STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465156	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monument Healthcare Stonecreek	523 North Main Street 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined for 1 out of 8 sampled residents, the facility did not ensure that all residents received the treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choice. Specifically, a resident was not provided wound vac supplies in a timely manner. Resident identifier: 2.Findings included: Resident 2 was admitted to the facility on [DATE] with diagnoses which included, encounter for orthopedic aftercare, acquired absence of left great toe, and type 2 diabetes.A review of resident 2's medical record revealed the following:a. On 6/5/25 at 7:02 PM, a progress note documented, Resident back from wound clinic appointment from [local hospital]. Notes state to order wound vac, and send it with patient to next appointment and doctor wants patient to do hyperbaric oxygen therapy, team at [facility] needs to talk about a decision. Resident aware of orders. DON [Director of Nursing] [name redacted] and ADON [Assistant Director of Nursing] [name redacted] aware of requests and orders.b. On 6/13/25 at 11:37 AM, a progress note documented, [resident 2] returned from her appt [appointment] with [name redacted]. Nurse's not [sic] to physician: Wound Vac to be used Monday, Wednesday, Friday Dressing changed every two days. Physician note/orders: Please start wound vac ASAP [as soon as possible] L F [left foot]. We were unable to place due to lack of supplies.c. On 6/16/25 an order documented, Wound vac to left foot- ensure wound vac is in place and functioning. ** CHANGE MONDAY, WEDNESDAY, FRIDAY AND PRN [as needed]** as needed for wound healingOn 1/5/26 at 10:46 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that the facility used wound vacs and they were supplied by a contracted company. LPN 1 stated that a wound vac required an order and was brought the same day it was ordered. LPN 1 stated that the wound vac was brought with all the supplies that a resident needed.On 1/5/26 at 1:23 PM, an interview was conducted with the DON. The DON stated that wound vacs arrived at the facility within two hours on the day they were ordered. The DON stated the facility used an outside company to supply the wound vac and supplies that were needed. The DON stated that she called the wound vac company with the order and gave the resident's name and insurance information and it would be delivered. The DON stated that it would not take more than a week for a wound vac and supplies to be delivered to a resident. The DON stated that she was unsure why it took so long for resident 2 to receive her wound vac supplies.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 2 out of 8 sampled residents, the facility did not provide routine and emergency drugs and biologicals to its residents. Specifically, residents were not provided multiple medications due to them being out of stock and unavailable from the pharmacy. Resident identifiers: 2 and 8.Findings included: 1. Resident 2 was admitted to the facility on [DATE] with diagnoses which included, encounter for orthopedic aftercare, acquired absence of left great toe, and type 2 diabetes.Resident 2's medical record was reviewed on 1/5/26.A review of resident 2's medication orders revealed:a. Glimepiride Oral Tablet 4 MG [milligram] Give 4 mg by mouth at bedtime for T2DM [Type 2 diabetes mellitus]. The start date of this medication was 5/15/25.b. Eucerin Advanced Repair External Cream (Emollient) Apply to [NAME] [bilateral] Lower extremites [sic] topically two times a day for Dry scaley [sic] skin. The start date of this medication was 5/26/25. c. Amitriptyline HCl [hydrochloride] Oral Tablet 25 MG. Give 25 mg by mouth at bedtime for antidepressant. The start date of this medication was 5/15/25.A review of resident 2's Medication Administration Record (MAR) revealed: a. Glimepiride was not administered on: 9/18/25, 9/19/25, 9/20/25, 9/21/25, 9/22/25, 9/23/25, 9/24/25, 9/25/25, 9/27/25, and 9/28/25.b. Eucerin Advanced Repair Cream was not administered on: 6/9/25, 6/10/25, 6/17/25, 6/23/25, 6/24/25, 6/25/25, 6/26/25, 6/27/25, 6/28/25, 6/29/25, 6/30/25, 8/24/25, 8/25/25, and 8/26/25. c. Amitriptyline was not administered on 6/15/25 and 6/16/25.A review of resident 2's progress notes revealed:a. On 6/9/25 at 10:02 AM, an eMAR (electronic Medication Administration Record) note documented, Eucerin Advanced Repair External Cream.Out of supply. Supply personal [sic] made aware.b. On 6/15/25 at 10:00 PM, an eMAR note documented, Amitriptyline HCl Oral Tablet 25 MG.No med [medication] .c. On 6/16/25 at 1:00 AM, an encounter note documented, . She wanted to verify that she was still receiving her amitriptyline dosing. I verified Mrs. Still [sic] active that she should be getting this on a nightly basis.d. On 6/16/25 at 10:00 PM, an eMAR note documented, Amitriptyline HCl Oral Tablet 25 MG.medication not available.e. On 6/17/25 at 9:10 AM, an eMAR note documented, Eucerin Advanced Repair External Cream.Out of supply, on order.f. On 9/18/25 at 9:17 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.Not able to give medication because we do not have it on hand.g. On 9/19/25 at 9:49 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.Med reordered.awaiting refill