STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465072	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City Creek Post Acute	165 South 1000 East Salt Lake City, UT 84102

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 interview and record review, the facility did not ensure each resident received adequate supervision to prevent accidents. Specifically, for 1 out of 43 sampled residents, one resident sustained a third-degree burn to his left wrist from spilling a prepackaged soup prepared and served by facility staff. Resident identifier: 3.It was determined the provider's non-compliance with the requirements of participation had caused harm. The harm was related to the State Operations Manual, Appendix PP, S483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents, F689, at a scope and severity of G. However, based on the facility's corrective actions and a review of its current compliance in this regulatory area, the deficiency was determined to be past noncompliance.The facility developed and implemented a corrective action plan before the survey start date. The facility's corrective action plan, which was developed and implemented by 3/11/26 included the following measures: 1. The resident was assessed and a new order obtained for treatment of the burn wound.2. Removed microwave and coffee pots from nutrition rooms.3. Director of Nursing (DON) reviewed the food and beverage process to determine where lapse in process occurred.4. Identified others at risk as all residents who requested food or fluids be warmed in the microwave.5. DON/designee re-educated facility staff on the facility process for reheating food and liquids.6. DON/designee ordered food grade thermometers for staff to use to verify temperature of food/liquids prior to serving residents.7. Microwaves returned to nutrition rooms after staff education completed. Process posted above microwaves.8. Temperature logs posted with microwaves for additional monitoring.9. DON/designee audited 5 resident foods/liquids temperatures bi-weekly x 4 weeks, weekly x 4 weeks or until substantial compliance was achieved. Audits were reviewed with the Interdisciplinary Team (IDT) team during Quality Assurance and Performance Improvement (QAPI).10. Plan of correction reviewed with QAPI team and resident council President and [NAME] President.The survey team verified all interventions were completed before the survey start date (3/23/26).Findings included:Resident 3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included end stage renal disease, type 2 diabetes mellitus, pericardial effusion, chronic obstructive pulmonary disease, and acquired absence of left leg above knee.On 3/6/26 at 10:46 AM, the facility reported to the State Survey Agency that the Resident asked a staff member (RNA [Restorative Nurse Aide]) to cook his top ramen for him to take into his room. The food was heated in the microwave in the nutrition station behind the nurse's station as per the packaging directions and returned to the resident by a nurse. Resident turned in his power wheelchair causing the ramen to spill out and the liquid created a burn to the palmar side of his left wrist. Nurse immediately assessed the skin and began applying wound care application.On 3/5/26 at 5:35 PM, a progress note documented Notified that resident received a burn to his left wrist after spilling hot soup. Wound was assessed, wound care provided and new orders placed per consult with wound provider. Resident tolerated treatment well and denies any pain or other concerns at this time.On 3/10/26, a wound provider progress note classified the severity of the burn to resident 3's left wrist as third-degree. On 3/26/26 at 3:02 PM, an interview was conducted with Certified Nursing Assistant (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	(CNA) 3, who stated resident 3 would ask CNAs to heat up food for him in the microwave, and that he insisted on carrying food himself, saying that he did not want to be treated like a child. CNA 3 stated they would not heat Resident 3's food due to the resident's refusal to allow staff to safely carry it to his room, because it was dangerous for resident 3 to carry it himself. CNA 3 stated they were unable to recall if thermometers were available for use before resident 3 sustained the burn, because they did not search for a thermometer. CNA 3 stated after resident 3 sustained the burn, thermometers were available for use, a temperature log was used, and they were educated to not give residents food or drinks that had a temperature reading higher than 140 Fahrenheit (F). On 3/26/26 at 3:09 PM, an interview was conducted with Licensed Practical Nurse (LPN) 2. LPN 2 stated resident 3 utilized a motorized wheelchair, was very independent, and did not want staff to carry items for him. LPN 2 stated before resident 3 sustained the burn, thermometers were not available for use. LPN 2 stated they would heat food up in 30 second increments until it was adequately heated, and touched the dinnerware to determine if the temperature was safe to return to the resident. LPN 2 stated after resident 3 sustained the burn the microwaves were removed from the nutrition stations until staff received training on how to use the thermometers and knew to not return food to residents until it measured below 140 F. LPN 2 stated thermometers were available for use when the microwave was returned to the nutrition station. On 3/26/26 at 3:23 PM, an interview was conducted with the Director of Nursing (DON), who stated that before resident 3 sustained the burn, staff heated food according to package directions and determined if it was safe to return food based on touch. The DON stated that when they were notified of the burn all microwaves and coffee pots were removed from the nutrition stations, resident 3 was provided wound care, and a 4-Step Action Plan was begun to ensure resident safety. The DON stated that microwaves were returned on 3/10/26, after all staff had completed education and were trained on appropriate reheating of resident foods and thermometer use. The DON stated that thermometers and coffee thermoses with pumps, instead of coffee brewers, were placed in nutrition stations when the microwaves were returned.