STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465066	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Taylorsville	6246 South Redwood Road Salt Lake City, UT 84123

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** Based on observation, interview, and record review, the facility failed to ensure that each resident received adequate supervision to prevent accidents. Specifically, for 1 out of 41 sampled residents, one resident sustained a second-degree burn from a heat therapy treatment and will be cited at a harm level. Resident identifier: 76. Findings included:Resident 76 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included anterior cord syndrome at C3 level of cervical spinal cord; completed lesion at C4, C5, and C6 level of cervical spinal cord; cognitive communication deficit; spastic hemiplegia; and paresthesia of skin.On 2/2/26 at 8:31 AM, an interview was conducted with resident 76 who stated he was in the shower last Friday and the hot, hot water burned his arm. Resident 76 was observed to have a wrap on his left forearm and two blisters, approximately the size of a dime, on two of the knuckles on his left hand. Resident 76's medical record was reviewed from 1/26/26 through 2/3/26.An Alert Charting note dated 2/1/26 at 3:46 PM, indicated, Pt [patient] sent to [hospital name redacted] per on call [Medical Doctor's name redacted] orders. Pt found to have a rash with skin peeling to left arm and large blisters to knuckles on left hand.An Emergency Department document dated 2/1/26 at 5:05 PM, indicated, Findings consistent with second-degree burn to the left forearm. Scattered blistering of the skin.Isolated entirely to the left forearm. Also there are uncomplicated appearing bullae [large fluid-filled blisters] to the 3rd, 4th, and 5th digits of the left hand to the PIP [proximal interphalangeal] joints. It further indicated, In my opinion, this does not seem to be a medication reaction. This very much looks like a burn, and is isolated only to the left forearm. There is no oral involvement. There is no skin involvement anywhere else on the body. Out of an abundance of caution I elected to review this case with the on-call dermatologist. They reviewed photos. They agree that this does not seem like some sort of a systemic emergency process such as SJS [Stevens-Johnson_syndrome, a rare, serious adverse reaction, usually to a medication] or TEN [Toxic Epidermal Necrolysis, a rare, life-threatening skin reaction, usually to a medication], and again it looks like a burn. On 2/3/26 at 11:01 AM, an interview was conducted with the RNA. The RNA stated they provided heat therapy to resident 76 on 2/1/26. The RNA stated they obtained hot water from the sink in the therapy room, poured it into a basin, and submerged towels in the water. The RNA stated that they were supposed to use a thermometer to test the water but they did not test it that day. The RNA stated the temperature should have been between 105 to 115 degrees. The RNA stated they placed a dry towel on the resident's left forearm to his knuckles and then placed the hot wet towels on top of that. The RNA stated they touched the towel and it felt warm but resident 76 said it was good and that he did not express any pain through the heat therapy treatment. The RNA stated when they uncovered it they noticed it was more red than usual so they notified the nurse immediately. A Progress note dated 2/2/26 at 5:18 AM, indicated, Pt returned from [hospital name redacted] at 2000 pm [8:00 PM] after evaluation for left forearm/hand burn. Diagnosis : partial-thickness (second-degree) burn of left forearm.A Restorative Nursing Program document dated 4/24/25, indicated no heat therapy was included in the recommendations.On 2/3/26 at 9:18 AM, an interview was conducted with the Director (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 0689 Level of Harm - Actual harm Residents Affected - Few	of Rehabilitation (DOR). The DOR stated Rehabilitation Services made recommendations for the Restorative Nurse Aide (RNA) program and that nursing ran the program and trained the RNAs. The DOR stated the Restorative Nursing Program document dated 4/24/25, listed the recommendations that were made for the RNA program for resident 76 and that there were no recommendations for heat therapy. The DOR stated he did not provide any heat therapy training to the RNA's. The DOR stated they did not have a hydrocollator so the facility was not equipped to provide heat therapy in an appropriate manner. The DOR stated a hydrocollator was temperature controlled and was designed to prevent burns. The DOR stated warmed or heated towels could not be heat regulated to prevent burns and that they could contain hot pockets. The DOR stated that a resident who was completely cognizant would be a better candidate to determine if a heated towel was too hot and remove it themselves. The DOR stated resident 76 had intermittent confusion.On 2/3/26 at 11:09 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that therapy trained the RNAs and that she thought there was a recommendation to provide heat therapy.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility did not ensure that drugs and biologicals were labeled in accordance with accepted professional principles and stored in locked compartments. Specifically, observations were made of resident medications left unlocked and unattended on top of the medication cart, a multidose vial of insulin was available for use past its expiration date, and a multidose vial of tuberculin did not contain an open date for the vial. Resident identifiers: 7 and 70. Findings included:1. On 1/28/26 at 8:25 AM, an observation was made of Licensed Practical Nurse (LPN) 1 during morning medication administration. LPN 1 left a blister pack of simvastatin for resident 70 on the top of the medication cart outside the resident's room. LPN 1 walked away from the medication cart to administer medication without securing the simvastatin in the locked medication cart. An immediate interview was conducted with LPN 1. LPN 1 stated that it was easier to pull all the blister packs out of the cart while dispensing medication and she forgot to put the simvastatin back inside the cart before she walked away. 2. On 1/28/26 at 9:45 AM, an observation was made of the 200 hallway medication cart with Unit Manager (UM) 1. An open multidose vial of Lantus insulin for resident 7 with an open date of 12/25/25, was observed. UM 1 stated that an open vial of insulin was good for 28 days past the open date. UM 1 stated that the insulin should be discarded. 