STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465186	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs Senior Living	350 East 2200 North North Logan, UT 84341

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, food items in the refrigerator and freezer were undated, and sanitizer buckets did not meet the required sanitation testing levels. Findings included: 1. On 2/23/26 at 8:25 AM, an initial tour of the kitchen was conducted. The following observations were made: a. The Dietary Manager (DM) was behind the preparation table and was not wearing a hairnet. b. An opened and undated bag of whipped topping was in the refrigerator. c. A pan of meatballs was undated in the refrigerator. d. A bag of frozen rolls were opened and undated in the freezer. e. The sanitation bucket at the preparation table was tested by the DM and resulted at 150 parts per million (PPM). The DM stated that the level should be at 200 PPM. The DM stated that she needed to pour out the water from the bucket and start again. The DM stated that the sani buckets were changed at least three times a day after every meal service. 2. On 2/24/26 at 9:09 AM, a follow-up tour of the kitchen sanitation was conducted. The sanitation bucket at the front end of the kitchen tested at 150 PPM. The DM stated that it should be at 200 PPM. The DM stated that the dishwasher was responsible for changing the sanitation buckets and that he changed the sanitation bucket at 8:00 AM, that morning. On 2/24/26 at 9:13 AM, an interview was conducted with the dishwasher. The dishwasher stated that he was responsible for preparing the sanitation buckets and that he changed the solution when they transitioned from breakfast to lunch. The dishwasher stated that he had not changed the sanitation buckets in the kitchen that morning because dishes had started to pile up and he needed to get them washed. 3. On 2/25/26 at 10:46 AM, a follow-up tour of the kitchen was conducted. The following observations were made: a. An opened dijon honey mustard was opened and undated in the refrigerator. b. A bag of opened and undated frozen rolls were in the freezer. On 2/25/26 at 10:55 AM, a follow-up interview was conducted with the DM. The DM stated that all items in the refrigerator and freezer should have dates on them. The DM stated that she expected all of her staff to wear a hairnet while in the kitchen, including herself. The DM stated that she had new kitchen staff and some of them were not dating foods when they were placed in the refrigerator and freezer or when they opened items. The DM stated that the sanitation buckets should be at the correct sanitation levels and if they were not then they were not sanitizing surfaces to kill germs.

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
	465186	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs Senior Living	350 East 2200 North North Logan, UT 84341

