

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Monument Healthcare Millcreek		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 East 4500 South Salt Lake City, UT 84117	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 37 sampled residents, that the facility did not immediately inform or consult with the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status or a need to alter treatment. Specifically, the physician was not notified when a resident's Trulicity was held. Resident identifiers: 28. Findings included: 1. Resident 28 was admitted to the facility on [DATE] with diagnoses which included orthopedic aftercare following amputation, Type 2 DM, and morbid obesity. On 11/18/25 9:37 AM, an interview was conducted with resident 28. Resident 28 stated that when she was first admitted she missed 3 weeks of injections of her Trulicity (Dulaglutide) medication. Resident 28 stated that the nurse had to re-order the medication and it delayed her injection. Resident 28's medical records were reviewed 11/17/25 through 11/20/25. On 9/3/25, resident 28's physician ordered Dulaglutide Subcutaneous Solution Auto-injector 1.5 milligram (mg)/0.5 milliliter (ml) (Dulaglutide), Inject 1.5 mg subcutaneously one time a day every Sun (Sunday) for Diabetes. On 10/1/25, resident 28's physician ordered Dulaglutide Subcutaneous Solution Auto-injector 1.5 mg/0.5 ml (Dulaglutide), Inject 1.5 mg subcutaneously one time a day every Wed (Wednesday) for Diabetes. Resident 28's September 2025 MAR documented a code 9 on 9/07/25, 9/21/25, and 9/28/25 for see progress note. Resident 28's progress notes revealed the following: a. On 9/7/25 at 11:15 AM, the Medication Administration Note documented that the Dulaglutide was waiting for delivery from the pharmacy. b. On 9/7/25 at 2:21 PM, the progress note documented, Pharmacy called to report that the resident's last labs show that hgb [hemoglobin] is over 8. They will not be sending it. c. On 9/8/25 at 5:44 PM, the Medication Administration Note documented that the Dulaglutide was Given 9/8 at 1745 [5:45 PM] after patient said she hadn't gotten it, and [provider name omitted] said it was okay to give a day late. It should be noted that the provider notification was 24 hours after the medication was scheduled to be delivered. d. On 9/21/25 at 4:09 PM, the Medication Administration Note documented for the Dulaglutide, Resident to have family member bring it in. e. On 9/28/25 at 11:04 AM, the Medication Administration Note documented for the Dulaglutide, On order from pharmacy. On 11/19/25 at 1:28 PM, an interview was conducted with LPN 1. LPN 1 stated that if medication was unavailable she would notify the MD and ask for orders to hold or give when available. On 11/20/25 at 10:06 AM, an interview was conducted with the DON. The DON stated that she was not aware that resident 28 had missed 3 doses of the Dulaglutide medication. The DON stated that the nurse should notify the MD if a medication was not available for administration and ask for new orders. The DON stated that the nurse should then document that the MD was notified in a progress note.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 37 sampled residents, that the facility did not ensure that the resident received treatment and care in accordance with professional standards of practice. Specifically, a resident was admitted with wounds and dressings on their bilateral feet and did not have wound care orders initiated until 9 days after admission. Resident identifier: 117. Resident 117 was admitted to the facility on [DATE] with diagnoses which included arthritis due to bacteria of left ankle and foot, gout, Methicillin-resistant Staphylococcus aureus (MRSA), diabetes mellitus, chronic kidney disease, congestive heart failure, pain, and edema. On 11/18/25 at 9:07 AM, an interview was conducted with resident 117. Resident 117 stated that he had both ankles surgically cleaned out and the left foot had MRSA. Resident 117 stated that he had 2 dressing changes completed since admission. Resident 117 stated that he was supposed to have dressing changes completed 3 times a week. Resident 117 stated that he went to the surgical doctor and had his dressing changed there one time. Resident 117's medical records were reviewed 11/17/25 through 11/20/25. On 10/24/25, resident 117's hospital history and physical documented status post left ankle incision and drainage [I & D]. The lateral aspect of the left ankle was packed with 1/4in [inch] iodoform packing and redressed. The hospital progress note documented that the left ankle was found to have MRSA septic arthritis and bacteremia. The plan documented 4-6 weeks of intravenous Vancomycin treatment. Resident 117's hospital discharge orders dated 10/25/25 did not contain any orders for wound care. On 