3. On 1/28/26 at 9:59 AM, an observation was made of the medication fridge at the front of the 200/300/400 hallway. An open multidose Tuberculin vial was available for use with no open date documented on the vial or box. On 1/28/26 at 10:06 AM, an interview was conducted with UM 2. UM 2 stated that the Tuberculin vial should have an open date documented on the vial or the box. On 1/28/26 at 10:24 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the multidose vial of Tuberculin was good for 30 days once opened. The DON stated that the nursing staff should write the open date on the vial and on the box. The DON stated that medication blister packs should be placed back into the medication cart after dispensing the medications. The DON stated that the insulin should have been discarded as it was past the expiration date and if staff could not determine the open date they should discard the medication.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the resident had the right to manage their financial affairs and included the right to know, in advance, what charges the facility imposed against a resident's personal funds. Specifically, for 1 out of 41 sampled residents, a resident was not informed in advance that the facility was going to charge against their personal funds the supplemental insurance premiums. Resident identifier: 54. Findings included:Resident 54 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included Multiple Sclerosis, functional quadriplegia, type 2 diabetes mellitus, epilepsy, major depressive disorder, anxiety disorder, and cognitive communication deficit. On 1/27/26 at 3:28 PM, an interview was conducted with resident 54's Power of Attorney (POA). The POA stated that resident 54 received $42.00 a month from the Social Security Administration. The POA stated that resident 54's current account balance was zero. The POA stated that she had asked the Business Office Manager (BOM) for a record of last year's account and had not heard back from her. Resident 54's medical record was reviewed on 1/26/26 through 2/3/26. Resident 54's profile listed the POA as the responsible party, POA for Care and Financial. The profile also indicated that resident 54 was their own responsible party. On 8/15/23, resident 54's POA completed an application for supplemental dental and vision insurance and the monthly premiums were $159.00 for dental and $59.00 for vision for a total of $218.00 per month. The application indicated to send the bill to the facility. Resident 54's financial statement documented insurance premium deductions that totaled $2,280.00 from their personal funds account from May 2025 through December 2025. On 1/29/26 at 10:48 AM, an interview was conducted with the BOM. The BOM stated that the facility was resident 54's representative (rep) payee. The BOM stated that resident 54's supplemental dental and vision insurance was provided through Medicaid. The BOM stated that the premiums for the insurance were supposed to be deducted from the facility's Cost of Care (COC) amount. It should be noted that the insurance premiums were not paid from the COC withdrawals but instead from resident 54's remaining account balance. The BOM stated that she became aware of the situation with resident 54's insurance in July 2025. On 1/29/26 at 12:54 PM, an interview was conducted with the Accounts Receivable Director (ARD). The ARD stated that they were not deducting the insurance premiums from the facility's COC. The ARD stated that they used resident 54's remaining account balance to pay the overdue back payment for the insurance premiums. The ARD stated that they had no documentation verifying that resident 54 or the POA authorized the facility to pay the back payment from resident 54's account balance or personal funds. On 1/29/26 at 1:23 PM, a follow-up interview was conducted with the ARD. The ARD then stated that the facility was resident 54's rep payee so they decided to deduct the back payment for the insurance premiums from resident 54's account balance. The ARD stated at one point resident 54 had an excess of funds, and they therefore took her money to pay the insurance. The ARD stated that they did not obtain authorization from resident 54 or the POA to use her excess funds to spend down her account to pay for the insurance. The ARD stated that the facility's practice was to ask the resident or POA to authorize access to the resident's personal funds. On 1/29/26 at 4:41 PM, a telephone interview was conducted with resident 54's POA. The POA stated that the facility was supposed to make the insurance payment and it was not supposed to come out of the resident's personal funds. On 2/3/26 at 9:31 AM, an interview was conducted with the ARD. The ARD stated that because they were resident 54's rep payee they did not need to notify the resident of the cost of services or any changes that were made. The ARD confirmed that they did not give resident 54 the opportunity to be informed of the changes made to her financial account. [Cross-refer F571]

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the financial record was available to the resident through quarterly statements and upon request. Specifically, for 1 out of 41 sampled residents, a resident's quarterly statements were not provided to the resident or their personal representative and Power of Attorney (POA). Resident identifier: 54. Findings included:Resident 54 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included Multiple Sclerosis, functional quadriplegia, type 2 diabetes mellitus, epilepsy, major depressive disorder, anxiety disorder, and cognitive communication deficit. On 1/27/26 at 3:28 PM, an interview was conducted with resident 54's POA. The POA stated that resident 54 received $42.00 a month from the Social Security Administration. The POA stated that resident 54's current account balance was zero. The POA stated that she had asked the Business Office Manager (BOM) for a record of last year's account and had not heard back from her. Resident 54's medical record was reviewed on 1/26/26 through 2/3/26. Resident 54's profile listed the POA as the responsible party, POA for Care and Financial. The profile also indicated that resident 54 was their own responsible party. On 1/29/26 at 10:48 AM, an interview was conducted with the BOM. The BOM stated that resident 54's POA should get a quarterly statement but she did not think it was done. On 1/29/26 at 12:54 PM, an interview was conducted with the Accounts Receivable Director (ARD). The ARD stated that they mailed statements to the POA quarterly but they had no documentation to verify that it was sent. The ARD then stated that the quarterly statements were delivered to resident 54's room and then it was shredded because they did not want to leave the documentation behind for anyone to see. The ARD then stated that the statement would not be mailed to the POA because they were resident 54's representative payee. The ARD then asked if resident 54 had a POA. [Cross-refer F571]