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, for 1 of 39 sampled residents, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice. Specifically, a resident was not provided crushed medications as ordered by the physician. Resident identifier: 64. Findings include: Resident 64 was admitted to the facility on [DATE] and discharged on 1/5/26 with diagnoses which included fractures of right pubis and left pubis, sacrum fracture, dysphagia, and age-related osteoporosis. Resident 64's medical record was reviewed 2/23/26 through 2/25/26. The facility reported to the SSA on 12/30/25, that resident 64's family reported resident 64 was receiving whole pills instead of crushed medications. The investigation revealed that resident 64 had 3 medications that were not able to be crushed. Resident 64's Discharge Summary from the hospital dated 12/20/25, revealed resident 64 was observed to have an episode of choking on toast while eating breakfast. There were reports this had been going on for about 6 months, mostly with bread. A Speech Language Pathology (SLP) evaluation and Treatment was completed on 12/19/25. The use of swallow strategies were documented to sit upright as much as possible, single small bites and sips, slow rate, turn head for solids, continue to add moisture, chase with a liquid sip, and chew well. A diet order and communication dated 12/20/25, revealed regular soft and bite sized. There were no chewing/swallowing problems checked on the order. SLP Evaluation and Treatment Plan from 12/22/25 through 1/20/26, revealed Pills/meds [medications]= [equal] severe: Clinical S/S [signs and symptoms] dysphagia: difficulty initiating oral stage coughing after swallow and watery eyes. No recommendations regarding medication texture were documented. A diet order and communication dated 12/23/25, revealed regular, thin liquids with allergies to red dye. Medication Administration: crushed in puree. A Physician's order dated 12/23/25, revealed Crush meds r/t [related to] choking risk. every shift for choking risk. There were nurses' initials in the Medication Administration Record twice daily. On 12/30/25, the Director of Nursing performed a crushed medication audit. The following medications were not able to be crushed and were administered until 12/31/25. a. Align Oral Capsule give 4 milligrams (mg) by mouth every morning for probiotic. It was noted Acidophilus. b. Cholecalciferol Oral tablet 50 micrograms give 3 tablets by mouth in the morning for supplement. It was noted will get tab [tablet] form. c. Celebrex Oral Capsule 200 mg give 1 capsule by mouth in the morning for pain management. It was noted the capsule could be opened. d. Vitamin E Oral tablet give 400 units by mouth in the morning for supplement. It was noted needs a tablet form. e. Tamsulosin hydrochloride oral capsule 0.4 mg give 1 capsule by mouth in the morning for urine retention. It was noted get different form. f. PreserVision AREDS 2 oral capsule give 2 capsule by mouth in the morning for supplement. It was noted tab next to the medication. On 12/31/25 at 4:01 PM, there was a progress note Doing crush med audit and will DC [discontinue] Align and start Acidophilus, Vitamin E, Preservation will be sent in different form Celecoxib can be opened. On 2/25/26 at 12:28 PM, an interview was conducted with the Administrator. The Administrator stated the facility had a process with the SLP after admission to have the resident evaluated for medication swallowing. The Administrator stated the facility used to have a physician's order to Crushed as needed for medications but they felt that was too much on the nurse to determine when a medication needed to be crushed. The Administrator stated the physician now gave orders on crushing medications or not. The Administration stated during the investigation regarding resident 64's medication not being crushed, they found there were medications that could not be crushed so the Director of Nursing reached out to the pharmacist to determine if medications needed to be changed in order for them to be crushed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465186	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs Senior Living	350 East 2200 North North Logan, UT 84341

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, the facility did not ensure each resident had supervision to prevent accidents. Specifically, for 2 out of 39 sampled residents, a resident was not secured in the facility van and tipped backwards sustaining a closed head injury. This example was cited at a harm level. Resident identifier: 73. Findings included: Resident 73 was admitted to the facility on [DATE] and discharged on 6/21/25 with diagnoses which included urinary tract infection, acute respiratory failure with hypoxia, chronic kidney disease, hypertension, diastolic heart failure, and anxiety. The facility reported to the State Survey Agency (SSA) on 5/29/25, that resident 73 was transported to an appointment when her wheelchair tipped backwards and she bumped her head on the ramp that was folded up behind her. The transport driver asked resident 73 if she was okay, tipped the wheelchair upright, and strapped the front of the chair in, and took her to instacare where her appointment was and ensured that the medical staff knew of the event so they could assess her. Resident 74's medical record was reviewed on 2/23/26 through 2/25/26. There was no information on the incident in resident 74's medical record. There were neurological checks completed after. A final report from an Urgent Care Clinic dated 5/29/25, revealed resident 74 presented for an evaluation of a head injury after an injury earlier today. The patient reported that she was in a facility transport vehicle when her wheelchair was not secured and it rolled back and she struck her head on the back door. She did not lose consciousness and did not have any pain or symptoms present. She came in here for evaluation based on recommendation from her primary care clinic. She denies headache, neck pain, or back pain. Resident 74 was diagnosed with a closed head injury. On 2/25/26 at 8:34 PM, an interview was conducted with the Transportation Director (TD). The TD stated when he started with transportation 5 years ago, he was not provided much training besides how to secure a resident in the van. The TD stated he had transported with another facility prior. The TD stated there were 4 staff who transported residents including Transportation Driver 1. The TD stated Transportation Driver 1 occasionally transported residents maybe one time per week and had been a driver for 5 years. The TD stated 2 to 3 years ago the facility developed an online training for drivers and the drivers completed it yearly. The TD stated resident 74 was loaded into the van and there were back straps hooked but not the front straps. The TD stated resident 74 fell backwards, hit her head, and chipped some teeth. The TD stated after the incident a training with drivers was completed on how to hook in the wheelchairs and a sign was placed in the van to make sure all straps were secured correctly. The TD stated he also completed a monthly check off. The TD provided the Securement 101: Basic Wheelchair Securement Training certificates for the drivers including Transportation Driver 1 which was completed on 4/17/24. In addition, a form titled Resident Transportation Checklist was completed on 1/13/26, with no concerns. On 2/25/26 at 8:40 AM, an interview was conducted with Transportation Driver 1. Transportation Driver 1 stated he occasionally did transport, usually less than one time per week. Transportation Driver 1 stated he had been transporting residents for about 8 years. Transportation Driver 1 stated he received online training and there were monthly checks done by the TD to make sure they were correctly placing residents in the vehicle and making sure everything was safe. Transportation Driver 1 stated there were two vans and one had built-in retention straps in the front secured to the floor and the other van had a place to secure straps. Transportation Driver 1 stated resident 74 was in the van that did not have the built in retention straps. Transportation Driver 1 stated he secured the back 2 straps but forgot the front straps and when he stopped she tipped over. Transportation Driver 1 stated she did not fall all the way to the floor but was tipped at a 45 degree angle backwards in her wheelchair. Transportation Driver 1 stated he asked if resident 74 was okay and she said yes, so he lifted her chair upright, secured the 4 straps and took her to an appointment. Transportation Driver 1 stated he informed her father of what (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465186	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs Senior Living	350 East 2200 North North Logan, UT 84341