10/25/25, resident 117's nursing assessment documented under skin impairments that the site of the right outer ankle had Septic Arthritis Wash out 10/23, Dressing intact, right toes Dressing intact covering toe. On 10/25/25, resident 117 had a care plan created for has the potential for skin breakdown/pressure ulcers r/t [related to] Infection Lt [left] foot and ankle. has surgical incision to left lateral ankle and left medial ankle and right foot great toe. Interventions identified on the care plan included to administer treatments as ordered and monitor for effectiveness. On 11/2/25, resident 117's physician ordered Left Lateral Ankle Wound Care: Cleanse with wound cleanser, pat dry. Gently pack the wound with 1/4 iodoform then cover with adaptic. Cover with kerlix then Ace bandage 3 times a week and as needed (PRN) on Monday, Wednesday, and Friday. It should be noted that the wound care orders were initiated 9 days after admission to the facility. No documentation could be found of wound care that was completed prior to 11/2/25. On 11/19/25 at 9:16 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that the floor nurse would conduct the admission assessment for newly admitted residents. LPN 1 stated that the floor nurse along with a second staff member would review the discharge orders from the hospital and input the orders into the resident medical records. LPN 1 stated that if the resident was admitted with wounds or dressings it would be documented on the admission assessment and the nurse that did the assessment should verify orders for wound care and refer the resident to the wound care team. On 11/20/25 at 11:04 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a resident was admitted with wounds and dressings and did not have admission wound care orders she would expect the admitting nurse to follow-up with the Medical Doctor for wound care orders.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was defined as any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences. Specifically, for 3 out of 37 sampled residents, 2 of the residents' blood pressure medications were administered outside of the physician's ordered parameters and the third resident was not given an ordered medication as scheduled. Resident identifier: 26, 28, and 146.1. Resident 26 was admitted to the facility on [DATE] with diagnoses which included, hypertensive chronic kidney disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and atrial fibrillation. Resident 26's medical record was reviewed on 11/17/25 through 11/20/25. On 12/18/24, Metoprolol Tartrate oral tablet was ordered for hypertension, with the following parameters: Hold for systolic [blood pressure] < [less than] 110, hr [heart rate] < [less than] 60. The Medication Administration Record (MAR) for the months of September, October, and November 2025 revealed that Resident 26 received Metoprolol revealed that Metoprolol was administered 6 times when it should have been held per the physician ordered parameters: On 9/6/25, SBP was 107. On 9/9/25, SBP was 106. On 10/3/25, HR was 58. On 10/10/25, HR was 59. On 11/10/25, SBP was 100. On 11/14/25, SBP was 56. On 11/20/25 an interview was conducted at 3:06 PM with the Director of Nursing (DON). The DON stated that blood pressure medications should not be administered outside of the ordered parameters. 2. Resident 28 was admitted to the facility on [DATE] with diagnoses which included orthopedic aftercare following amputation, Type 2 DM, and morbid obesity. On 11/18/25 9:37 AM, an interview was conducted with resident 28. Resident 28 stated that when she was first admitted she missed 3 weeks of injections of her Trulicity (Dulaglutide) medication. Resident 28 stated that the nurse had to re-order the medication and it delayed her injection. Resident 28's medical records were reviewed 11/17/25 through 11/20/25. On 9/3/25, resident 28's physician ordered Dulaglutide Subcutaneous Solution Auto-injector 1.5 milligram (mg)/0.5 milliliter (ml) (Dulaglutide), Inject 1.5 mg subcutaneously one time a day every Sun (Sunday) for Diabetes. On 10/1/25, resident 28's physician ordered Dulaglutide Subcutaneous Solution Auto-injector 1.5 mg/0.5 ml (Dulaglutide), Inject 1.5 mg subcutaneously one time a day every Wed (Wednesday) for Diabetes. Resident 28's September 2025 Medication Administration Record (MAR) documented a code 9 on 9/7/25, 9/21/25, and 9/28/25. The MAR legend indicated that code 9 was see Nurse Note. Resident 28's progress notes revealed the following: a. On 9/7/25 at 11:15 AM, the Medication Administration Note documented that the Dulaglutide was waiting for delivery from the pharmacy. b. On 9/7/25 at 2:21 PM, the progress note documented, Pharmacy called to report that the resident's last labs show that hgb [hemoglobin] is over 8. They will