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that charges were not imposed against the personal funds of a resident for any item or service for which payment was made under Medicaid or Medicare. Specifically, for 1 out of 41 sampled residents, a resident's Medicaid funded insurance premiums were deducted from the resident's personal funds account and not from the facility Cost of Care (COC). Resident identifier: 54. Findings included:Resident 54 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included Multiple Sclerosis, functional quadriplegia, type 2 diabetes mellitus, epilepsy, major depressive disorder, anxiety disorder, and cognitive communication deficit. On 1/27/26 at 3:28 PM, an interview was conducted with resident 54's Power of Attorney (POA). The POA stated that resident 54 received $42.00 a month from the Social Security Administration (SSA). The POA stated that resident 54's current account balance was zero. The POA stated that she had asked the Business Office Manager (BOM) for a record of last year's account and had not heard back from her. Resident 54's medical record was reviewed on 1/26/26 through 2/3/26. Resident 54's profile listed the POA as the responsible party, POA for Care and Financial. The profile also indicated that resident 54 was their own responsible party. On 8/15/23, resident 54's POA completed an application for supplemental dental and vision insurance and the monthly premiums were $159.00 for dental and $59.00 for vision for a total of $218.00 per month. The application indicated to send the bill to the facility. On 12/17/24, resident 54's Notice of Decision for the eligibility of benefits documented that resident 54's COC amount was $1688.00 and would begin in January 2025. This was the amount that must be given to the nursing home as resident 54's contribution towards COC. On 12/16/25, resident 54's Notice of Decision documented that the COC changed from $1688.00 to $1736.00 and would begin in January 2026. On 1/30/26, resident 54's Notice of Decision documented that the COC changed from $1736 to $1467.00 and would begin in February 2026. On 2/22/25, resident 54's Department of Health/Form 114AR Attachment D Authorization to Disclose Medical Information documented that resident 54 gave the facility the authority to Speak or act on my behalf as an authorized representative, which includes receiving Medicaid,.This authorization is effective from the date this form is signed until a written notification to revoke the authorization is received by the Department of Workforce Services. The form did not contain a signature and only had an X in the signature field and was dated 2/22/25. No other signatures were contained within the form. Resident 54's Financial Account Statement from the facility documented that resident 54's SSA monthly payment was $1733.00 per month. After the COC deduction of $1688.00, resident 54 was left with a personal funds credit of $45.00 per month. On 3/24/25, resident 54's Medical Review Complete Notice documented a countable income form Social Security of $1733.00. On 4/3/25, resident 54's starting account balance was $1733.00. On 5/1/25, resident 54's account balance was $2256.40 after a deposit of $2211.40 was credited to the account. The description is documented from PCC (abbreviation unknown). On 5/19/25, resident 54's account had a deduction of $872.00 for insurance premiums. On 6/11/25, resident 54's account had a deduction of $1935.70 for COC payment. It should be noted that the resident's COC amount was actually $1688.00 as designated on the Notice of Decision dated 12/17/24. This amounted to an additional $247.70 deducted from resident 54's account. On 6/27/25, resident 54's account had a deduction of $218.00 for insurance premiums. On 7/10/25, resident 54's account had a deduction of $436.00 for insurance premiums. On 8/28/25, resident 54's account had a deduction of $50.00 for PERSONAL NEEDS ITEMS. The payee was documented as the facility Administrator. It should be noted that no other documentation could be found to account for the expense of the $50.00. On 9/9/25, resident 54's account had a deduction of $218.00 for insurance premiums. On 10/8/25, resident 54's account had a deduction of $218.00 for insurance premiums. On 11/18/25, resident 54's (continued on next page)

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	account had a deduction of $218.00 for insurance premiums. On 12/12/25, resident 54's account had a deduction of $100.00 for insurance premiums. After this last deduction resident 54's account balance was $38.79. It should be noted that resident 54's insurance premium deductions totaled $2,280.00 from their personal funds account. The additional unexplained deduction of $247.70 on 6/11/25, added to the insurance premiums brings the deductions other than COC to $2527.70. On 1/29/26 at 10:48 AM, an interview was conducted with the BOM. The BOM stated that the facility was resident 54's representative (rep) payee. The BOM stated that resident 54's supplemental dental and vision insurance was provided through Medicaid. The BOM stated that the premiums for the insurance were supposed to be deducted from the facility's COC amount which would result in the facility receiving a lower monthly amount from resident 54. The BOM stated that Medicaid took resident 54 off of the supplemental insurance and the notice of this decision was sent to the POA. The BOM stated that she had been paying the supplemental insurance premiums because she was not notified of Medicaid's decision. It should be noted that the insurance premiums were not paid from the COC withdrawals but instead from resident 54's remaining account balance. The BOM stated that resident 54's POA was mad. The BOM stated that the previous BOM was behind in payment to the insurance company and they were going to cancel the plan. The BOM stated that she paid the bill from resident 54's account balance or personal funds. The BOM stated that the facility had a change of ownership in February 2025, and during the acquisition they did not receive the financial records from the previous company. The BOM stated that resident 54's POA was also making withdrawals from the account. The BOM stated that she was responsible for the accounting and ensuring that funds were available for withdrawal. The BOM stated that she became aware of the situation with resident 54's insurance in July 2025 and she was attempting to get a refund from the insurance company and an accounting prior to the new company acquisition. The BOM stated that she was in the process of conducting a financial audit of resident 54's records. On 1/29/26 at 12:54 PM, an interview was conducted with the Accounts Receivable Director (ARD). The ARD stated that the facility had a change of ownership in February 2025 and the resident's trust was opened in March 2025. The ARD stated that they were not deducting the insurance premiums from the facility's COC. The ARD stated that they used resident 54's remaining account balance to pay the overdue back payment for the insurance premiums. The ARD stated that the insurance company was going to stop services for non-payment. The ARD stated