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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, a Bluetooth speaker was stored on a shelf used to store items used in food preparation and a male staff member with a beard was observed to be preparing food without wearing a beardnet. Findings included:On 3/23/26 at 8:02am an initial observation was conducted of the facility kitchen. There was a Bluetooth speaker sitting on a shelf used to store hotel pans used for meal preparation.On 3/25/25 at 11:31am a follow up observation was conducted of the facility kitchen. [NAME] 1 was observed to have a beard. [NAME] 1 was not wearing a beard net while preparing enchiladas that were to be served to residents at lunch. On 3/26/26 at 8:36am, an interview was conducted with the Dietary Manager (DM). The DM stated that she would purchase beard nets for the male staff member that was not wearing a beard net while preparing food. The DM also stated that she would move the bluetooth speaker to an area of the kitchen not used for food preparation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections. Specifically, for 3 out of 43 sampled residents, staff did not wear personal protective equipment (PPE) when residents were on Enhanced Barrier Precautions (EBP) and hand hygiene was not performed during wound care. Resident identifiers: 14, 73, and 74.Findings included:1. Resident 14 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included, but were not limited to, encephalopathy. On 3/23/26 at 2:21 PM, EBP signage was observed on the door frame and a PPE cart was observed outside of resident 14's room. A care plan Focus documented [name redacted] has potential for pressure ulcer development r/t [related to] Limited mobility d/t [due to] Parkinson's, Encephalopathy and Neurocognitive DO [disorder] 3/17/26 - Stage 3 Left buttock. There was no date to determine when the care plan was initiated. The interventions included, but were not limited to, use Enhanced Barrier Precautions. On 3/24/26 at 1:47 PM, the Skin/Wound Note documented . Wound assessment completed. Wound type: Stage 3 pressure Wound Location: Left Buttock Measurements: 0.6x0.5x0.2 [centimeters] Odor and Drainage if noted: No odor withsmall [sic] serosanguineous drainage Surrounding tissue: Thin and fragile . On 3/24/26 at 8:40 AM, a wound care observation was conducted with the Unit Manager (UM)/Wound care nurse and the Nurse Practitioner (NP). EBP signage was observed on resident 14's door frame and a PPE cart was observed outside of resident 14's room. The NP was observed to use an alcohol based hand rub on her hands prior to donning gloves. The UM and the NP did not don gowns at any time during the wound care. An immediate interview was conducted with the NP. The NP stated that she would wear a gown if the resident was on precautions. The NP stated that she was not sure what precautions were required for residents on EBP and the facility would set up the precautions. On 3/26/26 at 10:11 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 14 was on EBP for a wound to the right buttock and resident 14 had a Foley catheter. 2. Resident 74 was admitted to the facility on [DATE] with diagnoses which included encounter for orthopedic aftercare, right below the knee amputation, fusion of spine, displacement of internal fixation device, spinal stenosis, muscle weakness, radiculopathy lumbar region, and chronic pain. On 3/10/26, resident 74 had an order initiated for EBP and the indication was for a surgical wound. The order documented PPE required for high resident contact care activities. On 3/23/26 at 2:08 PM, an observation was made of resident 74's room. A sign for EBP was posted on the door. A PPE cart was not located outside of resident 74's room. An observation was made of Occupational Therapist (OT) 1 assisting resident 74. OT 1 was observed assisting resident 74 with pulling up the resident's trousers while lying in bed, repositioning from a lying to a sitting position at the bedside, and then a one person assisted transfer from the bed to the wheelchair. OT 1 was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed kneeling on resident 74's bed during repositioning. OT 1 wore gloves during the care but no gown was worn. On 3/26/26 at 9:00 AM, an interview was conducted with Certified Nursing Assistant (CNA) 2. CNA 2 stated that EBP was for catheter or ostomy care. CNA 2 stated that if a resident had an exposed wound and they were assisting with wound care she would wear a gown and gloves. CNA 2 stated if she was changing bed linens, toileting a resident, or if a wound was protected by a dressing she would not wear PPE. On 3/26/26 at 9:17 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that EBP