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	06/25/2026

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 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 2 out of 40 sampled residents, the facility did not ensure each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident left the facility and called his daughter to report he was lost and a week later another resident, who needed to be supervised during a Leave of Absence, left the facility. Resident identifiers: 29 and 110.Findings included:1. Resident 110 was admitted to the facility on [DATE] and discharged on 3/27/26 and readmitted on [DATE] and discharged on 6/2/26 with diagnoses which included depression, alcohol dependence, and history of transient ischemic attack. The facility reported to the State Survey Agency (SSA) on 5/22/26 at 11:32 AM, that resident 110 took an uber to get a haircut and called his daughter because he did not know how to get back on 5/14/26 at 11:35 AM. The daughter called the facility and they went and picked him up. It should be noted the incident happened on 5/21/26, not 5/14/26 as reported. An elopement risk evaluation completed on 3/19/26, documented that resident 110 scored a 2. There was no information regarding what a score of 2 meant and if he was an elopement risk. It should be noted this was from his previous admission and he did not have a current elopement assessment. An admission Minimum Data Set assessment dated [DATE], revealed resident 110 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. An admission Nursing assessment dated [DATE], revealed resident 110 had altered mental status and was alert and oriented to person and place. There were no care plans regarding a possible wander risk or elopement. A nursing progress note dated 5/21/26 at 12:59 PM, revealed Resident left in an Uber to get a haircut and his nails done, notified his daughter when he was finished with the hair cut that he did not know how to get back. Resident [sic] daughter is concerned with his confusion as it is not baseline, notified NP [Nurse Practitioner], to obtain UA [urine analysis]. Resident is being retrieved from salon and back to the facility. Will place wander guard on resident to promote safety, daughter consent. A care plan focus area stating I utilize a wander guard devices to promote safety r/t [related to] potential or history of wandering/exit seeking was initiated on 5/26/26, along with the intervention wanderguard placed on 5/26/26. It should be noted the care plan was initiated 5 days after the incident. Resident 110 was found to have a urinary tract infection and was treated with antibiotics. The investigation the facility conducted into the incident was reviewed. There was a timeline that was created which revealed resident 110 left the building on 5/14/26 at 11:35 AM, unaccompanied in an Uber for a haircut. Shortly after resident 110 called his daughter stating he did not know how to get back. Resident 110's daughter called the facility and About 11:35 AM - 12:xx [sic] facility staff [name removed] went and picked him up. Resident was assessed upon return with no injuries. The facility determined the root cause was a: process gap - lack of a prominent, consistently utilized LOA [Leave of Absence] tracking mechanism at the main exit/front desk combined with momentary lapse in exit monitoring/verification for a resident with cognitive/mobility risk. The departure was not detected in real time because the sign-out step was not followed or verified. The Determination was This was an isolated event. There was no evidence of systemic neglect, willful failure to supervise, or violation of the resident's rights. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Documented precautions were in place. The identified gap was procedural and had been immediately addressed through process improvement. No substantiated finding of neglect was warranted. Corrective Action Implemented was improvement dedicated LOA sign-out book/process at front desk/main exit, updated care plan and elopement-risk interventions, staff education on elopement protocols and new LOA process, reinforce special instructions and exit monitoring, and Quality Assurance and Performance Improvement initiated a review. 2. Resident 29 was admitted to the facility on [DATE] and discharged on 6/4/26 with diagnoses which included chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, convulsions, dementia, heart failure and cannabis use. The facility reported to the SSA on 5/31/26 at 6:50 PM, resident 29 required supervised LOA when leaving the facility. Left the building at approximately 6:50 PM. Staff identified that the resident was missing and contacted police for assistance in locating him. The resident returned to the facility on his own at approximately 7:10 PM. The resident stated that he was going to the gas station. Resident's care status requires supervision for any leave of absence; he was not authorized to leave the facility unaccompanied.Planned/initiated actions: Reassess resident on return and monitor respiratory status; review and update care plan and elopement-risk interventions; review supervision/staffing and exit-monitoring for the affected area; reinforce supervised-LOA