that they had no documentation verifying that resident 54 or the POA authorized the facility to pay the back payment from resident 54's account balance or personal funds. On 1/29/26 at 1:23 PM, a follow-up interview was conducted with the ARD. The ARD stated that the PCC deposit on 5/1/25, for $2211.40 was the balance carried forward from the old trust during the change of ownership. The ARD stated that resident 54's financial statement showed the deposits, deductions for COC, and back payments to the insurance premiums. The ARD stated that the remaining account balance showed an excess of $2000.00 so her $45.00 a month was accumulating. The ARD stated that after the last deduction in December 2025 resident 54's account balance was $38.00, and we don't know where the money went. The ARD then stated that the facility was resident 54's rep payee so they decided to deduct the back payment for the insurance premiums from resident 54's account balance. The ARD stated at one point resident 54 had an excess of funds, and they therefore took her money to pay the insurance. The ARD stated that they did not obtain authorization from resident 54 or the POA to use her excess funds to spend down her account to pay for the insurance. The ARD stated that the facility's practice was to ask the resident or POA to authorize access to the resident's personal funds. On 1/29/26 at 2:28 PM, the ARD stated that resident 54's POA was only for health and not financial and she was not sure why the resident profile in the electronic medical record documented her financial POA. The ARD stated that she was not sure if resident 54's POA had been given access to her finances. The ARD again stated that the supplemental vision and dental insurance was a Medicaid provided program. The ARD stated resident 54's medical POA signed her up for the supplemental insurance, and the facility as the rep payee was allowed to distribute the funds as they (continued on next page)

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F 0571 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saw fit. The ARD stated that Medicaid messed up on the COC for the vision and dental insurance. The ARD stated that they identified the issue with Medicaid in November 2025 when resident 54's POA started asking questions. The ARD stated that based on the bank statement they took an excess of $450.00 that would be refunded. The ARD stated that the Medicaid COC was messed up in January 2025 and resident 54 would have funds that needed to be refunded to her since that date. The ARD stated that as rep payee they should have been notified of the change from Medicaid but they never received the information. The ARD stated that it was information that should have been transferred during the change of ownership. On 1/29/26 at 3:08 PM, the ARD stated that the BOM was paying off the insurance balance. The ARD stated that they were pulling the statements for the insurance now. The ARD stated that there was a potential that they overpaid but they did not know for sure. The ARD stated that they did not know the date of cancellation for the insurance policy. The ARD stated that the withdrawal on 8/28/25, for personal needs, was the only withdrawal that they knew of and that resident 54 did not usually take money out for herself. On 1/29/26 at 4:41 PM, a telephone interview was conducted with resident 54's POA.The POA stated that resident 54's SSA benefits went directly to the facility. The POA stated that she withdrew funds from resident 54's account through the BOM when resident 54 wanted or needed anything purchased. The POA stated that she did not have financial POA for resident 54. The POA stated that she called the BOM about the missing money and the BOM told her that she was working with the insurance company about it. The POA stated that she called the insurance company herself and was informed that they had not spoken to the facility's BOM about resident 54's account but did verify that the BOM was the individual who made the payments for the insurance. The POA stated that the insurance representative told her that the facility was not supposed to deduct the premium payments from the resident funds. The POA stated that the facility was supposed to make the insurance payment and it was not supposed to come out of the resident's personal funds. The POA stated that the insurance representative told her to contact the BOM to obtain a printout of all the transactions. The POA stated that when she signed resident 54 up for the insurance she was told that the policy was to be paid by the facility and the resident would not be charged for it, and that was the only reason she agreed to the supplemental insurance. They said it wouldn't impact her social security and Medicaid. On 2/3/26 at 9:31 AM, the ARD stated that as resident 54's rep payee they had the authority to access resident 54's personal funds to make medical payments on behalf of the resident. The ARD stated that resident 54 should be able to get those funds refunded to her account one way or another. The ARD stated that they were not notified from Medicaid that the insurance was no longer covered. The ARD stated that they should have been informed but they never received the notice and the post office loses stuff all the time. The ARD stated that she had not verified the address that the Medicaid notices were sent to. The ARD stated that because they were resident 54's rep payee they did not need to notify the resident of the cost of services or any changes that were made. The ARD confirmed that they did not give resident 54 the opportunity to be informed of the changes made to her financial account.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not inform Medicaid-eligible residents when changes were made to the items and services provided. Specifically, for 1 out of 41 sampled residents, changes were made to the residents Medicaid funded supplemental vision and dental insurance and the facility did not provide notice to the resident of the changes timely. Resident identifier: 54. Findings included:Resident 54 was admitted to the facility on [DATE] and was re-admitted on [DATE] with diagnoses which included Multiple Sclerosis, functional quadriplegia, type 2 diabetes mellitus, epilepsy, major depressive disorder, anxiety disorder, and cognitive communication deficit. On 1/27/26 at 3:28 PM, an interview was conducted with resident 54's Power of Attorney (POA). The POA stated that resident 54 received $42.00 a month from the Social Security Administration. The POA stated that resident 54's current account balance was zero. The POA stated that she had asked the Business Office Manager (BOM) for a record of last year's account and had not heard back from her. Resident 54's medical record was reviewed on 1/26/26 through 2/3/26. Resident 54's profile listed the POA as the responsible party, POA for Care and Financial. The profile also indicated that resident 54 was their own responsible party.On 1/29/26 at 10:48 AM, an interview was conducted with the BOM. The BOM stated that resident 54's supplemental dental and vision insurance was provided through Medicaid. The BOM stated that Medicaid took resident 54 off the supplemental insurance and the notice of this decision was sent to the POA. On 2/3/26 at 9:31 AM, an interview was conducted with the Accounts Receivable Director (ARD). The ARD stated that they were not notified from Medicaid that the insurance was no longer covered. The ARD stated that they should have been informed but they never received the notice and the post office loses stuff all the time. The ARD stated that because they were resident 54's representative payee they did not need to notify the resident of the cost of services or any changes that were made. [Cross-refer F571]

