member noted that although residents were instructed to remain in their rooms, some confused residents were seen walking through the contaminated sewage water in the hallway and their rooms wearing only socks. On 7/28/2026 at 12:46 PM, the surveyor interviewed Resident 2, stated that on 7/19/2026, sewage water containing urine and feces backed up through toilets and shower drains, a ran down the second-floor hallway and into resident rooms on both sides of the corridor, including their own. Resident 2 stated that residents in wheelchairs or wearing socks traversed the contaminated water to go outside and find relief from the odor. On 7/28/2026 at 1:19 PM, the surveyor interviewed Resident 6, who resided on the second floor, and stated that sewage flooded out of the bathrooms into resident rooms and the main hallway, creating a severe odor. Resident 6 stated that staff placed sheets and towels across the hallway floor to soak up the water, and they had to drive their wheelchair directly through the flooded sewage water in the hallway to go outside. On 7/28/2026, the surveyor interviewed the Maintenance Director, who stated residents were instructed to stay in their rooms, but chose not to due to the smell. The Maintenance Director observed residents wheeling their wheelchairs with their hands through the sewage water and subsequently touching their faces.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to provide housekeeping and maintenance services necessary for a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Specifically, the facility failed to maintain the main sewer plumbing line in good repair, resulting in raw sewage containing urine and feces backing up through shower drains and toilet bases into resident rooms and corridors. This required the main building water supply to be shut off for over 6 hours, exposing residents to unsanitary conditions, hazardous biohazardous waste, and noxious fumes. Resident Identifiers: 2, 6, and 7. On 7/28/26, the surveyors viewed staff video footage from the incident, which revealed standing sewage water covering portions of the second-floor hallway, with wet bath towels and bedsheets used to soak up the wastewater. The flooding extended to both sides of the hallway and leaked through the first-floor ceiling into an administrative office. On 7/28/26 at 12:46 PM, the surveyors observed stained ceiling tiles in room [ROOM NUMBER]. Resident 2 reported that a clogged toilet occurred about six months prior, causing the observed damage. On 7/28/26 at 11:23 AM, the surveyors interviewed Resident 7, who indicated that approximately one week prior (7/19/26), the facility shut off the building water supply for several hours after a toilet clogged and flooded elsewhere in the facility. On 7/28/26, the surveyors interviewed Resident 2 and Resident 6, who confirmed that sewage water containing urine and feces backed up through toilets and shower drains on 7/19/26, flooding the hallway and resident rooms, including theirs. Both residents stated flooding was a recurring issue, with resident 6 noting another clog on 7/27/26. Both residents, along with a visitor, reported that residents had to drive their wheelchairs through the contaminated water to escape the odor. On 7/28/26, the surveyors interviewed Maintenance 1, who indicated the main sewer drain backs up due to corroded cast-iron piping and flushed wipes. On 7/19/26, Maintenance 1 responded to the flooding, shut off the main water supply for over six hours, and contacted a restoration company to clean and sanitize the areas after the plumbing line was cleared at 4:30 PM. Maintenance 1 confirmed sewage entered resident rooms and that residents in wheelchairs traversed the contaminated water. Another near-backup was noted on 7/27/26. On 7/30/26 at 10:35 AM, the surveyors interviewed the Director of Nursing (DON), who indicated that staff notified the Administrator of the incident on 7/19/26, and restoration teams were called to pump out water, mop, and disinfect the walls and floors. On 7/30/26, the surveyors interviewed the Administrator, who confirmed the main sewer line backed up on 7/19/26 due to pipe separation and flushed wipes. The Administrator stated that staff attempted to divert traffic, kept unaffected residents in their rooms, and distributed masks due to the odor. However, the Administrator confirmed that no medical or clinical assessments were conducted on the residents following their exposure to the sewage and fumes.		

