STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465185	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millcreek Rehabilitation and Nursing	3520 South Highland Drive Salt Lake City, UT 84106

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, observation, and record review, for 1 of 5 sampled residents, the facility did not ensure that allegations of neglect were reported immediately to the State Survey Agency. Specifically, the facility did not report an incident where a resident was not secured while being transported in a facility van. Resident Identifier: 2 Findings include: The surveyor reviewed the facility's grievance binder. A resident grievance, dated 3/26/26, stated, Resident reported to SS/RA [social services/resident advocate] that during transportation to their appointment earlier this week, the [sic] observed that the other resident in the transport vehicle was not strapped in appropriately, resident specified that the residents w/c [wheelchair] was not anchored via straps to the van floor. It was documented that the grievance was confirmed. The corrective action to the grievance included: Driver 1 was written up and re-educated regarding the incident; all staff who drove the van were re-educated on the transport evaluation checklist; additional training on wheelchair securement, technique, and safety; and reminder for all staff on the importance of adhering to all safety guidelines. On 4/7/26 at 12:54 PM, an interview was conducted with the Administrator (ADM). The ADM stated when there was an abuse or neglect allegation, there was a trigger call made with the company [NAME] President, Corporate representative, and Director of Nursing (DON) to discuss if they felt like it was at the level of abuse to report. The ADM stated if anyone on the call felt it was abuse, then he reported the incident immediately, called the police and contacted Adult Protective Services. The ADM stated neglect was defined as residents not receiving goods and services. The ADM stated the incident was not reported to the State Survey Agency because they felt it didn't meet the criteria. The ADM stated resident 2 was not injured and Driver 1 went through retraining and a write up. The ADM was provided the definition of neglect and the ADM stated with the definition of neglect, the incident should have been reported.

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
	465185	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millcreek Rehabilitation and Nursing	3520 South Highland Drive Salt Lake City, UT 84106

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. Based on interview, observation, and record review, for 1 of 5 sampled residents, the facility did not ensure that a resident's environment remained free of accident hazards. Specifically, a resident's wheelchair was not secured during transport. Resident Identifier: 1 and 2. It was determined the provider's non-compliance with the requirements of participation caused potential harm However, based on the facility's corrective actions and a review of its current compliance in this regulatory area, the deficiency was determined to be past noncompliance. 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 on 3/27/26, educated and retrained all staff members who transport residents. Specifically, the facility provided Driver 1 with additional training, during which he demonstrated his step-by-step knowledge of proper wheelchair securement, and all drivers were given additional education to ensure ongoing compliance. In addition,, the Administrator performed random audits. Findings include: The surveyor reviewed the facility's grievance binder. A resident grievance, dated 3/26/26, stated, Resident reported to SS/RA [social services/resident advocate] that during transportation to their appointment earlier this week, the [sic] observed that the other resident in the transport vehicle was not strapped in appropriately, resident specified that the residents w/c [wheelchair] was not anchored via straps to the van floor. It was documented that the grievance was confirmed. The corrective action to the grievance included: Driver 1 was written up and re-educated regarding the incident; all staff who drove the van were re-educated on the transport evaluation checklist; additional training on wheelchair securement, technique, and safety; and reminder for all staff on the importance of adhering to all safety guidelines. On 4/7/26 at 11:51 AM, an interview was conducted with Driver 1. Driver 1 stated he transported resident 2 and assisted her into the building for her appointment. Driver 1 stated after determining they were at the wrong location, he drove to the correct destination across the parking lot but failed to secure resident 2's wheelchair with straps. Driver 1 provided a text message dated 3/25/26, that he wrote to the Administrator that stated, During the short transfer, I made a mistake and did not secure the wheelchair with straps, as the distance was very close. I understand this was not the correct procedure, and I take responsibility for it. On 4/7/26 at 11:07 AM, an interview was conducted with resident 1. Resident 1 provided a video of resident 2 in a facility van in a wheelchair not secured. Driver 1 was observed in the video driving and holding the base of resident 2's wheelchair with his right hand. Resident 2 was observed to be holding on to the back of the driver's seat. The video was 49 seconds long, and the speed of the vehicle was unable to be determined from the video. On 4/7/26 at 11:00 AM, an interview was conducted with resident 2. Resident 2 stated that staff transported her in the van to appointments. Resident 2 stated that the staff always secured her wheelchair and made sure she was buckled, and that she had never been injured or had an incident in the van. On 4/7/26 at 12:07 PM, an interview was conducted with the Director of Nursing (DON) regarding the incident with resident 2. The DON stated that Driver 1 transported resident 2 around the building and when he put her back in the van, he did not put the wheelchair strap on appropriately because it was just in the same parking lot. The DON stated Driver 1 did not secure resident 2 in the van and he should have done that. The DON stated immediately they did training again with Driver 1 regarding no matter the distance, the resident must be secured. The DON stated Driver 1 also received a write up for not securing resident 2 in the van prior to transporting. On 4/7/26 at 12:54 PM, an interview was conducted with the Administrator (ADM). The ADM stated Driver 1 was at a large campus with lots of medical offices and he had gone to the wrong building 3 times. The ADM stated Driver 1 did not secure resident 2's wheelchair in the van because the office building was in the same parking lot and driver 1 was in a hurry. The ADM stated Driver 1 was written up and step by step directions on how to secure the wheelchair were done immediately. The ADM stated when a resident is not secured, they could sustain an injury. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465185	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millcreek Rehabilitation and Nursing	3520 South Highland Drive Salt Lake City, UT 84106

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	ADM stated after the incident with resident 2, all van drivers received retraining, and increased monitoring was implemented for Driver 1 when he left the facility to make sure residents were secured The ADM stated the changes were implemented on 3/27/26.