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	happened so he could let the physician know. Transportation Driver 1 stated there was a sign placed in the van to remind the driver to check for all 4 straps before transporting a resident. On 2/25/26 at 12:23 PM, an interview was conducted with the Administrator. The Administrator stated the training process for transportation drivers was to submit their drivers license to the facility insurance, orientation was done, and an on-line training on how to latch the equipment. The Administrator stated the TD then passed off the driver by observing the driver securing residents in the van. The Administrator stated there were 2 different vans used, one of the vans had four built in straps to the floor of the van. The Administrator stated the one that resident 74 was in was different and the straps needed to be latched in the front to the floor hooks. The Administrator stated Transportation Driver 1 loaded resident 74 into the van and unfortunately forgot the front hooks. The Administrator stated when he was down the street from the facility resident 74 tipped backwards but did not fall. The Administrator stated Transportation Driver 1 continued on to resident 74's appointment after securing her in the van because there were no visible signs of injury at that time. The Administrator stated after the incident, there was a discussion of what to do and they determined adding a sign to the van to remind the driver to secure in 4 areas was appropriate. The Administrator stated all transportation drivers were educated to call emergency medical services if there was an accident of any kind to assess the resident. The sign was hung in the van on 5/29/25. On 2/25/26, an observation was made of the van and there was a stop sign on the glove box reminding staff to secure the straps.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465186	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs Senior Living	350 East 2200 North North Logan, UT 84341