was for any catheter care, wound care, or perineal care and they needed to wear a gown and gloves. RN 1 stated she was not sure if it was just for wound care or if they needed PPE for any other care for residents who had wounds. On 3/26/26 at 10:10 AM, an interview was conducted with the DON. The DON stated that EBP was for any indwelling medical device, wounds, or anything that puts the resident at risk for infection. The DON stated that staff should don a gown and gloves for direct patient care in EBP rooms. The DON stated that PPE should be donned for any care in a EBP room when care was for an extended period of time. The DON stated that resident 74 was on EBP for his surgical wound to his right leg and that the resident had a total of five wounds. The DON stated that the best case scenario was that staff wore PPE for any resident on EBP when providing direct patient care. 3. Resident 73 was admitted to the facility on [DATE] with diagnoses which included general anxiety disorder, major depressive disorder, obstructive sleep apnea, type 2 diabetes mellitus, and left below the knee amputation. On 3/23/26 at 10:52 AM, an interview was conducted with resident 73. Resident 73 stated he had a sore on his buttocks and the dressing was changed every other day. Resident 73 stated he had sores on his right foot that were healing and that the dressing was also changed every other day. On 3/12/26, resident 73 had an order initiated for EBP and the indication was for an indwelling medical device (foley catheter). On 3/19/26, resident 73 had an order for wound care to the right foot to be completed every day shift. The order documented to cleanse the wound with wound cleaner, pack with collagen (Alginate), apply a foam dressing to the wound, and secure with tape or gauze. On 3/26/26 at 1:58 PM, a wound care observation was conducted with RN 1. RN 1 stated that resident 73's wound order was to irrigate the wound with normal saline or wound cleanser, apply alginate to the wound bed, cover with a foam dressing, and wrap in Kerlix and Coban. RN 1 was observed to don a gown and gloves prior to wound care. RN 1 propped resident 73's right foot on a pillow and removed the resident's sock and old dressing. RN 1 doffed her dirty gloves and new gloves were donned. RN 1 did not perform hand hygiene prior to applying new gloves. RN 1 proceeded to irrigate resident 73's wound bed with normal saline. RN 1 then obtained a gauze soaked in wound cleaner and cleaned the wound bed working from the inside outward. RN 1 doffed her gloves and new gloves were donned. RN 1 did not perform hand hygiene prior to applying new gloves. RN 1 applied skin prep to the surrounding wound bed. RN 1 tore a piece of calcium alginate into two pieces and applied them to two separate wound beds. RN 1 doffed her gloves, performed hand hygiene and then applied new gloves. RN 1 then applied a bordered foam dressing over the alginate. RN 1 doffed her gloves, performed hand hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and donned new gloves. RN 1 applied a gauze roll over top of the foam dressing, covering the entire foot and ankle. RN 1 then applied Coban on top of the gauze dressing. An immediate interview was conducted with RN 1. RN 1 stated that hand hygiene should be performed after changing the dressing and prior to the application of a new dressing. RN 1 stated that when going from a dirty to clean area hand hygiene should be performed. RN 1 stated that she forgot to do this during the wound care because she was nervous. On 3/26/26 at approximately 2:30 PM, an interview was conducted with the UM/Wound care nurse. The UM stated that anytime staff went from a dirty area to a clean area during wound care they should doff their gloves, perform hand hygiene, and then put on clean gloves. The UM stated pretty much with each step during wound care gloves should be changed and hand hygiene should be performed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that when they transferred or discharged a resident that it was documented in the resident's medical record and that the information contained the contact information of the practitioner responsible for the care of the resident; resident representative information; Advanced Directive information; all special instructions for ongoing care; comprehensive care plan goals; and all other necessary information to ensure a safe and effective transition of care. Specifically, for 1 of 43 sampled residents, the facility did not document in the residents' medical record the information that was given to the receiving provider when the resident was transferred to the hospital. Resident identifier: 9. Findings included: Resident 9 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included