not be sending it [Dulaglutide]. c. On 9/8/25 at 5:44 PM, the Medication Administration Note documented that the Dulaglutide was Given 9/8 at 1745 [5:45 PM] after patient said she hadn't gotten it, and [provider name omitted] said it was okay to give a day late. It should be noted that the provider notification was 24 hours after the medication was scheduled to be delivered. d. On 9/21/25 at 4:09 PM, the Medication Administration Note documented for the Dulaglutide, Resident to have family member bring it in. e. On 9/28/25 at 11:04 AM, the Medication Administration Note documented for the Dulaglutide, On order from pharmacy. On 11/19/25 at 1:28 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that if medication was unavailable for administration she would notify the Medical Doctor (MD) and ask for orders to hold or give when available. LPN 1 stated that they had difficulty getting the Dulaglutide medication and that it was due to a pharmacy issue. LPN 1 stated that she gave the medication on Wednesdays and then would reorder it for the following week's administration. LPN 1 stated that she thought that the insurance was not covering it but now it was. On 11/20/25 at 9:41 AM, an interview was conducted with the Doctor of Pharmacy (PharmD) District Director of Operations for the facility. The PharmD stated that medication delivery schedules were Monday through Friday at 2:30 PM or 8:00 PM, and stat [immediate] orders were within a 4 hour delivery window from the time they received the request. The PharmD stated that the Dulaglutide was dispensed on 9/3/25 and was delivered at 8:27 PM. The PharmD stated that the medication was delivered one time per week. The PharmD stated that the next delivery was on 9/9/25 at 3:09 PM, then on 9/21/25 at 8:05 PM, and then on 9/29/25 at 3:33 PM. The PharmD stated that on 10/1/25 the medication order changed to deliver on Wednesday. On 11/20/25 at 10:06 AM an interview was conducted with the DON. The DON stated that she was not aware that resident</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 37 sampled residents, that the facility did not ensure that the resident was free from any significant medication errors. Specifically, multiple doses of Vancomycin were omitted from the residents scheduled medication administration. Resident identifier: 117. Resident 117 was admitted to the facility on [DATE] with diagnoses which included arthritis due to bacteria of left ankle and foot, gout, Methicillin-resistant Staphylococcus aureus (MRSA), diabetes mellitus, chronic kidney disease, congestive heart failure, pain, and edema. On 11/18/25 at 8:55 AM, an interview was conducted with resident 117. Resident 117 stated that he had a Peripherally Inserted Central Catheter (PICC) line in his right arm and had multiple daily doses of intravenous antibiotics. Resident 117 stated that he had 3 doses of Vancomycin that were missed by the facility. On 10/30/25, resident 117's physician ordered Vancomycin Hydrochloride (HCl) Solution Reconstituted, Use 1250 mg intravenously two times a day for Vancomycin therapy related to ARTHRITIS DUE TO OTHER BACTERIA, LEFT ANKLE AND FOOT and; METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS INFECTION, UNSPECIFIED SITE. The order was discontinued on 11/12/25. On 11/12/25, resident 117's physician ordered Vancomycin HCl Solution Reconstituted, Use 1 gram intravenously two times a day for Vancomycin therapy related to ARTHRITIS DUE TO OTHER BACTERIA, LEFT ANKLE AND FOOT and; METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS INFECTION, UNSPECIFIED SITE. Resident 117's Medication Administration Record (MAR) revealed the following: a. On 11/6/25 the evening dose of Vancomycin was documented as code 9. b. On 11/12/25 the morning dose of Vancomycin was documented as code 5. c. On 11/13/25 the evening dose of Vancomycin was documented as code 9. d. On 11/14/25, the evening dose of Vancomycin did not have any documentation that the medication was administered or held. The MAR legend indicated that a code 9 was see Nurse Note and a code 5 was HOLD see Nurse Note. It should be noted that no documentation was located in a nurse progress note to explain why the Vancomycin was held on 11/6/25, 11/12/25, 11/13/25, or 11/14/25. On 11/19/25 at 1:43 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that if medication was not available for the scheduled administration she would call the pharmacy to see where the medication was and why it was not delivered, and then she would call the Medical Doctor (MD) to notify that the medication was not administered. LPN 1 stated she would document a code 9 in the MAR for a medication that was unavailable and enter a progress note. LPN 1 stated that if a medication was coded 9 then it should have a progress note documented with the details of why it was not administered. LPN 1 stated that if there was no documentation in the MAR for a medication administration then it was flagged for the Director of Nursing (DON) or the Assistant Director of Nursing (ADON) to review. LPN 1 stated that her access to the MAR did not show if prior medication was missed. On 11/20/25 at 10:42 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that she expected that nursing staff notify the MD of any missed medication doses and then document a progress note why it was missed.</p>		

