STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465093	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Brigham City	775 North 200 East Brigham City, UT 84302

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that for 1 out of 13 sampled residents, the facility did not ensure residents had a right to be free from neglect. Specifically, a resident was left in a wet brief for an extended period of time and sustained a rash and excoriation to the groin. This resulted in a finding of harm for the resident. Resident identifier: 9.Findings included: Resident 9 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included, unspecified urinary incontinence, mild cognitive impairment of uncertain or unknown etiology, and cognitive communication deficit.Resident 9's medical record was reviewed on 12/3/25.On 3/13/25 at 10:00 PM, a progress note documented, Oncoming aides rounded on resident and discovered excoriated peri-area [perineum] with a split open area at the left waist approx [approximately] 3 inches long. There is also an area on her left shoulder that appears to be a rash approx 4x 4 without any open areas. Antifungal powder was applied to peri area. Collagen and dressing was applied to split open area. Monitor rash on shoulder for improvement vs [versus] worsening.It should be noted that a skin assessment dated [DATE] for resident 9 showed no skin abnormalities.The facility Incident Report Form was reviewed. The facility reported that staff found (resident 9) had not been changed for a long period. (Certified Nursing Assistant 5) discovered (resident 9) saturated with dried and wet urine up to her shoulders and notified the nurse (Registered Nurse 1) who confirmed the condition. (Certified Nursing Assistant 4), assigned to the room, claimed she had changed (resident 9), but the resident's condition indicated otherwise. (Registered Nurse 1) assessed (resident 9), noted a rash, excoriation, and a yeast area, and applied barrier cream. The Director of Nursing was notified, and the facility immediately suspended (Certified Nursing Assistant 4) pending investigation. The RNC (Regional Nurse Consultant) ordered psychosocial checks for 72 hours and two-hour nurse checks. The facility began an investigation and planned staff education on the bowel and bladder program.The facility Follow-up Investigation Report was reviewed. Resident 9 had severe dementia so staff interviews provided most of the information. (Certified Nursing Assistant 4) gave conflicting accounts and admitted she had not performed the required two hour checks. Oncoming staff found the resident heavily soiled and appeared to have lain in urine for about eight hours. The nurse assessed resident 9 and documented a rash, excoriation, and a yeast area, then provided treatment. Staff also reported that (Certified Nursing Assistant 4) yelled at (Certified Nursing Assistant 5).A review of Registered Nurse (RN) 1's initial interview documented, RN 1 reported that around 10:00 PM, she heard Certified Nursing Assistant (CNA) 4 yelling, you're not going to ruin my reputation, while blocking CNA 5 from entering resident 9's room. After RN 1 knocked, CNA 4 allowed her in. CNA 4 first claimed she had changed resident 9 multiple times, then changed her story and admitted she had not changed the resident since 2:30 PM. RN 1 observed that the resident appeared to have been sitting in urine for at least 8 hours, with urine up to her shoulders, despite typically staying dry and not tolerating being wet. RN 1 also noted that CNA 4 had repeatedly stated over the radio that she was all caught up during her shift.A review of CNA 6's initial interview documented, Upon arriving at work CNA 4 attempted to give CNA 6 report of her residents and she informed CNA 4 to give report to CNA 5. CNA 6 overheard CNA 5 say the situation was unacceptable and CNA 4 began to yell at CNA 5. CNA 4 blocked the door, but opened it when the nurse intervened. CNA 6 observed that CNA 5 remained calm while CNA 4 yelled. CNA 6 noted that CNA 4's outburst was unusual but that care issues with CNA 4 had occurred on previous shifts, often requiring additional work from the next shift.A review of CNA 5's initial interview documented, When CNA 5 arrived for her shift, CNA 4 admitted she had not given resident 9 her scheduled shower and that the resident needed a full bed change. CNA 5 saw that resident 9 had urine up to her shoulders and appeared to have been in that state for some time. CNA 5 handed supplies to CNA 4 refusing to participate, but CNA 4 yelled at her, slammed the door, and blocked her from re-entering the room. RN 1 had to knock on the door to gain access to the room. CNA 4 told RN 1 that the resident was last changed around 2:30 PM and this had occurred at shift change around 10:00 PM.A review of the alleged perpetrator CNA 4's initial interview documented, CNA 4 reported that CNA 5 yelled at her for not changing resident 9's brief. She initially claimed she had changed the resident around 5:30-6:00 PM. CNA 4 admitted she likely had not checked the resident for 2-3 hours and acknowledged she should have followed the two hour check policy. CNA 4 blocked the door briefly to compose herself but let RN 1 in, who also questioned her. CNA 4 said she did a quick check around 8:00 PM and discovered the resident's condition at 9:45 PM. CNA 4 admitted she handled the situation poorly by