STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465139	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Millcreek	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)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident 2 was admitted to the facility on [DATE] with diagnoses which consisted of displaced bimalleolar fracture of right lower extremity, displaced avulsion fracture of right talus, chronic pulmonary edema, congestive heart failure, chronic kidney disease, kidney transplant status, unspecified protein-calorie malnutrition, fistula of the intestine, contusion of the abdominal wall, dyspnea, disorders of phosphorus metabolism, and hypokalemia. On 1/20/26 through 1/21/26 resident 2's medical records were reviewed. On 10/29/25, resident 2's admission Minimum Data Set (MDS) Assessment documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident was cognitively intact. On 10/24/25, resident 2's physician ordered TPN 1600 milliliter (ml) to run continuously in the evening per the pharmacy instructions. The pharmacy order summary documented the following for resident 2's TPN:Start Volume - 100 mlStart Rate - 62.5 ml/hour (hr.)Start Period - 1.6 hrs.Run Volume - 1600 mlRun Rate - 125 ml/hr.Run Period - 12.8 hrs.End Volume - 100 mlEnd Rate - 62.5 ml/hr.End Period - 1.6 hrs.Overfill Volume - NoneContainer Type - Single ChamberCompounded Volume - 1800 mlThe order summary was last updated on 11/20/25. It should be noted that the total volume to be infused in the order summary was 1800 ml with a total run period of 16 hrs. On 12/29/25, resident 2's pharmacy label for the TPN documented Infuse intravenously 1800 ml continuously in the evening. Run at 125 ml/hr. over 12 hrs. It should be noted that the order summary start volume and start rate and the end volume and end rate did not match the pharmacy label nor did the combined run period times equaling 16 hrs. Additionally, it was unclear whether the pharmacy label had not matched the original physician orders since October 2025. Resident 2's progress notes revealed the following: a. On 12/28/25 at 11:01 PM, the Alert Charting note documented, Entered room to check on resident and found her connected to the TPN bag. The bag is empty. Bag is not on the pump. She has received her 1600 ml of TPN already although it is scheduled for 12 hours. VS [vital signs] assessed. Dr on call notified. BS [blood sugar] checked. Neuro check at her baseline. Lung sound clear x's [times] 4. Resident refuses to have her family called. States 'you can call them in the morning. Don't bother them this time of night.' Dr on call-DON [Director of Nursing]- and nurse manager notified. b. On 12/29/25 at 12:18 AM, the Order Note documented, .Received TPN over a short time period. New orders: STAT [immediate] CMP [complete metabolic panel] in the am, Head of bed elevated at all times, assess lungs every 2 hours, monitor every 2 hours for altered mental status, vital signs every 2 hours. Resident agrees with change in plan of care. New orders noted and implemented. c. On 12/29/25 at 9:26 AM, a physical medicine and rehabilitation follow up note documented, Patient assessed w/ [name of Medical Doctor omitted] this visit. [Resident 2] is observed in bed. Noted to be lethargic with altered mental status. Arousable to loud voice and tactile stimulation; however, patient closes eyes almost immediately upon opening. She reports constant, sharp chest pain, non radiating. Vitals stable on 3L [liters oxygen] NC [nasal cannula], denies SOB [shortness of breath]. d. On 12/29/25 at 6:01 PM, the Alert Charting note documented, Report (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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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from night shift received that patient had been given TPN bolus during the night. On call provider called and ordered STAT CMP for AM. When day nurse went into draw labs, patient very sleepy and displayed understanding and agreement upon getting blood drawn. RN returned around 9AM to give morning meds. Patient more difficult to arouse. She would respond to her name and wake up for a second and then go back to sleep. MD notified at this time. Physiatrist came around 9:15 [AM]. After examining her, she came out and reported to RN [registered nurse] and UM [unit manager] that patient was complaining of chest pain. UM told RN to ask patient if she would like to go to the hospital. Patient stated no. UM went to take [sic] to patient around 0927 [9:27 AM] and stated that we need to send her to the hospital. 