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the health or safety of an individual in the facility is endangered; the licensee ceases to operate the facility; the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility; the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; or the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. Specifically, for 2 out of 41 sampled residents, two residents were inappropriately discharged from the facility after going on leave of absence. Resident identifiers: 115 and 137. Findings included: 1. Resident 115 was admitted to the facility on [DATE] and discharged on 11/24/25. Resident 115 had diagnoses which included, but were not limited to, congestive heart failure, respiratory failure, muscle weakness, Crohn's disease, type II diabetes and chronic obstructive pulmonary disease. Resident 115's medical record was reviewed. A Brief Interview for Mental Status (BIMS) was conducted on 11/20/25, and resident 115 scored a 15 out of 15 which indicated resident 115 was cognitively intact. A safety evaluation dated 11/19/25, documented resident 115 was alert and oriented and required minimal assistance with mobility. On 11/24/25 at 8:09 PM, a Progress note documented Came back to facility with partner at side. Resident was told he had to leave the building for leaving AMA [against medical advice] previously. Resident left with belongings. Officer [name omitted] with local pd [police department] came and walked the building to make sure resident left. On 11/24/25 at 11:34 AM, a late entry Progress note documented [Resident 115] came back to the facility after an outing. [Resident 115] did not follow the LOA [leave of absence] process and had been considered AMA. [Resident 115] left the building with his partner. On 11/24/25 at 8:37 PM, a Medication Administration Note documented left AMA. On 11/25/25 at 9:51 AM, a Provider discharge evaluation note documented . It was reported that patient left later in the day AMA. Please note: the provider did not document rationale why the resident was discharged AMA. On 11/25/25 at 11:27 AM, an Interdisciplinary note documented Resident left the facility AMA without notifying staff. Upon review, resident had signed the LOA sign-out book; however, per prior education, resident is required to be supervised for all LOAs due to history of psychoactive substance use, impaired judgment, and prior unsafe exits. Resident did not request staff assistance or supervision and did not inform nursing of his departure from the building. Staff noted resident missing during routine safety rounds. Multiple attempts were made by nursing staff to contact the resident via phone to determine his whereabouts; all attempts were unsuccessful. Resident remained unreachable for an (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extended period. Resident returned to the facility at 7:00 PM. Nursing staff assessed resident upon return. Resident was alert and oriented but was advised to seek emergency evaluation at the hospital due to his history of psychoactive substance abuse, unsafe behaviors, and the risk associated with leaving the facility unsupervised. Due to safety concerns, police were contacted to ensure the resident vacated the premises after being instructed to proceed to the hospital. Resident left the building under police supervision without incident. The facility LOA absence sign out book was reviewed. It was documented resident 115 had signed out both times he left the facility. The LOA paperwork did not indicate that resident 115 required supervision. On 1/29/26 at 9:27 AM, an interview was conducted with the Director of Nursing (DON) and Unit Manager (UM) 3 who stated the safety evaluation done on admission determines whether a resident requires supervision on LOA. The DON stated resident 115 was not compliant with being supervised and he did not let the nurses know where he had gone, they could not get ahold of him, and he left with IV (intravenous) access. The DON stated resident 115 was aware of the LOA policy and what happened if he broke it. The facility was unable to provide a LOA policy when requested. On 1/29/26 at 10:58 AM, an interview was conducted with UM 2 who stated the resident did not have IV access when he left the day of his AMA discharge. On 1/29/26 at 11:59 AM, an interview was conducted with the Resident Relations Manager (RRM) who stated she was over resident discharges and resident 115 was not a planned discharge. On 1/29/26 at 1:00 PM, an interview was conducted with Licensed Practical Nurse (LPN) 4 who stated when the resident returned to the facility after his LOA visit that he was no longer a resident of the facility and had to leave. LPN 4 stated she was not exactly sure why, other than he had been gone longer than four hours from the facility. LPN 4 stated resident 115 did return and she called the police to assist with him not staying at the facility. LPN 4 stated the resident was not taken for medical treatment; the police were just present to protect the staff and keep the resident out of the facility. LPN 4 stated resident 115 did not sign an AMA form. On 1/29/26 at 1:22 PM, an interview was conducted with LPN 3 who stated the LOA process was confusing and resident 115 did not need supervision, he was alert and oriented. On 2/2/26 at 2:45 PM, a telephone interview was conducted with Registered Nurse (RN) 2 who stated resident 115 was alert and oriented and did not need supervision. RN 2 stated she noticed the resident was gone during her shift but was unsure how long he had been gone. RN 2 stated she called the Administrator and was told to discharge the resident AMA for being gone too long. RN 2 stated she was not told to call the authorities at any time to look for the resident, she was only told to discharge the resident and not allow him back into the facility. RN 2 stated resident 115 still had belongings in the facility. 