

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Monument Healthcare Bountiful		STREET ADDRESS, CITY, STATE, ZIP CODE 460 West 2600 South Bountiful, UT 84010	

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	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the provider failed to ensure that all residents had appropriate supervision to prevent accidents. Specifically, one resident was being pushed in a wheelchair without footrests by facility staff, and the resident fell out of the wheelchair, hitting her face, causing scrapes and a lip laceration. Resident identifier: 2.</p> <p>In response to the incident involving Resident 2, the facility identified the quality deficiency and developed a corrective action plan. At the time of the complaint survey, it was determined that the facility had implemented corrective measures and met the requirements of F689. Due to the facility's corrective measures, the noncompliance was determined to be past noncompliance.</p> <p>The facility's corrective action plan, which was developed and implemented by May 10, 2025, included the following measures:</p> <ul style="list-style-type: none"> a. Therapy and nursing inspected the wheelchair used by Resident 2 during the incident and removed it from service pending the evaluation. b. The facility's Fall Prevention policy was updated to clarify that footrests must be used at all times during resident transport unless medically contraindicated. On April 29, 2025 a staffing inservice was conducted on the policy. c. The Director of Nursing (DON) conducted weekly wheelchair safety rounds to verify the proper positioning of footrests. d. Facility staff completed daily visual wheelchair safety checks for all high-risk residents. e. Therapy evaluated all wheelchair- dependent residents by May 10, 2025. The evaluations conducted were to ensure each wheelchair met safety standards and was equipped with all necessary components. f. On April 28, 2025, Resident 2's care plan was updated with the intervention of the use of bilateral footrests when staff transported the resident. While allowing Resident 2 to use a single footrest when self-propelling. <p>Findings include:</p> <p>The surveyor reviewed Resident 2's medical records, and the following entries were observed:</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>a. Resident 2's care plan at the time of the incident indicated that due to diagnoses of Cerebral Palsy, pain, functional quadriplegia, contractures to the right and left hands and fingers, and balance deficits, she had difficulty completing activities of daily living independently. It was also documented that Resident 2 was able to self-propel in her wheelchair, as she was able to use one foot.</p> <p>b. A nurse documented in a nursing note on April 28, 2025 that Resident 2 was being propelled in a wheelchair by a Certified Nursing Assistant (CNA) to her bedroom, and Resident 2 fell out of her wheelchair and was unable to brace her fall due to her cerebral palsy and quadriplegia; she landed on her face. Resident 2 was bleeding from her mouth and was coughing and crying. Resident 2 was able to inform the nurse what hurt on her body, but was unable to say full sentences due to shallow breathing. Resident 2 stated that her back, mouth, face, and chest hurt. The nurse documented that Resident 2 had abrasions noted under her right eye, and on the right side of her nose, and had blood running down her mouth with clots forming. Resident 2 also had a skin tear to her right wrist and redness noted on her back. Resident 2 had an abnormal breathing rhythm with shallow breathing noted. Resident 2 stated she wanted to go to the hospital when asked. Emergency Medical Services (EMS) arrived and transferred Resident 2 to a local hospital.</p> <p>c. A review of Resident 2's emergency room (ER) visit notes revealed there were no Fractures. There was superficial abrasion to the facial area and wrist.</p> <p>d. A dental appointment note dated April 29, 2025, completed by the dentist, included documentation that an oral evaluation was conducted on Resident 2 at the request of a nurse practitioner, as Resident 2 had fallen and there was concern that some of her teeth might be broken. The Dentist documented that Resident 2 had no broken teeth from the fall, and that two teeth that were broken had already been broken before the fall. The Dentist documented that it appeared Resident 2 had bitten through her lip when she fell, which could be causing the pain.</p> <p>A surveyor reviewed the investigation summary, which revealed that the staff involved in the incident were pushing Resident 2 in her wheelchair. Resident 2's foot caught the ground, and she then fell forward onto the ground.</p> <p>On June 9, 2025, at approximately 10:30 am, a surveyor conducted an interview with Resident 2. Resident 2 stated that she had not experienced any falls and that the staff had taken care of her needs. The surveyor observed that Resident 2 had bilateral footrests on her wheelchair.