

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Monument Healthcare South Salt Lake		STREET ADDRESS, CITY, STATE, ZIP CODE 2472 South 300 East Salt Lake City, UT 84115	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 1 out of 6 sampled residents, the facility failed to ensure that the resident environment remained as free of accident hazards as possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident who was dependent on staff for bed mobility and repositioning fell out of bed during a bed bath while being assisted by one staff member. Resident identifier: 6. The facility developed and implemented a corrective action plan before the survey start date. The facility's corrective action plan, which was developed and implemented by 5/1/2026, included the following measures: conducting a house-wide audit on mechanical lifts, air mattresses, bed-bound residents, and heavier residents; updating care plans to ensure a two-person assist was required for positioning and bed baths for applicable individuals; increasing air mattress pressure settings to improve stability; and providing education to all staff regarding resident mobility and proper bed placement. The survey team verified that all these interventions were completed before the survey start date. Review of the medical record for Resident 6 revealed that the resident was admitted to the facility on [DATE], with diagnoses that included encephalopathy, chronic respiratory failure with hypercapnia, and severe obesity. Review of the comprehensive care plan for Resident 6 revealed an intervention initiated on 3/5/2026, stating that the resident required up to total assistance with bed mobility, sitting to lying, lying to sitting, or rolling. Review of the Minimum Data Set (MDS) assessment for Resident 6, dated 3/4/2026, revealed that the resident was completely dependent on staff to roll left and right while in bed. The surveyor reviewed a progress note dated 4/27/2026, at 1:36 pm. It was documented on the note that during a bed bath, a staff member reported that while repositioning Resident 6, the resident's lower body slipped off the edge of the bed. The staff member was unable to prevent the fall, and the resident fell off the left side of the bed, landing on their left side. The staff member notified a registered nurse and called for additional assistance. The resident was initially evaluated on the floor and then transferred back to bed using a mechanical lift. The resident did not have any apparent injuries. Due to uncertainty about a potential head injury, the decision was made to transfer the resident to the hospital for further evaluation. The surveyor reviewed an acute care progress note dated 4/30/2026, at 11:24 pm. It was documented on the note that staff were called into the room after a fall. During a bed bath, the bottom half of the resident's body slipped off the edge of the bed, resulting in a fall initially onto bilateral knees, after which the upper body hit the ground and presumably hit the head. The resident complained of diffuse pain in bilateral knees, collarbone, shoulders, cervical spine, and hip joints. Due to the fall, concurrent blood thinner therapy, and likely head trauma, the resident was sent to the emergency department for further evaluation and a head computed tomography (CT) scan to rule out a bleed and fractures. On 7/8/2026, at 11:00 AM, the surveyor interviewed Staff 1. Staff 1 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 465146	Facility ID: 465146 If continuation sheet Page 1 of 2

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that they were performing a bed bath for Resident 6 while the resident was laying on their side holding onto the grab bars. Staff 1 stated that they saw the resident's feet go forward, and the resident slipped down and out of bed. Staff 1 stated that the bed was in a low position. Staff 1 stated that they immediately obtained help from the nurse and followed orders from the nurse and provider. Staff 1 further stated that they believed that the resident was positioned correctly in the bed. Staff 1 stated that the [Unit Manager] educated them that day, and two days later, they received more education from the Director of Nursing (DON) and the Administrator regarding resident mobility and proper bed placement. On 7/8/2026, at 11:14 AM, the surveyor attempted to interview Resident 6 and left a voice message. Resident 6 did not respond to the voice message. On 7/8/2026, at 2:10 PM, the surveyor interviewed the DON. The DON stated that the resident was on a low-pressure air mattress and had large legs that provided leverage, causing the resident to move forward and slip out of the bed during the bed bath. The DON stated that the hospital emergency room found what appeared to be an older compressed chronic fracture that was not due to fall, and that the resident was subsequently transferred to another facility. The DON reported that Resident 6 did not sustain any injuries. The DON further stated that in response to the incident, the facility completed a house-wide audit on mechanical lifts, air mattresses, bed-bound residents, and heavier residents. Care plans were updated to ensure a two-person assist was mandated for positioning, bed baths, and other mobility tasks for affected residents. Additionally, the facility implemented a plan to increase air mattress pressures to provide more stability during care, and completed emergency preparedness and mobility education for all staff. The facility's Performance Improvement Plan was reviewed and was implemented by 5/1/2026. The plan included the following A facility-wide audit was conducted to identify residents requiring two-person assistance, ensuring care plans and Kardex were accurate and updates, and to confirm assistance levels were clearly documented and consistently followed. Care plans were updated for residents on air pressure mattresses to increase the pressure prior to beginning personal care and to return the mattress to the prescribed therapeutic setting. All residents who required a Hoyer lift were now a 2-person assist for all cares, including mobility in bed. Education on 2-person assist techniques, safe transfers, bed bath procedures, care plan/Kardex review, and proper use of mattresses was provided to all care staff Random daily audits by learning leadership that includes direct observation of care, and checks for documentation accuracy was started.		