2. Resident 137 was admitted to the facility on [DATE] and discharged on 8/4/25 with diagnoses which included, but were not limited to, fracture of one rib on the left side. A BIMS was conducted on 7/31/25, and resident 137 scored an 8 out of 15 which indicated resident (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	137 was moderately cognitively impaired. On 8/4/25 at 1:55 PM, an Interdisciplinary Team (IDT) Progress Note documented a late entry discharge: [resident 137] went on LOA and never returned. Attempted to contact with no success. No nomnc [Notice of Medicare Non-Coverage] issued due to left AMA. It should be noted that AMA signed paperwork was unable to be located in the medical record. On 8/4/25 at 6:26 PM, a Skilled Needs Review note documented . IDT Determination: [resident 137] Reviewed by IDT on 07/29/2025 07/29/2025 DC [discharge] Planning/Barriers : Resident expects to be discharged to the community. Overall discharge goal details: Plans to discharge to the community. Has not decided if he goes back to the streets or to his sisters; Highest level of function goal: Independent as possible; Potential barriers to discharge/functional goals: Unhoused; Discharge planned in the next week. Discharge driven by IDT determination. Resident will be discharged to community. On 8/5/25 at 8:53 AM, a Medication Administration Note documented Patient left ama. On 8/5/25 at 10:13 AM, a Follow up Note documented . ADDENDEM: it was reported by nursing that he left LOA and never returned to the facility and is discharged as AMA. Disposition: discharged from facility AMA. signed out as 'Sis' in LOA book and never returned. Discharge Information: RN/CNA [Certified Nursing Assistant]/PT [Physical Therapy]/OT [Occupational Therapy] to evaluate and treat needs and cares. Follow up: SS [Social Services] will attemptto [sic] set up appointment unclear if he has PCP [Primary Care Physician]. On 2/2/26 at 3:16 PM, an interview was conducted with LPN 2. LPN 2 stated the evening before resident 137 left the facility for the period of time the residents were allowed. LPN 2 stated the residents were allowed to leave for four hours maximum and it could not interrupt therapy time or major medications. LPN 2 stated that she would ask the resident if they want to take their medications on LOA and it would depend on what the medications were. LPN 2 stated that 137 tried to come back to the facility the next day and talk with the Administrator. LPN 2 stated resident 137 did not have any lines but resident 137 was mentally unstable. LPN 2 stated that because resident 137 did not come back to the facility he was discharged . LPN 2 stated if a resident left the facility for more than four hours, we would try to reach out to them and if we could not reach them it was an AMA. LPN 2 stated if the resident was not alert and oriented she would call the police. LPN 2 stated that resident 137 was very alert and came back the next day wanting to know why he could not come back to the facility. LPN 2 stated that she remembered that day because the lobby smelled like marijuana. On 2/2/26 at 3:25 PM, an interview was conducted with the Administrator (ADM). The ADM stated that resident 137 left the faciity on LOA and was independent. The ADM stated that staff attempted to call resident 137 with no answer. The ADM stated that resident 137 did not attempt to come back to the facility. On 2/3/26 at 9:55 AM, an interview was conducted with the ADM. The ADM stated the facility did not have a determination on a time frame that the residents could leave the facility. The ADM stated he would typically have communication with the resident and if they were supervised. The ADM stated that the only time lines given for LOA were with the insurance and Medicare who stated the residents could only be gone for four hours. The ADM stated that insurance would set an allotted number of (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days that the residents could leave in a year. The ADM stated that right before resident 137 left LOA the staff discussed the discharge plan with him. The ADM stated that resident 137 did not notify the staff and did not sign out. The ADM stated an AMA determination would have been put in the medical record from the signing of the form. The ADM stated that on the day resident 137 left the facility staff did not communicate AMA with resident 137, but the day before they did. The ADM stated the provider would have been notified of the discharge. The ADM stated in both situations when the staff did not have any communication with the residents and they did not return to the facility, at some point the staff needed to have a conversation with the Provider.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide the necessary care and services to ensure that the resident was given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living. Specifically, for 1 out of 41 sampled residents, a resident was not provided assistance with showers per their preferences and as outlined in their shower schedule. Resident identifier: 116. Findings included:Resident 116 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction, bacterial meningoencephalitis, nontraumatic intracranial hemorrhage, ataxia, dysphagia, and cognitive communication deficits.On 1/26/26 at 9:08 AM, an interview was conducted with resident 116. Resident 116 stated she only had two showers since admission and would like to receive more. Resident 116's medical record was reviewed on 1/26/26 through 2/3/26. Resident 116's bathing task documented that the resident was scheduled for showers on Wednesday and Saturday during the day shift. Resident 116's bathing task for the last 30 days documented that resident 116 required substantial/maximal assistance to dependent assistance for bathing. The task documented that resident 116 received a shower or bed bath on 1/7/26, 1/12/26, 1/19/26, and 1/28/26. Resident 116's medical record did not have any documented refusals for showers. According to the shower schedule resident 116 should have received a shower on 12/24/25, 12/26/25, 12/31/25, 1/3/26, 1/10/26, 1/14/26, 1/17/26, 1/21/26, and 1/24/26. On 1/28/26 at 2:18 PM, an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated that resident 116's shower schedule was a morning shower on Wednesday and Saturday. CNA 1 stated that they documented the shower on a skin observation shower form and then in the electronic medical record under the bathing task. CNA 1 stated that resident 116 required supervision for bathing to ensure she did not fall. On 1/28/26 at 2:38 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that residents were provided showers two days a week per the shower schedule. The DON stated that she would expect to see documentation that the resident either received the shower or refused the shower. The DON confirmed that based on the resident's shower schedule she did not receive two showers per week as scheduled.