911 called at 0930 [9:30 AM]. Daughter called at 0940 [9:40 AM] to inform her of situation. EMS [emergency medical services] showed up at 0940 and transferred patient out to [name omitted] hospital. RN followed up at 1300 [1:00 PM] and found out patient was admitted for sepsis. Resident 2's Neurological Assessment documented the following abnormalities from baseline: a. On 12/28/25 at 11:30 PM, resident 2's Heart Rate (HR) was 107, Blood Pressure (BP) was 155/51, and Respiratory Rate (RR) was 22. b. On 12/29/25 at 1:30 AM, resident 2's HR was 112, BP was 173/83, RR was 24, and Temperature was 99.1. c. On 12/29/25 at 3:30 AM, resident 2's HR was 105, and RR was 20. d. On 12/29/25 at 5:30 AM, resident 2's HR was 102, RR was 20, and eyes opened to speech which was a change from opening spontaneously. e. On 12/29/25 at 7:30 AM, resident 2's eyes opened to speech, and motor response was localized to pain which was a change from obeys commands. f. On 12/29/25 at 9:30 AM, resident 2's HR was 61, eyes opened to speech, verbal response was confused, and motor response was localized to pain. A handwritten note on the bottom of the neurological assessment form documented a blood sugar of 450 [at approximately 11:01 PM] before calling the provider and a blood sugar of 278 at 9:30 AM. On 12/29/25 the Nursing Home Emergency Transfer Notice documented the reason for transfer was chest pain, low BP, fever, and high HR. The form did not document that resident 2 had received a TPN bolus the night before. On 12/29/25, resident 2's Hospital History & Physical documented the chief complaint as abdominal pain and chest pain. The reason for the emergency department (ED) visit further documented that the resident came from a care facility due to fever, altered mental status, and complaints of chest pain and abdominal pain. Emergency Medical Services (EMS) noted febrile, tachycardia and initially hypotensive but then had a normal reading upon arrival to the ED. The physical exam documented that the resident was positive for chills, fatigue and fever, positive for abdominal pain, positive for myalgias, and positive for confusion. Resident 2's vital signs in the ED were BP was 119/57, HR was 106, RR was 28, and Temperature was 99.4. The chest x-ray impression documented underinflated lungs, no acute intrathoracic findings. Differential diagnoses included sepsis, urinary tract infection, pneumonia, viral ailment including influenza or COVID-19, line sepsis due to indwelling line. We will consider as well heart failure, renal failure. Electrolyte abnormality. It should be noted that no documentation could be found to indicate that the hospital was notified of the TPN bolus with a subsequent change in condition. Resident 2's facility abuse investigation summary documented, At approximately 1945 [7:45 PM], an agency RN initiated the residents ordered TPN infusion. The RN reported an IV [intravenous] pump was not present in the room and manually calculated the drip rate, regulating the infusion via roller clamp. It was later confirmed that an IV pump was present in the room. Between 2200-2230 [10:00 PM - 10:30 PM], the agency RN reported the TPN bag was approximately half full prior to leaving the shift. At approximately 2300-2330 [11:00 PM to 11:30 PM], the facility RN assessed the resident and observed the TPN bag was empty. The IV tubing was connected to the resident's PICC [peripherally inserted central catheter] line but was not routed through the IV pump. The TPN was infused over approximately 3 hours and 15 minutes, rather than the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed 12 hours. On the morning shift, the resident was noted to be more difficult to arouse than at baseline. The physician was notified. A subsequent evaluation noted complaints of headache, nausea, and chest pain. The resident later became confused and incoherent. At 0930 [9:30 AM], emergency services were activated . It was substantiated that the patient did receive the TPN administration incorrectly. The patient was sent to the ER [emergency room] due to her COC [change of condition] of lethargy, altered mental status and cognition which was initially believed to be related to the TPN error. On 1/20/26 at 12:36 PM, an interview was conducted with the Director of Nursing (DON) and the Administrator (ADM). The DON stated that she received a phone call at 11:00 PM on 12/28/25 from RN 1 and she reported that the TPN tubing was attached directly to resident 2's PICC line and not through the pump and that the TPN bag was empty. The DON stated that she confirmed that an IV pump was in the room the following day. The DON stated that the TPN infusion was hung between 7:30 PM and 8:00 PM as reported by the agency nurse who administered the TPN. The agency nurse stated that he could not find a pump so he figured out the drip rate, calculated the flow rate and used the tubing to count the drips per minute. The DON stated that the agency nurse did not mention the duration of the infusion that was used to calculate the drip rate. The DON stated that the TPN order with the rate of infusion, total volume, and duration of infusion was located on the bag from the pharmacy. The DON stated that the TPN order details should also be in the resident's medical records on the order. The DON stated that the agency nurse had not worked in the facility prior and the nurse was not allowed to return to the facility after the incident. The ADM stated that he reported the nurse's license to the Division of Professional Licensing (DOPL). The DON stated that the Medical Doctor (MD) was notified and ordered to monitor resident 2 every 2 hours. The DON stated that the nurse should be monitoring the VS for any changes in BP, HR, or RR. The DON stated that resident 2's VS monitoring documented an elevated heart rate and high blood pressure. The DON stated that the nurse was to notify the MD of any systolic blood pressure greater than 200 and any diastolic blood pressure greater than 100. It should be noted that the VS monitoring orders did