STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465094	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Murray Creek	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure that each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with professional standards of practice. Specifically, for 1 of 12 residents reviewed for medication administration, one nurse failed to follow professional standards for medication identification, resulting in the administration of two medications (Lorazepam and Carvedilol) to the wrong resident (Resident #1).The facility's noncompliance was determined to be Past Noncompliance. The facility developed and implemented a corrective action plan on August 13, 2025, which included staff education on the five rights of medication administration, skills competency check-offs, and internal monitoring to ensure no further errors occurred. The survey team verified these interventions were completed prior to the survey start date of March 30, 2026. A review of facility incident reports on March 30, 2026 revealed an entry dated July 21, 2025 involving Resident #1. The report documented that a nurse inadvertently administered 0.25 mL of Lorazepam (an anti-anxiety medication) and 25 mg of Carvedilol (a beta-blocker used for blood pressure) to Resident #1. These medications were intended for a different resident.Professional standards of medication administration (the Five Rights) require that the right medication is given to the right resident, in the right dose, via the right route, at the right time.A review of a facility Progress Note dated July 22, 2025 at 7:07 AM documented that Resident #1's vital signs were monitored throughout the night following the medication error. The note indicated that the hospice nurse, nurse practitioner, and family were notified of the error. The note stated, The resident remained stable, alert, and without any signs of distress throughout the shift.During an interview on March 31, 2026, Administrator 1, Administrator 2, and the Director of Nursing (DON) acknowledged the medication error. The DON confirmed that the nurse failed to properly identify the resident prior to administering the medications.The facility provided evidence of the following corrective actions implemented prior to the start of the survey:By August 13, 2025, the facility implemented mandatory education for all licensed staff who administer medications. This training included a review of the facility's medication administration policy and the five rights of medication administration.The facility completed clinical skills check-offs (competency evaluations) for medication administration for all nursing staff to ensure adherence to safety protocols.The facility conducted a retrospective review of medication error logs and current administration cycles, which revealed no additional concerns regarding residents receiving incorrect medications.The survey team verified the completion of the education logs and competency check-offs. Through interviews and a review of quality assurance documentation, it was determined that the facility's corrective actions were implemented and effective as of August 13, 2025, prior to the current survey.

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
	465094	A. Building B. Wing	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Murray Creek	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 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. Based on interview, observation, and record review, it was determined that the facility failed to ensure that a resident's environment remained free of accident hazards for one of one resident reviewed for accidents (Resident #11). Specifically, the facility failed to ensure a mechanical lift sling was in safe, functional condition, resulting in a strap breakage during a transfer. This failure caused Resident #11 to fall, resulting in a 1cm scalp laceration and severe pain (9/10).The facility's noncompliance was determined to be Past Noncompliance. The facility developed and implemented a corrective action plan on August 26, 2025, which included staff retraining on mechanical lift competencies, disposal and replacement of all slings, and verification of interventions prior to the start of the survey on March 30, 2026. Review of Resident #11's medical records revealed that Resident 11 had a diagnosis of Parkinson's Disease. Review of a facility Incident Report dated August 5, 2025 revealed that while two Certified Nursing Assistants (CNAs) were transferring Resident #11 from the bed to a chair using a mechanical (Hoyer) lift, a sling strap broke. This equipment failure caused Resident #11 to fall to the floor.Review of Nursing Notes and Interdisciplinary Team (IDT) Fall Review notes dated August 5, 2025 documented that Resident #11 sustained an abrasion to the back of the head, a 1cm laceration to the scalp, and reported pain in the shoulders and neck following the fall. The resident was subsequently transferred to the hospital for evaluation.Review of Nurse Practitioner (NP) notes dated August 6, 2025 confirmed the 1cm scalp laceration was bleeding and documented that Resident #11 rated his back pain as a 9 out of 10 on a numeric pain scale.During an interview on March 31, 2026, CNA #1 stated that upon arriving to assist CNA #2 with the transfer on August 5, 2025, Resident #11 was already positioned in the sling. CNA #1 reported that as the resident was being lifted, the strap snapped, causing the resident to fall and strike his head.Review of the manufacturer's instructions for the mechanical lift and slings explicitly required staff to inspect slings and lifting straps for signs of wear, fraying, or weakness prior to every use. Although maintenance records showed a general audit was conducted on July 15, 2025, there was no evidence that the specific sling used for Resident #11 had been inspected for integrity prior to the transfer on August 5, 2025.During an interview on March 31, 2026, Administrator #2 acknowledged the equipment failure and stated that the breakage resulted in the resident's fall and subsequent injury.The facility's failure to identify a worn or defective sling strap resulted in Actual Harm for Resident #11. The facility provided evidence of the following corrective actions implemented prior to the survey:On August 5, 2025, the facility removed the defective sling from service.By August 26, 2025, the facility disposed of all existing slings and replaced them with new equipment.Between August 5, 2025 and August 26, 2025, the facility completed mechanical lift and sling competency training for CNA #1 and all other nursing staff, focusing on the requirement to inspect straps for wear before every lift.The facility updated its maintenance protocols to include specific documentation of sling integrity.The survey team verified the replacement of equipment and reviewed training logs, confirming that the corrective actions were implemented and effective by August 26, 2025.