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 1 out of 41 sampled residents,an assessment of the resident's condition and monitoring for complications before and after dialysis treatments were not completed. Resident identifier: 13. Findings included:Resident 13 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease, automatic cardiac defibrillator, cardiomyopathies, and hypo-osmolality and hyponatremia.Resident 13's medical record was reviewed from 1/26/26 through 2/3/26.A Physician's Order dated 8/25/25, indicated, COMPLETE the Dialysis Post Assessment Form after resident returns from dialysis. Ensure resident returns from dialysis with the Pre-Dialysis Assessment and Communication Form. Review and follow up as indicated. Call Dialysis center if not returned with resident.A Physician's Order dated 8/22/25, indicated that resident 13 was to receive dialysis on Mondays, Wednesdays, and Fridays at 8:00 AM.Pre and post dialysis assessments were reviewed through the dates of 12/10/25 through 1/28/26. Out of 44 opportunities, 15 pre and/or post dialysis assessments were not in the medical record.On 2/2/26 at 12:52 PM, an interview was conducted with Licensed Practical Nurse (LPN) 5. LPN 5 stated that before a resident goes to dialysis, the nurse should have checked the fistula site and checked their blood pressure to ensure it was not too low. LPN 5 stated when a resident returned from dialysis the nurse should have obtained vital signs, checked the fistula site for the bruit and thrill to ensure it was functioning properly, look for any swelling or redness, and to monitor for bleeding.On 2/3/26 at 10:35 PM, an interview was conducted with the Director of Nursing who stated a pre and post dialysis assessment should be completed in the electronic medical record each time a resident had dialysis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, for 2 out of 41 sampled residents, a resident receiving medication to prevent infection and a resident receiving medication for diabetes mellitus did not have those medications available from the pharmacy for administration. Resident identifiers: 2 and 49. Findings included:1. Resident 2 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus (DM).A physician order dated 1/3/26, documented Dapagliflozin Propanediol Oral Tablet 5 MG [milligrams] (Dapagliflozin Propanediol) Give 1 tablet by mouth one time a day for DM.The January 2026 Medication Administration Record (MAR) was reviewed. Resident 2 had missed seven doses of the medication due to the dapagliflozin propanediol being not available from the pharmacy.2. Resident 49 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, diverticulitis of large intestine without perforation or abscess without bleeding.On 1/27/26 at 8:54 AM, an interview was conducted with resident 49. Resident 49 stated she broke her tooth a week ago here at the facility. Resident 49 stated that the pain could be a little stabby. Resident 49 stated the staff had not offered her pain medications and she felt like the staff had forgotten about her. Resident 49 stated the staff told her she would see a dentist but that had not happened.A COMMUNICATION: with physician (narrative) note dated 1/23/26 at 12:41 PM, documented . Ordered peridex mouthwash BID [twice daily]. Patient notified of above and agreed. The January 2026 MAR was reviewed. Resident 49 missed the first seven doses of the medication due to the Peridex being not available from the pharmacy.On 1/29/26 at 11:37 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated the facility had issues with the pharmacy and they were switching on March 1st. LPN 2 stated that the Nurse Practitioner (NP) ordered the Peridex mouthwash until they could get resident 49 seen by the dentist. LPN 2 stated the NP ordered the Peridex to prevent the tooth from getting infected.On 2/2/26 at 11:16 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility was switching pharmacies in March. The DON stated there were issues with communication. The DON stated the pharmacy had been trying to be better and she was in constant communication with them. The DON stated that providers were aware.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was defined as any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences. Specifically, for 1 out of 41 sampled residents, blood pressure medications were administered outside of parameters and professional standards of care. Resident identifier: 13. Findings included:Resident 13 was admitted to the facility on [DATE] with diagnoses which included heart failure, end stage renal disease, automatic cardiac defibrillator, pulmonary hypertension, and ventricular tachycardia.Resident 13's medical record was reviewed from 1/26/26 through 2/3/26.A Physician's Order dated 12/23/25, indicated, Metoprolol Succinate ER [extended release] Oral Tablet Extended Release 24 Hour (Metoprolol Succinate) Give 12.5 mg [milligrams] by mouth one time a day for Hypertension.A Physician's Order dated 12/23/25, indicated, Midodrine HCl [hydrochloride] Oral Tablet (Midodrine HCl) Give 5 mg by mouth two times a day for Hypotension Hold if BP [blood pressure] 110/60 or Higher .The December 2025 Medication Administration Record (MAR) was reviewed.a. Midodrine was administered for a blood pressure of 110/60 or higher, one time.b. Metoprolol Succinate was administered for a systolic blood pressure below 100, five times.c. Midodrine (a medication prescribed to treat low blood pressure) and Metoprolol Succinate (a medication prescribed to treat high blood pressure) was administered at the same time, four times.The January 2026 MAR was reviewed.a. Midodrine was administered for a blood pressure of 110/60 or higher, one time.b. Metoprolol Succinate was administered for a systolic blood pressure below 100, six times. It should be noted that on 1/7/26, resident 13 was administered Metoprolol Succinate when he had a documented blood pressure of 87/42.c. Midodrine and Metoprolol Succinate were administered at the same time, 13 times.On 2/2/26 at 12:52 PM, an interview was conducted with Licensed Practical Nurse (LPN) 5. LPN 5 stated that Metoprolol should be held if a resident had a systolic blood pressure under 110 because that medication could cause the resident's blood pressure to drop too low and result in a medical emergency. LPN 5 stated there usually was a parameter given in the orders for Metoprolol, but if there was not, she would use her nursing judgement and hold it if the resident had a systolic blood pressure of less than 110 and then call and clarify the order with the medical doctor. LPN 5 stated Midodrine should be held if the systolic blood pressure was over 110 because it caused the blood pressure to increase and could increase the risk of a stroke if the blood pressure went too high. LPN 5 stated Metoprolol and Midodrine should not be given at the same time.On 2/3/26 at 10:46 AM, an interview was conducted with the Director of Nursing (DON) who stated if a Metoprolol order had no parameters, it should have been held if the systolic blood pressure was less than 100 but every resident was different. The DON stated the nurse should have used clinical judgement and if the nurse had a concern about a blood pressure they should have contacted the provider. The DON stated Midodrine should have been held according to the ordered parameters and that Midodrine and Metoprolol should not have been administered at the same time.