from the pharmacy.h. On 9/21/25 at 8:19 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.Unavailable on order.i. On 9/22/25 at 7:00 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.Reordered. Awaiting delivery.j. On 9/23/25 at 7:58 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.reordered. Awaiting delivery.k. On 9/24/25 at 9:19 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.Not able to give medication because we do not have it in stock.l. On 9/25/25 at 9:17 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.We do not have this medication on hand.m. On 9/27/25 at 7:57 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.Unavailable, unable to administer, resident notified.n. On 9/28/25 at 9:32 PM, an eMAR note documented, Glimepiride Oral Tablet 4 MG.On order-not given.On 1/5/26 at 10:18 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that when a medication needed to be refilled it was refilled in the Electronic Medical Record and this would alert the pharmacy that a resident was out of medication. LPN 1 stated that she would alert the medical provider that the resident was out of medication and see if the provider wanted an alternative medication or to place the medication on hold. LPN 1 stated that a resident should never go a week without a medication and that nurses should document that they have discussed medications with the provider. LPN 1 stated that there were several ways to communicate with the provider regarding (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. LPN 1 stated that the pharmacy delivered medications to the facility twice a day during the week and at least once a day on weekends. LPN 1 stated that she would contact the pharmacy if a medication was not brought on the same day it was ordered and document this in a progress note.On 1/5/26 at 10:38 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that once a resident had one week left of medication she would reorder the medication through the pharmacy. RN 1 stated that a resident should never run out of medications. RN 1 stated that she would contact the pharmacy and ask where the resident's medications were if they were not delivered. RN 1 stated that it was the nurses job to order medications for residents and to make sure they did not run out. On 1/5/26 at 1:23 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that medications should be reordered for residents when there were 5 days left of the medication. The DON stated that nurses order medications through the Electronic Medical Record. The DON stated that if a medication was not administered or was unavailable then this should be communicated to the medical provider for further direction. The DON stated that she expected staff to document this in a progress note and to alert nursing management. 2. Resident 8 was admitted to the facility on [DATE] with diagnoses which included orthopedic aftercare following an amputation, acute osteomyelitis of right ankle and foot, cellulitis of right lower limb, and type 2 diabetes mellitus.Resident 8's medical records were reviewed on 1/5/26.On 1/4/26 at 10:40 AM, an admission evaluation nursing progress note revealed the following. Resident 8 was admitted on [DATE] at 6:05 PM, from a Short-Term General hospital via stretcher for post-operative rehabilitation intravenous (IV) infusions. On 1/3/26, a physician's order for Piperacillin-Tazobactam Solution Reconstituted 3-0.375 grams (g) Use 3.375g intravenously every 6 hours for infection.The MAR revealed administer times for Piperacillin-Tazobactam Solution 3-0.375g were as follows: 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM.It should be noted that resident 8 did not receive his ordered Piperacillin-Tazobactam Solution on 1/3/26 at 6:00 PM, and 1/4/26 at 12:00 AM. On 1/3/26, a physician's order for Vancomycin Hydrochloride Solution Reconstituted 1g intravenously two times a day for infection.The MAR revealed administer times for Vancomycin HCl Solution were as follows: 8:00 AM and 8:00 PM. It should be noted that resident 8 did not receive his ordered Vancomycin on 1/3/26 at 8:00 PM until 1/4/26 at 1:59 AM.On 1/3/26 at 7:10 PM, a Medication Administration Note for the ordered Piperacillin-Tazobactam Solution revealed that resident 8 admitted after 6:00 PM and medications not delivered from the pharmacy.On 1/4/26 at 1:59 AM, a progress note stated the following. Resident is just now getting his 2000 [8:00 PM] dose of Vanco [vancomycin]. None of his scripts were faxed to pharmacy on his arrival and now the faxes aren't going thru [sic]. I am trying to get him pain meds and IV abx [antibiotic]. The Vanco was in the e-kit [emergency]. The Zosyn is not. Resident is veryupset [sic] and yelling at staff and nurse. On 1/4/26 at 2:06 AM, a Medication Administration Note for the ordered Piperacillin-Tazobactam Solution revealed that the medications were not delivered from the pharmacy.On 1/4/26 at 10:55 AM, a late entry progress note revealed that the pharmacy did not deliver the Piperacillin-Tazobactam Solution the night of admission. The medical doctor (MD) was notified and the order was placed on hold until the arrival of the medication.On 1/5/26 at 11:05 AM, a progress note for an incident report stated that a new admitting resident had orders for Piperacillin-Tazobactam Solution. The orders were faxed to the pharmacy and