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 37 residents sampled, that the facility did not notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fell outside of the clinical reference ranges. Specifically, a resident's Vancomycin trough levels were high and the Medical Doctor (MD) was not notified of those high values. Resident identifier: 117. Resident 117 was admitted to the facility on [DATE] with diagnoses which included arthritis due to bacteria of left ankle and foot, gout, Methicillin-resistant Staphylococcus aureus (MRSA), diabetes mellitus, chronic kidney disease, congestive heart failure, pain, and edema. On 11/18/25 at 8:55 AM, an interview was conducted with resident 117. Resident 117 stated that he had a Peripherally Inserted Central Catheter (PICC) line in his right arm and had multiple daily doses of intravenous antibiotics. Resident 117 stated that he had 3 doses of Vancomycin that were missed by the facility. On 10/30/25, resident 117's physician ordered Vancomycin Hydrochloride (HCl) Solution Reconstituted, Use 1250 mg intravenously two times a day for Vancomycin therapy related to ARTHRITIS DUE TO OTHER BACTERIA, LEFT ANKLE AND FOOT and; METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS INFECTION, UNSPECIFIED SITE. The order was discontinued on 11/12/25. On 11/12/25, resident 117's physician ordered Vancomycin HCl Solution Reconstituted, Use 1 gram intravenously two times a day for Vancomycin therapy related to ARTHRITIS DUE TO OTHER BACTERIA, LEFT ANKLE AND FOOT and; METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS INFECTION, UNSPECIFIED SITE. Resident 117's lab results for the Vancomycin trough documented the following high results: a. On 10/27/25, the result was 14.5, high b. On 11/1/25, the result was 18.2, high; c. On 11/14/25 at 4:30 PM, the result was 12.9, high; d. On 11/14/25 at 10:50 PM, the result was 14.6, high; and e. On 11/18/25, the result was 23.2, high. No documentation could be found to indicate that the MD was notified of the high Vancomycin trough results. On 11/19/25 at 1:43 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that the Vancomycin monitoring included a Vanco trough lab result that was sent to the MD for review and documentation that the MD was notified of the results would be located in a progress note. On 11/20/25 at 10:42 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that a progress note should document that the MD was notified of trough results and pharmacy recommendation of medication dose adjustment. The DON stated that nursing staff would notify the MD by phone of critical lab results and when the MD came to the building they would sign the all lab report to verify that they had seen the results.</p>		

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<p>F 0779</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep signed and dated reports of x-rays and other diagnostic services in the residents record.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 out of 37 sampled residents, that the facility did not file in the resident's clinical record signed and dated reports of radiological and other diagnostic services. Specifically, a resident 21's Kidney, Ureter, and Bladder (KUB) was not in the medical records. Resident identifier 21. Resident 21 was admitted to the facility on [DATE] with diagnoses which included traumatic subdural hemorrhage with loss of consciousness, quadriplegia, spinal stenosis, and post-traumatic stress disorder. Review of resident 21's medical record was completed on 11/17/25 through 11/20/25. On 11/2/25, a physician's order documented an immediate (STAT) KUB radiograph (x-ray). On 11/2/25 at 12:48 pm, a nursing progress alert note stated the following: The patient decided to stay in bed all day today. The nurse noted that the patient's abdomen was bloated with a lot of gas and administered a gas pill. The patient stated that he had a watery bowel movement yesterday and last night his colostomy exploded twice. The nurse reported to the Nurse Practitioner at which time a KUB was ordered. On 11/3/25 at 3:46 am, a nursing progress radiology results note revealed the following. Abdomen x-ray. Impression: increased fecal material. The doctor on call was notified. No new orders. It should be