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F 0684 Level of Harm - Minimal harm or potential for 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 interview and record review, it was determined the facility did not ensure that each resident received care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. Specifically, for 1 out of 11 sampled residents, the facility failed to ensure a resident received a prescribed antidiabetic medication, as ordered by the physician. Resident Identifier 4. Resident 4 was admitted to the facility on [DATE], with a diagnosis which included type 2 diabetes mellitus, chronic diastolic heart failure, chronic respiratory failure, and obesity. Resident 4's physician order, initiated 2/2/26, ordered staff to administer Tradjenta Oral Tablet 5 mg by mouth one time a day. On 5/9/26 at 7:37 AM, a note in the medical record documented that Resident 4's Tradjenta 5 MG was unable to be administered because the medication was out of stock and had been reordered. On 5/11/26 at 10:29 AM, a note in the medical record documented that Resident 4's Tradjenta 5 MG was unable to be administered because the medication was not in stock. On 7/30/26 at 8:40 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1, who stated that residents should not run out of medications and that staff reorder medications through the electronic Medication Administration Record (eMAR) when five pills remain. LPN 1 added that if a medication was completely out of stock, the staff must notify the provider and pharmacy immediately. On 7/30/26 at 9:05 AM, an interview was conducted with Registered Nurse (RN) 1, who stated that if a medication was stocked in the emergency medication supply system, staff would retrieve it from the system. If it was not in the emergency medication supply system, staff would write the medication down, pull it from the pharmacy, and contact the pharmacy. Deliveries were at 4:00 PM. On 7/30/26 at 10:35 AM, an interview was conducted with the Director of Nursing (DON), who stated that Tradjenta was not available in the emergency medication supply system and staff would be required to order it directly from the pharmacy. The DON reported that Resident 4's prescription was received from the pharmacy on 5/9/26, meaning the medication was in stock at the facility and should have been administered on 5/9/26 and 5/11/26. The DON stated it was unknown why staff did not administer the medication on 5/9/26, after the facility received it, or why staff administered the medication on 5/10/26, but omitted the dose again on 5/11/26.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that each resident was supervised to prevent accidents. Specifically, for 1 out of 11 sampled residents, a resident who was assessed as being unsafe to leave the facility unsupervised had eloped from the facility. Resident Identifier: 1Resident 1 was admitted to the facility on [DATE] with diagnoses including hemiplegia, altered mental status, and schizophrenia. A Community Risk Assessment, dated 9/11/2025, indicated Resident 1 did not know the facility address/phone number, was unaware of basic traffic laws, and lacked awareness of surroundings and safety concerns (inclement weather, road hazards, emergency vehicles, or bike lanes).An Elopement Risk Assessment identified Resident 1 as At-Risk due to exit-seeking behaviors, poor compliance with safety instructions, and non-cooperation with safety plans.A Nursing Note, dated 9/19/2025 at 8:48 AM, was reviewed and documented a CNA had reported seeing Resident 1 operating her wheelchair on the sidewalk at approximately 6:40 AM. The nurse alerted floor staff and searched for the resident. The Director of Nursing (DON), Administrator (Admin), and police were subsequently notified.A Nursing Note, dated 9/19/2026 at 5:17 PM, was reviewed and documented Resident 1 returned via van but refused to leave the ambulance or allow medical staff near her for an assessment. She was subsequently sent to the hospital for an emergency involuntary psychiatric commitment. A Certification for Emergency Commitment, dated 9/19/2026, was reviewed and documented that Resident 1 eloped around 6:50 AM on 9/19/2026 and was located around 3:40 PM. She returned with an altered mental status, hallucinations, dehydration, and a refusal of all care.A Facility Investigation was reviewed and documented that Staff 1 reported responding to an outside kitchen alarm and encountered Resident 1 at the door. Resident 1 claimed she had signed papers to leave and proceeded outside. Staff 1 then sought assistance from other staff members.On 7/30/2026, the surveyor interviewed the DON, who confirmed Resident 1 was confused, expressed unrealistic desires to travel, and was unsafe to leave unsupervised. The DON noted that staff were expected to consult the elopement binder and medical charts to verify whether a resident was cleared for independent exit.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure that each resident was free of any significant medication errors. Specifically, for 1 out of 11 sampled residents, the facility failed to administer a prescribed dose of long-acting insulin, due to the medication being unavailable and the staff failed to access the facility's emergency medication supply. Resident Identifier 4. Resident 4 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus, chronic diastolic heart failure, chronic respiratory failure, and obesity. A physician order, initiated on 2/26/26 at 6:00 AM, prescribed Insulin Glargine Solostar Subcutaneous Solution Pen-injector 300 units/mL, to inject 50 units subcutaneously once daily. On 3/20/26 at 11:19 AM, a Registered Nurse (RN) progress note documented that the insulin was not administered due to the medication being unavailable. On 7/30/26 at 8:40 AM, the licensor interviewed LPN 1, who stated staff should reorder medications via the eMAR when five doses remain. If a medication was completely out, staff must immediately notify the provider and pharmacy, and utilize the emergency medication supply system. At 9:05 AM, the licensor interviewed RN 1, who confirmed that backup insulin was available via the emergency medication supply system in a lockbox within the third-floor refrigerator, and staff should not run out of insulin. At 11:12 AM, the licensor interviewed the Director of Nursing (DON), who confirmed the location of the backup insulin and the medication alert system for pharmacy restocking. The DON noted there was no documentation in the progress notes or Treatment Administration Record (TAR) which explained the omission, and because she was not employed at the facility at the time of the survey, the exact reason for the unavailable medication and omitted dose remained unknown.		