the medication was not located in the pharmacy bin. Resident 8 missed the first and second doses of the antibiotics. The MD was notified and new orders were given to hold the antibiotics until the pharmacy delivered the medication and adjusted the medication schedule as needed. The pharmacy was called and placed a STAT (immediately) order for the antibiotics. The medication orders were refaxed. The resident, MD, and management was notified.On 1/5/26 at 2:47 PM, an interview was conducted with (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 8. Resident 8 stated that he had come into the facility at a later time and it was during shift change. Resident 8 stated that the facility knew he was coming so he did not know why they did not have the medication here for him. Resident 8 stated that he did not get his antibiotics for about 6 hours after they were due. Resident 8 stated that he was worried about not having his antibiotics since the hospital kept him three extra days due to his white blood cell count not low enough to transfer to a skilled nursing facility. Resident 8 stated that he did not want his infection to flare up again and cause more problems.On 1/5/26 at 1:30 PM, an interview was conducted with the DON. The DON stated that she was informed about resident 8's antibiotics not arriving at the facility as expected. The DON stated she just started looking into why the medications did not come from the pharmacy, since the prescriptions were faxed. The DON stated that the admitting nurse should fax the ordered medications to the pharmacy. The DON stated that she would need to follow up with the pharmacy about the undelivered antibiotics and ask them what happened on their end. The provider was notified about antibiotics not coming from the pharmacy, the MD reviewed the order and updated it to add one additional day on the back end.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure residents were free of any significant medication errors. Specifically, 1 out of 8 sampled residents did not receive their intravenous (IV) antibiotics every 8 hours as ordered by the hospital. Resident identifier: 2. Findings included: Resident 2 was admitted to the facility on [DATE] with diagnoses which included, encounter for orthopedic aftercare, acquired absence of left great toe, and type 2 diabetes.Resident 2's medical record was reviewed on 1/5/26.A review of resident 2's hospital discharge orders dated 5/15/25 at 1:08 PM, documented Cefazolin 2 GM [gram] (TRADE NAME: ANCEF 2 GM/100 ML [milliliters] IVPB) [intravenous piggyback] INTRAVENOUS EVERY 8 HOURS 50 days. The last dose was documented as being received on 5/15/25 at 7:24 AM at the hospital.A review of resident 2's medication orders revealed: a. On 5/15/25 an order for CeFAZolin Sodium Solution Reconstituted 1 GM Use 2 gram intravenously every 24 hours for infection for 50 Days.b. On 5/15/25 an order with a start date of 5/16/25 for CeFAZolin Sodium Solution Reconstituted 1 GM Use 2 gram intravenously one time a day for Bacteremia, osteomyelitis L [left] great toe, cellulitis for 50 Days.A review of resident 2's Medication Administration Record (MAR) revealed that resident 2 received 2 grams of Cefazolin once on 5/16/25. It should be noted that resident 2 did not receive any additional doses on 5/15/25.A review of resident 2's progress notes revealed:a. On 5/18/24 at 8:14 AM, a progress note documented, Late Entry May 15th Med error occurred. Iv [intravenous] Antibiotic was entered into the system incorrectly. Antibiotic was scheduled for q [every] 24 hours. Antibiotic was supposed to be given q 8 hours. Resident reports she didn't receive antibiotic the night of admission. Residentreports [sic] she told nursing staff several times that antibiotic was supposed to be q 8 hours instead of q 24 hours. Medication Error adjusted in computer. Education given to admitting nurse and floor nurse.b. On 5/19/25 at 1:00 AM, an encounter note documented, XXX[AGE] year old female who was recently admitted to our facility after hospitalization with osteomyelitis. Patient presented to the hospital and was diagnosed with sepsis secondary to osteomyelitis of her great left toe. She had surgical debridement by podiatry. She had positive margins and it was recommended that she have an aggressive course of antibiotic therapy. She is on Ancef therapy and is scheduled to be on this for the next 50 days.c. On 7/1/25 at 8:58 AM, a progress note documented, Follow up on Med [medication] Error that occurred on 5/15/25. House MD [medical doctor] aware of med error and discussed at clinical meeting and ID [infectious disease] MD aware of Iv antibiotic error.On 1/5/26 at 1:23 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that the facility obtained medication orders from the hospital. The DON stated that nursing managers did a chart review of medications and orders within 72 hours after a resident was admitted . The DON stated that all nurses were instructed to have nursing management verify and perform a double check on all medications that were ordered. The DON stated that she expected staff to input orders correctly and to notify the medical provider if there was a medication error. The DON stated that there was an incident report made about resident 2's medication error. The DON stated that the admitting nurse misread the order from the hospital.