noted that no documentation of the x-ray results could be located in resident 21's medical record. On 11/20/25 at 1:15 pm, an interview was conducted with Licensed Practical Nurse (LPN) 3. LPN 3 stated once a physician gives an order, the LPN would enter the order into the resident's medical record. LPN 3 stated a lab slip/request would be filled out and a call to the x-ray company to get a technician dispatched to the facility. LPN 3 stated she will fax the x-ray company the physician's order for their records. LPN 3 stated the x-ray company will fax over the results. LPN 3 stated that when she gets the results, she will contact the Director of Nursing (DON) and the physician. LPN 3 stated she will enter the results on to the resident's medical record and any additional orders from the physician. LPN 3 stated that she will then make a copy of the results and put one in the DON's office and the other in the physician's office. LPN 3 stated after that she is unaware of what happens with the results after placing them in the offices. On 11/20/25 at 1:54 pm, an interview was conducted with LPN 2. LPN 2 stated she will get an order from the physician. LPN 2 stated that she will then create an order on the resident's medical record. LPN 2 stated that she will call the mobile x-ray company. LPN 2 stated that the x-ray company will fax the results to the facility. LPN 2 will call the physician regarding the results and get any new orders. LPN 2 will make a copy of the fax, one goes to the physician, and the other one goes to the unit manager. LPN 2 stated that once the unit manager reviews the results, they will give it to medical records to be scanned and put on the resident's medical record. On 11/20/25 at 3:06 pm, an interview was conducted with the Regional Compliance Nurse (RCN). The RCN stated that she was unable to locate the KUB results for resident 21 on their medical chart. The RCN stated that she needed to ask the unit manager to retrieve it from the portal to be able to provide it to the State Surveyor. On 11/20/25 at 3:07 pm, an interview was conducted with the DON. The DON stated that x-ray results are faxed to the facility. The DON stated that the nurse will contact the physician with the results. The DON stated that the received fax is copied and given to the unit manager and the physician for review. The DON stated that after the results are reviewed the fax is forwarded to medical records to be attached to the resident's medical chart. The DON stated that management expects that to be done within a week from the ordered date. On 11/20/25 at 3:07 PM, an interview was conducted with the Administrator (ADM). The ADM stated that he expects to have any documentation attached to a resident's medical chart within a week of receipt date.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that for 1 of 37 sampled residents, that the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Specifically, a resident was not placed on proper contact precautions. Resident Identifier: 117. Resident 117 was admitted to the facility on [DATE] with diagnoses which included arthritis due to bacteria of left ankle and foot, gout, Methicillin-resistant Staphylococcus aureus (MRSA), diabetes mellitus, chronic kidney disease, congestive heart failure, pain, and edema. On 11/18/25 at 8:55 AM, an interview was conducted with resident 117. Resident 117 stated that he had a Peripherally Inserted Central Catheter (PICC) line in his right arm and had multiple daily doses of intravenous antibiotics. Resident 117 stated that he had both ankles surgically cleaned out and the left foot had MRSA. A Personal Protective Equipment (PPE) cart was located inside the resident room and contained gloves and disposable gowns. A magnet with the number 6 printed on it was located on resident 117's doorframe on the outside of the door. No other signage was located on resident 117's door to indicate any type of Transmission Based Precautions. Resident 117's medical records were reviewed 11/17/25 through 11/20/25. On 10/24/25, resident 117's hospital history and physical documented status post left ankle incision and drainage [I & D]. The lateral aspect of the left ankle was packed with 1/4in [inch] iodoform packing and redressed. The hospital progress note documented that the left ankle was found to have MRSA septic arthritis and bacteremia. On 10/18/25, the left ankle aspiration and blood cultures were positive for MRSA and both specimens were susceptible to Vancomycin. The plan documented 4-6 weeks of intravenous Vancomycin treatment. On 10/25/25, the nursing admission evaluation documented that the resident was on Contact Precautions. The assessment further documented that the resident required Enhanced Barrier Precautions (EBP) due to his PICC line. The assessment documented