not document any BP parameters for MD notification. The DON stated that resident 2's lung sounds were monitored and within normal limits throughout the shift. The DON stated that resident 2 had a change in mentation and increased confusion. The DON stated that the MD was notified of resident 2's change in condition at 9:30 AM. The DON stated that after the incident education was provided to the nurses on TPN administration and that agency staff were no longer allowed to administer or monitor TPN. The DON stated that she also determined that any future TPN orders would also need to be in the electronic medical records and not just on the label from the pharmacy. The DON confirmed that the TPN label documented to infuse at a rate of 125 ml/hr. with a total volume of 1600 ml, and a duration of 12 hrs. The ADM stated that the TPN was infused in 3.5 hrs. and not the ordered 12 hours. The ADM confirmed that no other residents have had orders for TPN since the date of resident 2's incident. On 1/20/26 at 12:49 PM, a telephone interview was conducted with RN 1. RN 1 stated that she took over resident 2's hallway at 10:00 PM from the agency nurse on the night of the incident. RN 1 stated that she was previously in a different hallway. RN 1 stated that the agency nurse gave a report that everyone was fine. Because it was a telephone interview, RN 1 was read the progress note dated 12/28/25 at 11:01 PM and RN 1 verified that was what she had written. RN 1 stated that whatever she had written in the progress note was what had transpired. RN 1 stated that she had verified that resident 2 had an IV pump located in her room on the night of the incident. RN 1 stated that the rate of infusion and length of infusion was located on the bag of TPN from the pharmacy and it was supposed to run for 12 hours. RN 1 stated that she had found the empty TPN bag at 10:00 PM and she was not sure the time it was hung for administration. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure that residents received the treatment and care in accordance with professional standards of practice, related to pain management. Specifically 1 of 4 residents sampled, was hospitalized due to opiate toxicity. Resident Identifier: 4 Findings Included: Resident 4 was admitted to the facility on [DATE] with diagnoses which included sepsis, obstructive and reflux uropathy, and calculus of kidney. Review of resident 4's medical record was completed on 1/21/26. On 1/1/26 at 10:47 AM, a Physician's Progress Admit Note for resident 4 revealed that a medication reconciliation was done with the patient's family and his primary care physician's records. Morphine tablets (immediate release, 7.5 milligrams (mg) every 6 hours as needed), were ordered for resident 4's dorsalgia. On 1/2/26 at 1:49 PM, a Medical Doctor (MD) History and Physical Note for resident 4 stated, Patient with large kidney stones. Patient complains of ongoing pain and wants more morphine than he is getting. On 1/3/26 at 8:28 AM, a Nursing Progress Order Note for resident 4 stated, .Give 1/2 tab PO [by mouth] every 3 hours for pain AND Give 1 tablet by mouth every 3 hours as needed for pain. On 1/3/26, a physician's order for resident 4 revealed the following Morphine Sulfate Oral Tablet 15 mg. Give 0.5 tablet by mouth every 3 hours as needed for pain. On 1/3/26, a physician's order for resident 4 revealed the following Morphine Sulfate Oral Tablet 15 MG. Give 1 tablet by mouth every 3 hours as needed for pain. It should be noted the new physician order resulted in an increase of 150 mg of Morphine every 24 hours as needed. Further review indicated that, based on the prescribed frequency and dosage, there was a potential for a total of 180 mg of Morphine to be administered within a 24-hour period. On 1/5/26 at 2:51 PM, a Physician's Follow Up Note for resident 4 revealed the following. Interval History: Patient seen in his room patient relays to me that his family felt like his [sic] he was slurring his words today. Patient has a new cough and feels congested in the lungs Pain management adequate with morphine.Details : Chief Complaint: slurred speech.Respiratory : Lungs CTA, Other: He has a congested cough.Assessment/Plan:.Ongoing management of nephrostomy, pain management, awaiting surgery. Pain management with morphine. I think there is some intermittent dysarthria caused by the morphine and we need to back off on this unless needed for pain levels higher than 4. It should be noted that an updated morphine was not located in the medical record. On 1/6/26 at 5:26 AM, a Nursing Progress Order Note for resident 4 stated, Resident is lethargic and wasn't speaking clearly. He slept all night but was smiling and compliant with medication and breathing treatment. BP [blood pressure] 167/95, HR [heart rate] 122, oxygen with CPAP [Continuous Positive Airway Pressure] is 88, and temp [temperature] is 97.7. Orders for chest x-ray are in but [name redacted] never arrived, resident complained yesterday of SOB [shortness of breath] and coughing. DON [Director of Nursing], ADON [Assistant Director of Nursing], and MD notified. On 1/15/26 at 4:16 PM, a Nursing Progress Note for resident 4 states, Pt with low O2 [oxygen] sat [saturations] at 83%; groggy and dry mouthed; not eating meals well; lungs with rhonchi bilaterally; nebulizer