calculus of bile duct, urinary tract infection (UTI), pneumonia, type 2 diabetes mellitus, systemic inflammatory response syndrome, hypertension, chronic pancreatitis, emphysema, dysphagia, obstructive reflux uropathy, history of malignant neoplasm of prostate, anemia, benign prostatic hypertrophy, and generalized anxiety disorder. On 3/23/26 at 1:10 PM, an interview was conducted with resident 9. Resident 9 stated that he went to the hospital for a UTI and was treated with antibiotics for three days afterwards. On 3/8/26 at 2:48 PM, a nursing progress note documented, Resident not arousable with verbal stimuli or sternal rub, resident vitals bp [blood pressure]: 110/50, hr [heart rate]: 103, rr [respiratory rate]: 19, temp [temperature] : 98.8. Resident sent to [name omitted] hospital, son [name omitted] notified. It should be noted that no documentation could be found of a hospital transfer sheet or any documentation of what information was sent to the hospital with resident 9. On 3/25/26 at 1:56 PM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that when they transferred a resident to the hospital they sent a face sheet, a copy of the bed hold, and a medication list. RN 1 stated that it should be documented in a progress note what was sent with the resident to the hospital. On 3/25/26 at 3:14 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that for transfers the nurse should obtain an order from the provider, fill out a hospital transfer agreement, and go over the bed hold policy. The DON stated that they printed out a face sheet, medication list, physician order for life sustaining treatment (POLST), and the transfer sheet which contained the reason for the transfer. The DON stated that if the transfer form was not found in the resident's medical record then it probably did not get done. The DON stated that he was not able to tell from resident 9's medical record what information was sent to the receiving provider for the transfer on 3/8/26.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that when a bed rail was utilized that the resident was assessed for the risk of entrapment from the bed rail prior to installation. Specifically, for 1 out of 43 sampled residents, the facility did not evaluate a resident for entrapment from the bed rail prior to use and the resident reported that her hand was caught in the bar. Resident identifier: 65. Findings included: Resident 65 was admitted to the facility on [DATE] with diagnoses which included secondary malignant neoplasm of the brain, malignant neoplasm of the left breast, disorders of bone density, hemiplegia and hemiparesis following a cerebrovascular accident, seizures, weakness, thyrotoxicosis, adjustment disorder with anxiety, and depressed mood. On 3/23/26 at 11:13 AM, an interview was conducted with resident 65 and their representative. Resident 65 stated that she fell off the bed and her hand was caught in the side bar. Resident 65's representative stated that he reported the incident but was unable to recall who he told. Resident 65 was observed with a sling on her left arm and left hand. Resident 65 was observed to adjust her left hand in the sling with the use of her right hand. Resident 65's bed was observed with bilateral upper side rails. The rails were observed with a gap between the mattress frame and the side rail and the rails were not stationary but shifted when touched. On 3/24/26 at 1:18 PM, a follow-up interview was conducted with resident 65. Resident 65 stated that her hand got caught in the side rail and that this happened approximately two weeks ago on a Saturday. Resident 65 did not have an assessment of the side rail for entrapment in her medical record. On 3/24/26 at 12:18 PM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 65 required a two person assist for transfers and bed mobility. On 3/24/26 at 12:49 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that they evaluated the resident for entrapment with bedrails on admission. LPN 1 stated that the nurse did the initial assessment for the resident's bed mobility and if they saw an issue they would contact physical therapy to evaluate the resident as well. LPN 1 stated that the functional abilities assessment conducted on 3/5/26, assessed resident 65's mobility status but did not assess the resident for positioning bars or entrapment. On 3/24/26 at 1:07 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated that on admission the beds did not have any side rails. The RNC stated that if therapy recommended side rails then an assessment would be conducted for that mobility device to determine if it was a restraint vs. an enabler device. The RNC stated that therapy did the assessment and then obtained