status with staff; confirm smoking materials remain secured; provide staff education on monitoring and elopement protocols; notify physician. Investigation initiated.An elopement risk evaluation was completed on 3/15/26 at 7:48 PM. Resident 29 scored a 12 which indicated he was at risk for elopements. Resident 29 had a prior elopement or near-elopement and other behaviors that put him at risk for elopements marked on the evaluation. There was no care plan located in resident 29's medical record regarding his elopement risk. There were no nursing progress notes in resident 29's medical record about the incident on 5/31/26.The facility investigation was reviewed and revealed, The incident was classified as an isolated event with an identified process gap that has been promptly corrected. The timeline was on 5/31/26 at 6:50 PM, resident left the facility unaccompanied. Between 6:55 PM until 7:05 PM, staff identified resident 29 was missing. Local police were contacted for assistance in locating him. At 7:10 PM, resident 29 returned to the facility independently. Resident 29 stated he went to the gas station. There were no signs of distress or injury and the resident assessed. Notified police of resident return. The facility conducted a root cause analysis and determination which revealed there was a process gap - lack of a prominent, consistently utilized LOA tracking book/log at the main exit/front desk combined with a momentary lapse in exit monitoring/verification of supervision status for a high-risk resident. The resident's departure was not detected in real time because the sign-out step was not followed or verified. The determination was that This was an isolated event. There is no evidence of systemic neglect, willful failure to supervise, or violation of resident's rights. Documented precautions (supervised LOA designated and special instructions) were in place. The identified gap was procedural and has been immediately addressed through process improvement. No substantiated findings of neglect is warranted. The corrective action was Resident reassessment [plus] respiratory monitoring on return. The facility Implemented a dedicated LOA sign-out book at the front desk/main exit. The resident's care plan was updated, staff education on elopement and new LOA book process. It should be noted that resident 29's care plan was not updated. It should also be noted this was not an isolated event. Resident 29 eloped from the facility after he was evaluated as unsafe to leave the facility without supervision on 5/31/26, despite the root cause analysis performed and corrective action taken after Resident 110 had left the faciity on 5/21/26.On 6/25/26 at 10:35 AM, an interview was conducted with the Administrator (ADM). The ADM stated he must have put the wrong date on the initial reporting of resident 110's elopement. The ADM stated that previously there was an LOA binder for residents to sign out at each nurses station, but there was no check in or sign out at the front door. The ADM stated the process was updated to require the receptionist to check out residents for LOA after resident 110 left. The ADM stated if a resident scored a 14 or higher on the elopement evaluation then the resident was at risk. The ADM stated nurses completed the elopement (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluation and then the Interdisciplinary Team reviewed the assessment and created the care plan. The ADM stated there was no assessment available during resident 110's last admission. The ADM stated the assessment was being revamped and was unavailable for review.On 6/25/26 at 1:36 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated resident 110's elopement assessment in March 2026 was not useful. The RNC stated the facility wanted to update their elopement assessment because some residents triggered to be at risk when they should not have been. The RNC stated resident 29 did not have an elopement assessment and the facility would have gone off of his BIMS score. On 6/25/26 at 2:43 PM, a follow up interview was conducted with the ADM. The ADM stated resident 110 went out of the facility on 5/21/26, and they got consent from the daughter to put a wanderguard on him that day. The ADM stated the LOA sign out book was moved to the front desk and an elopement drill was completed on 5/26/26. The ADM stated resident 29 did not have a history of elopements until he left on 5/31/26, because he wanted cigarettes. The ADM stated he was a wander risk and needed to be supervised for LOA because of his BIMS score. The ADM stated they discussed putting a wanderguard on him but he stated he would cut it off. The ADM stated resident 29 was transferred to another facility for safety. The ADM stated all staff were provided training on elopements on 6/17/26, after he had finalized what the investigations and corrective actions. The ADM stated training was provided to the front desk staff to check out the elopement risk book prior to allowing a resident to leave. The ADM stated the front desk staff and the Social Service Director were educated prior to 6/17/26, but resident 29 was able to leave the facility unsupervised and did not have an elopement evaluation completed.