</p> <p>On June 9, 2025, a surveyor conducted an interview with two CNAs. Both CNAs stated that when transferring a resident in a wheelchair they will make sure the footrests are down and the residents feet are on the wheelchair and to make sure the residents back and butt are all the way back on the wheelchair.</p> <p>On June 9, 2025, a surveyor conducted an interview with the DON. The DON stated that after Resident 2 fell, the facility educated the staff member involved 1 on 1, as well as group education with staff. The DON stated that she performed visual checks on each resident who used a wheelchair to ensure they were sitting properly in the chair with their feet in the correct position. Additionally, when being transferred by staff, the leg rests were lowered. DON stated that the therapy team reviewed all wheelchair-dependent residents to ensure their wheelchairs were safe. The DON stated that the hospital's recommendation for a dental appointment pertained to teeth that were broken prior to the fall.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on observation, interview, and record review, the provider failed to ensure that each resident was free from significant medication errors. Specifically, a nurse administered the incorrect medications to a resident. Resident identifiers: 1</p> <p>In response to the incident involving Resident 1, the facility identified the quality deficiency and developed a corrective action plan. At the time of the complaint survey, it was determined that the facility had implemented corrective measures and met the requirements of F760. Due to the facility's corrective measures, the noncompliance was determined to be past noncompliance.</p> <p>The facility's corrective action plan, which was developed and implemented by May 17, 2025, included the following measures:</p> <ul style="list-style-type: none"> a. The nurse involved in the incident was removed from the facility staff. b. Medication training was implemented for both current and new staff. c. The quality assurance nurse initiated a monthly medication pass audit to ensure physician orders were followed and medication administration was accurately documented. d. Medication error and risk management reviews were added to the facility's (monthly/quarterly) Quality Assurance and Performance Improvement agenda. <p>Findings Include:</p> <p>The surveyor reviewed resident 1's medical records and incident reports. The following entries were observed.</p> <ul style="list-style-type: none"> a. A nurse documented in an Incident Note on May 17, 2025 at 11:21 PM that Resident 1 was accidentally given her roommate's medications. The physician was notified and ordered the nurse to hold Resident 1's scheduled Tylenol (for pain), Senna (for constipation), and Trazodone (for insomnia). The nurse was ordered to monitor resident 1 and contact their emergency contact. b. After the incident, nursing staff initiated additional assessments each shift for Resident 1 to promptly identify any changes in status resulting from the medication error. Throughout May 18, 2025, Resident 1's condition remained at its baseline, with no noted changes. <p>The surveyor reviewed the facility's investigation that was completed on May, 21, 2025. On May 21, 2025, the DON interviewed RN 1, the nurse who administered the incorrect medications to Resident 2. RN 1 reported that she administered Resident 1 her roommate's medications by accident. The medications were acetaminophen tablet 325 milligrams (mg), senna tablet 8.6mg, trazodone oral tablet 50mg, and extended release morphine 15mg. RN 1 called the nurse manager on call for further directions, contacted the on-call provider for recommendations, checked the resident for allergies, and initiated neurological checks. The on-call provider told RN 1 to hold Resident 1's Tylenol 1000mg, senna 8.6mg, and trazodone 50mg. RN 1 called Resident 1's emergency contact and continued to check on Resident 1 throughout her shift, which ended at 12:00 PM. RN 1 passed the report on to the oncoming nurse and confirmed that Resident 1 did not experience any side effects from the incorrect medications.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The surveyor interviewed the DON on June 9, 2025. The DON stated that she had received a phone call on May 17th, 2025 from RN 1, who reported that she had accidentally given Resident 1 her roommate's medications. The DON directed RN 1 to call the on-call provider, start neurological checks, and report any adverse reactions. The DON stated that this had been the only medication error in the past 60 days, and multiple measures were in place to prevent the incident. The DON stated that the agency nurse was not permitted to work at the facility after the incident.</p>		