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide or obtain outside resources for routine or emergency dental services to meet the needs of the resident. Specifically, for 1 out of 41 sampled residents, a resident that asked to see the dentist for a broken tooth did not have those services arranged. Resident identifier: 49. Findings included:Resident 49 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, diverticulitis of large intestine without perforation or abscess without bleeding.On 1/27/26 at 8:54 AM, an interview was conducted with resident 49. Resident 49 stated she broke her tooth a week ago here at the facility. Resident 49 stated that the pain could be a little stabby. Resident 49 stated the staff had not offered her pain medications and she felt like the staff had forgotten about her. Resident 49 stated the staff told her she would see a dentist but that had not happened.On 1/23/26 at 12:41 PM, a COMMUNICATION: with physician (narrative) note documented . Ordered peridex mouthwash BID [twice daily]. Patient notified of above and agreed.On 1/29/26 at 11:25 AM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated that herself and the Nurse Practitioner (NP) were in resident 49's room addressing some swelling that the resident had in her left arm and resident 49 mentioned that she had a broken tooth. LPN 2 stated they were working on getting the resident seen by the dentist. LPN 2 stated that Social Services would coordinate the dentist and would get the resident on the list. LPN 2 stated that the NP ordered Peridex mouthwash until they could get resident 49 seen by the dentist. LPN 2 stated the NP ordered the Peridex to prevent the tooth from getting infected. LPN 2 stated there was a standing order for the residents to see the dentist. LPN 2 stated that she would notify Social Services if a resident needed to be seen by the dentist but the NP on that day told her that she would notify Social Services because she shared an office with them. On 1/29/26 at 11:43 AM, an interview was conducted with the Resident Relations Manager (RRM). The RRM stated that she was not aware that resident 49 needed to be seen by the dentist and she would add resident 49 to the list. The RRM stated that she would make a referral to the dentist and they would come to the facility. The RRM stated the Resident Relations Assistance would ask the residents in their Interdisciplinary Team meeting if they had any dental needs. The RRM stated if the resident was receiving skilled services she would schedule the appointment with the resident's outside dentist. The RRM stated if a resident had dental needs the staff would let her know. The facility policy was reviewed Personal Care: Dental Services Policy StatementRoutine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care.Policy Interpretation and Implementation1. Routine and 24-hour emergency dental services are provided to our residents through:a. a contract agreement with a licensed dentist that comes to the facility monthly;b. referral to the resident's personal dentist;c. referral to community dentists; ord. referral to other health care organizations that provide dental services.6. Social services representatives will assist residents with appointments, transportationarrangements, and for reimbursement of dental services under the state plan, if eligible.This policy had an effective date of 2/1/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465066	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Taylorsville	6246 South Redwood Road Salt Lake City, UT 84123

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not store food in accordance with professional standards for food service safety. Specifically, the residents personal food fridge had two food containers that were not labeled with a date. Findings included:On 1/28/26 at 9:59 AM, an observation was made of the resident personal food fridge. On the front of the fridge was a sign that indicated, Resident Personal Food Fridge Put residents name & date on ALL items. Items must be covered and will be thrown out after 3 days from the date. Inside the refrigerator there was one large container that had a cloudy, brown, soup-like liquid in it with brown meat-like substance. Another styrofoam container was located in the fridge that contained vegetables. Both containers were not labeled with a resident name or date.A concurrent interview was conducted with Licenced Practical Nurse (LPN) 6. LPN 6 stated the two unlabeled food containers should be thrown away because they were not labeled with a resident name and date.On 2/3/26 at 10:44 AM, an interview was conducted with the Director of Nursing (DON) who stated that she was the one who checked the fridge for expired food or food not labeled with a date and discarded them. The DON stated food was supposed to be thrown away after three days of being in the fridge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465066	A. Building B. Wing	02/03/2026

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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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the use of outside resources. Specifically, for 1 out of 41 sampled residents, a referral for a urology consultation was not made for a resident. Resident identifier: 70.Findings included:Resident 70 was admitted to the facility on [DATE] with diagnoses which included, but not limited to muscle weakness, need for personal assistance, catheter use, and neurogenic bladder. A physician order dated 11/17/25, documented Refer patient to urology for suprapubic eval [evaluation] r/t [related to] frequent catheter leaking.No referral was made for resident 70 until 1/13/26. On 2/3/26 at 9:26 AM, an interview was conducted with the Director of Nursing (DON) who stated she was unsure why the referral to the urologist for resident 70 had not been made. On 2/3/26 at 9:29 AM, an interview was conducted with the Resident Relations Manager (RRM) who stated there was not an appointment for resident 70 on the calendar. RRM stated nursing makes those appointments and the RRM just sets up the transportation for the appointments. On 2/3/26 at 9:34 AM, an interview was conducted with Unit Manager (UM) 2 who stated she did not know what happened with the first referral, it was missed. UM 2 stated they started a new system last week for making appointments and following through with follow ups so this would not happen again. UM 2 stated the resident had seen the urologist recently and had another follow up scheduled.