treatment given, O2 placed at 2L [liter]/NC [nasal cannula]; effective; o2 SATs increased to 93-94%; NP [Nurse Practitioner] notified or change in status. On 1/17/26 at 2:08 AM, a Nursing Progress Note for resident 4 states, Pt [patient] yelling for help, upon entering room pt found between the bathroom and his bed on his Lt [left] side. When asked what happened pt stated I rolled out of bed, after careful evaluation, no injuries noted. Assisted x [times] 3 staff back into bed. Bed in lowest position, call light in reach. Pt instructed to call for assistance before getting out of bed, Pt stated I didn't know I was paralyzed MD, Wife, Administrator, DON, Unit Manager notified. On 1/17/26 at 8:18 AM, resident 4's MAR revealed 1 tablet of 15 mg of Morphine Sulfate Oral Tablet was given. Pain Level (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Noted as 10. On 1/17/26 at 10:30 PM, resident 4's MAR revealed 1 tablet of 15 mg of Morphine Sulfate Oral Tablet was given. Pain Level Noted as 7. On 1/18/26 at 7:38 AM, resident 4's MAR revealed 1 tablet of 15mg of Morphine Sulfate Oral Tablet was given. Pain Level Noted as 4. It should be noted that a total of 45 mg of Morphine Sulfate was administered in a 24 hour period. On 1/18/26 at 9:09 AM, a nursing progress note for resident 4 stated, Patient appears lethargic at this time. Oxygen saturation is unable to be obtained due to cold extremities; hands are cold to touch. Staff reported significant changes in patient condition compared to yesterday. Per report, patient experienced low oxygen saturation overnight. Oxygen has been titrated up to 5 L/min [minute] however, oxygen saturation remains unable to be obtained despite multiple attempts. Based on current assessment findings, including lethargy, inability to obtain oxygen saturation, cold extremities, and reported decline since yesterday. Patient is being transferred to [name redacted] via [name redacted] transportation. Dr. [name redacted] and management were notified of patient condition and transfer. Spouse, wife [name redacted], was notified; no answer-voicemail left requesting a call back. Patient's son, [name redacted], was also notified; no answer-voicemail left requesting call back for notification. Medication list, transfer records, and discharge documentation were sent with the patient. At time of transfer, vital signs were as follows: blood pressure 112/81 mmHg, temperature 97.1 F [Fahrenheit], pulse 78 bpm [beats per minute] , respirations 24 breaths per minute. Oxygen saturation remains unable to be obtained at this time. Blood sugar is 104 mg/dL [milligrams per deciliter]. Patient transferred in stable condition with ongoing concerns requiring further evaluation in the emergency department [ED]. The hospital ED provider notes dated 1/18/26 at 11:58 am, revealed the following. The patient arrives critically ill with hypoxia down to 68%, slow respiratory rate, confusion he will open his eyes. He is otherwise not very responsive.The patient is in critical condition, this patient's condition is life-threatening due to hypoxia, with ongoing risk of organ failure.He has been getting extra doses above the 0.5 tablets of morphine he supposed to be getting at least once a day maybe twice a day he has Narcan responsive and wakes up and his respiratory rate improved but his oxygenation does not, his blood pressure also improved with Narcan.the patient will be admitted to the intensive care unit with multiple diagnoses which include hypoxia, sepsis, and opiate toxicity.The following medications were administered: naloxone (NARCAN) 2mg in dextrose 5% (D%W) 500mL DRIP (has no administration in time range) .naloxone (NARCAN)0.4 mg/mL injection 0.2 mg (0.2 mg intravenously Given 1/18/26 1055) .naloxone (NARCAN)0.4 mg/mL injection 0.2 mg (0.2 mg intravenously Given 1/18/26 1230) On 1/21/26 at 9:19 AM, an interview with Licensed Practical Nurse (LPN) 1. revealed the following. LPN 1 stated when the physician gives an order, the nurse should verbally repeat the order back to the physician for verification. Once verification is completed the order is entered into the resident's medical record. LPN 1 stated he typically followed up with a provider if he encountered a morphine order with a frequency exceeding every four to six hours. LPN 1 stated that when administering pain medication, he evaluated parameters including pain levels, timing, the previous dose, and the resident's response. LPN 1 stated the resident should be able to verbalize the request for medication. LPN 1 stated that pain levels were subjective and that residents occasionally requested medication despite low pain levels. LPN 1 stated he would attempt to offer alternative interventions, but if the resident insisted, he administered the medication as prescribed. LPN 1 stated he had been resident 4's nurse previously when he returned back to work on 1/18/26, he was informed during shift report resident 4 had declined. LPN 1 stated that during the shift's initial assessment, resident 4 was alert but lethargic and requested a higher dose of morphine despite the LPN 1 offering a lower dose. LPN stated that his change of condition came within 3 hours. LPN 1 stated he did not follow up with the provider (continued on next page)

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