consent from the responsible party. The RNC stated that resident 65 did not have the assessment completed in their medical record. At 2:28 PM, the RNC followed up and stated that physical therapy evaluated resident 65 for the bedrail but they did not enter an assessment in the medical record. On 3/24/26 at 3:11 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that they assessed resident 65 for a restraint vs. enabler and they should have assessed her for the bedrail as well. The DON stated that therapy should have initiated the assessment and then once completed put the assessment in the resident's medical record. The DON stated that therapy would also put the order in the chart, update the resident care plan, and obtain a written consent for the device.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that each resident received food that accommodated the resident allergies, intolerances, and preferences. Specifically, for 1 out of 43 sampled residents, the facility did not provide the resident with the food preferences as outlined on their meal ticket. Resident identifier: 8. Finding included: Resident 8 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included severe protein-calorie malnutrition, cachexia, hypokalemia, hypotension, acute kidney failure, hypomagnesemia, depression, and pain. On 3/24/26 at 8:12 AM, an interview was conducted with resident 8. Resident 8 stated that he was on hospice for malnutrition and met with the Registered Dietician regularly. Resident 8 stated that the kitchen never followed the instructions for his meals. Resident 8 stated that last night's dinner was a salad and he could not digest any leafy green vegetables. Resident 8 stated that he had to order food out so much because he could not eat a lot of what the facility provided. Resident 8's breakfast meal tray was observed during the course of the interview and contained two plates of scrambled eggs, one English muffin, two tortillas, two glasses of milk, and two bowls of [NAME] Krispies. Resident 8 stated that the eggs were not hot and the muffin was not toasted or warm. Resident 8 stated that the kitchen knew he needed double protein. Resident 8 stated that he had a malabsorption issue, Irritable Bowel Syndrome, and had multiple surgeries on his stomach. Resident 8's meal ticket for breakfast was observed. The special instructions documented double portions with extra gravy/sauces. The likes documented double portions, add cold cereal, yogurt, two omelets with four salsa, two tortillas. No dislikes were documented on the meal ticket. On 10/6/25, resident 8's diet order was for a regular diet, regular texture, thin liquid consistency with double meal portions. On 11/20/24, the Nutrition admission Evaluation did not document any food likes or dislikes. The evaluation documented that the resident requested double portions due to malnutrition. On 7/18/25, the Nutrition - Quarterly Evaluation documented fortified double portions. Patient (Pt) requested extra sauces and gravies or butter with all meals I need to gain weight. Pt continues to have noted weight gain. Hospice services remain in place. Pt selective with meal preferences that are offered as possible. Pt continues to take a lot of outside foods and snacks as desired.Continue as set and honor requests. On 3/26/26 at 9:27 AM, an interview was conducted with the Dietary Manager (DM). The DM stated that ideally she liked to meet with the residents within the first couple of days of admission to obtain their likes and dislikes for food items. The DM stated that the food preferences were printed on the resident meal tickets. The DM stated that she had spoken to resident 8 multiple times and he preferred double portions. The DM stated that resident 8 was at the facility for malnutrition. The DM stated that resident 8 also requested extra gravy and sauces with his meals. The DM stated that resident 8's breakfast requests included cold cereal, two omelets with cheese, two yogurts, and two tortillas. The DM stated that lunch and dinner were also double portions with extra gravy and sauces, and pudding.The DM stated that resident 8 did not have any documented dislikes on his meal ticket. The DM stated that resident 8 was included in a list of residents that did not want any lettuce or fish. The DM stated that last night resident 8 had a meal substitution of chicken tenders instead of the fried fish. The DM stated that any time they had a side salad or a side of lettuce resident 8 should have a substitution of cooked vegetables instead. The DM was informed that resident 8 did not have cheese omelets or yogurt on his breakfast tray on 3/24/26, and that the resident received a side salad on 3/23/26, instead of cooked vegetables.