under skin impairments that the site of the right outer ankle had Septic Arthritis Wash out 10/23, Dressing intact, right toes Dressing intact covering toe, and PICC line right upper extremity. On 11/3/25, resident 117 had an order for Enhanced Barrier Precautions due to wounds PICC line for antibiotics. On 10/25/25, resident 117 had a care plan initiated for Enhanced Barrier Precautions r/t [related to] picc line, iv [intravenous] abx [antibiotics] and wounds. The interventions identified on the care plan were to don and doff gown and gloves per facility protocol for high contact care activities, a patient identifier would be on the resident's door frame, and perform hand hygiene per facility protocol. On 11/19/25 at 9:16 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that a number 6 magnet posted outside the resident door indicated that they were on precautions. LPN 1 stated that she would look in the resident chart on the homepage to verify the type of Transmission Based Precautions and what they were indicated for. LPN 1 stated that if a resident was on contact or droplet precautions it would indicate it on the resident's dashboard. On 11/19/25 at 2:01 PM, a follow-up interview was conducted with LPN 1. LPN 1 stated that they implemented EBP for cellulitis, urinary tract infections, for indwelling urinary catheter, for total parental nutrition (TPN), and for any intravenous access. LPN 1 stated that PPE for high contact care with EBP required the staff wear gloves only. LPN 1 stated that the Certified Nurse Assistants would wear gowns for brief changes and gowns would be donned when changing an indwelling catheter. LPN 1 was not able to state the difference between Contact Precautions or EBP and what PPE was required for each one. On 11/19/25 at 2:36 PM, an interview was conducted with the Director of Rehabilitation (DOR). The DOR stated that resident 117 came down to the gym for therapy services 5 days a week. The DOR stated that resident 117 was not on any Transmission Based Precautions. The DOR stated that resident 117 had a bandage on his toe but it was covered. The DOR stated that if resident 117 was on Contact Precautions he would not be allowed to come to the gym because it would be too easy to spread the infection in the gym. The DOR stated that when a resident was on Contact Precautions they provided therapy services in the resident's room and the staff wore a gown and gloves. The DOR stated that if they took any reusable equipment into a Contact Precautions room they would disinfect the equipment after use with Virex disinfectant. The DOR stated that they were notified of residents on Contact Precautions in their morning stand-up meetings and the resident would have a sign posted on the door with the type of PPE that should be utilized. The DOR stated that resident 117 had an infection in his wound because he was receiving antibiotics for it but he did not know what the organism was. The DOR stated that if it was MRSA</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Monument Healthcare Millcreek		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 East 4500 South Salt Lake City, UT 84117	
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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that the facility was not adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or a centralized staff area for toilet facilities. Specifically, the facility had seven public bathrooms that were accessible by residents and were not equipped with a call light system. On 11/20/25, an observation was made of the public bathroom facilities. The 300 hallway bathroom near room [ROOM NUMBER] was observed and did not contain a call light inside. The 400 hallway bathroom near the nurse's station was observed and did not contain a call light inside. The bathroom next to the staff break room was observed and did not contain a call light inside. The bathroom next to the Human Resource office and front desk was observed and did not contain a call light inside. None of the public bathrooms were locked. On 11/20/25 at 2:36 PM, an interview was conducted with the Director of Maintenance (DOM). The DOM stated that the facility had 7 public bathrooms. The DOM stated that technically anyone could use any of the bathrooms at any time, including residents. The DOM stated that they had two bathrooms in the Administration hallway, one bathroom in the 400 hallway west, one bathroom in the 400 hallway east, one bathroom in the activities room, one bathroom in the 300 hallway, and one bathroom next to the front office. The DOM stated that he just replaced all the bathroom doorknobs and removed the dead bolt. The DOM stated that he never thought to put call lights in those bathrooms and did not know that they needed to have a call light.</p>		