

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2025
NAME OF PROVIDER OR SUPPLIER Monument Healthcare Murray Creek		STREET ADDRESS, CITY, STATE, ZIP CODE 3855 South 700 East Millcreek, UT 84106	

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 - Some	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

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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 - Some	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, document review, and facility policy review, the facility failed to protect the residents' rights to be free from verbal and sexual abuse by a resident. Residents #33, #71, and #351 all reported they felt threatened and/or uncomfortable around Resident #346, a resident who was known to display sexually inappropriate behaviors. The facility further failed to protect the residents' rights to be free from physical abuse by staff. On 02/14/2025, Registered Nurse (RN) #9 willfully and intentionally yanked a walker from Resident #402, which caused the resident to fall to the floor. Resident #402 sustained a 2-inch goose egg to the forehead and bruised knees. The facility substantiated that abuse occurred and terminated the employment of RN #9. These deficient practices affected 4 (Residents #33, #71, #351, and #402) of 20 sampled residents. The undated facility policy titled, Abuse Prevention Program, indicated it is the policy of this community to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The policy specified, a. Abuse is defined as the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. 1. An admission Record revealed the facility admitted Resident #346 on 06/20/2023. According to the admission Record, the resident had a medical history that included diagnoses of paraplegia, anxiety disorder, major depressive disorder, muscle weakness, difficulty in walking, and need for assistance with personal care. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/26/2024, revealed Resident #346 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #346's Care Plan Report included a focus area initiated 06/21/2023, that indicated the resident was challenging and argumentative with staff, made sexually inappropriate comments and gestures to staff during care, and made inappropriate comments during group activities that were disruptive to other residents. Interventions specified the Administrator and Social Worker met with the resident to discuss their inappropriate sexual comments and the resident stated they would do their best to be respectful (initiated 06/16/2024), staff would provide 1:1 activities in the resident's room (initiated 02/03/2025), staff was instructed to perform care in pairs (initiated 12/16/2024), and staff would strive to interact pleasantly and patiently with the resident and report issues to management for assistance to manage a situation (initiated 10/16/2024). 1a. An admission Record revealed the facility admitted Resident #351 on 02/12/2024. According to the admission Record, the resident had a medical history that included diagnoses of generalized anxiety disorder, depression, and muscle weakness. Per the admission Record, Resident #351 discharged home on [DATE]. A MDS, with an ARD of 05/20/2024, revealed Resident #351 had a BIMS score of 15, which indicated the resident had intact cognition. A Grievance/Concern Report written by Resident #351 and dated 06/21/2024, indicated Resident #351 reported that Resident #346 insulted them in front of five witnesses. The Grievance/Concern Report revealed Resident #351 reported that Resident #346 said we had a deal and you would sit on my lap during bingo or [poker]. I did not appreciate it at all. I feel threatened. A Grievance/Concern Report written by Resident #351 and dated 06/24/2024, indicated Resident #351 reported that Resident #346 was stalking them and requested the resident give them an apology. During a telephone interview on 06/27/2025 at 8:52 AM, Resident #351 stated they filed the grievance to report Resident #346 because they were emotionally stressed. Resident #351 stated Resident #346 would look at them in a way that made them feel uncomfortable. According to Resident #351, they reported their concerns to the former Administrator, who did not talk with Resident #346 right away, but later told them the facility was handling the concern. Resident #351 stated they did not know what happened afterwards because they were discharged from the facility. During an interview on 06/27/2025 at 9:13 AM, the Dietary Manager (DM) stated she was assigned to do the investigation after Resident #351 filed a grievance on 06/21/2024. The DM stated she did not remember what was said or done about the grievance filed on 06/21/2024. 1b. An admission Record revealed the facility admitted Resident #33 on 06/19/2023. According to the admission Record, the resident had a medical history that included diagnoses of need for assistance with personal care and muscle weakness. An</p>		