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility did not ensure that all drugs and biologicals were stored and labeled in accordance with accepted professional principles, under proper temperature controls and cautionary instructions, and the expiration date when applicable. Specifically, for 1 out of 39 sampled residents, a controlled drug was stored in a manner that failed to prevent potential drug diversion and ensure safe medication administration. Resident Identifier: 21. Findings included: On 2/25/26 at 10:38 AM, during a review of the facility's medication carts, an observation was made of a blister pack containing Percocet 10-325 milligram tablets. The blister pack had 1 tablet taped into an opened blister cell. The Percocet, a Schedule II narcotic, was prescribed for resident 21. At the time of the observation an interview was conducted with Registered Nurse (RN) 2. RN 2 stated medication tablets should not be taped back into blister cells to prevent the incorrect medication from being replaced in the blister cell. Additionally, RN 2 stated if a narcotic tablet was removed from the blister cell and not administered, the tablet needed to be wasted (destroyed) with another nurse acting as witness. On 2/25/26 at 2:46 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if a medication was not administered, it should have been wasted in the drug disposal system that was available on all medication carts. The DON elaborated that if the medication was a controlled substance it would need to be wasted with another nurse witnessing and documented in the narcotic log. The DON stated medications would not be securely stored if taped into blister cells and could unintentionally fall out. Additionally, the DON stated taping medications into blister cells increased the risk of cross contamination and medication errors, such as the incorrect medication being returned to the blister cell or the medication being returned to the incorrect blister pack.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465186	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs Senior Living	350 East 2200 North North Logan, UT 84341

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Specifically, for 2 out of 39 sampled residents, one resident had a urinary catheter bag observed on the floor, and for a second resident receiving wound care, hand hygiene and glove changes were not performed. Resident identifiers: 2 and 9. Findings included: 1. Resident 9 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction, retention of urine, and obstructive and reflexive uropathy.Resident 9's medical record was reviewed.A physician's order with a start date of 1/28/26, documented, Catheter cares: Clean foley site with soap and water, check foley for kinks and that foley bag is being kept below the bladder and off the floor in privacy bag. every morning and at bedtime for foley use Do not irrigate. Change catheter and tubing prior to obtaining a sample for UA/UC [urinalysis/urine culture].The following observations were made of resident 9:a. On 2/23/26 at 10:18 AM, resident 9 was sitting in a recliner in his room. His urinary catheter bag was observed on the floor of his room to the left side of the recliner and was not in a privacy bag.b. On 2/24/26 at 10:07 AM, resident 9 was sitting in his recliner. His urinary catheter bag was observed to be on the floor next to a yellow basin and was not in a privacy bag.On 2/24/26 at 10:08 AM, an interview was conducted with resident 9. Resident 9 stated that he had just returned from physical therapy and wanted to sit in his recliner. Resident 9 stated that staff placed his urinary catheter bag on the floor anytime he was out of his wheelchair.On 2/24/26 at 11:04 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated urinary catheter bags should not be placed on the floor because the floor was not clean. CNA 1 stated that the urinary catheter bag should be hanging up off the floor.On 2/25/26 at 10:20 AM, an interview was conducted with CNA 2. CNA 2 stated that if a resident was sitting in a recliner or in bed the urinary catheter bag should be placed in a yellow basin. CNA 2 stated that a urinary catheter bag should not be placed on the floor because it was an infection hazard. On 2/25/26 at 10:23 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that urinary catheters need to be stored in the yellow buckets that were kept in the resident's room. RN 1 stated that storing a urinary catheter bag on the floor was an infection control issue because the bags could leak and it was safer for the resident and staff. On 2/25/26 at 10:25 AM, an interview was conducted with the Physical Therapy Assistant (PTA). The PTA stated that if she was doing therapy with a resident that had a urinary catheter she would make sure that the urinary catheter bag went into the yellow basin and never on the floor. The PTA stated there could be contamination risks if the urinary catheter bag was placed directly on the floor. On 2/25/26 at 10:35 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that catheter bags should be placed in a basin with a privacy bag and not on the floor. The DON stated that if urinary catheter bags were placed on the floor there was an increased risk of infection to the resident.2. Resident 2 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, orthopedic aftercare of the left ankle.Resident 2's medical record was reviewed. On 2/18/26, resident 2's wound care orders documented Pressure Sore L [left] Heel: Cleanse w/ [with] NS [normal saline] or Wound Cleanser, (No topicals) Cover w/Non-Adherent Pad as Primary, Place Offloading Dressing as Secondary, Secure w/Keflex and Tape.On 2/25/26 at 10:43 AM, an observation was made of resident 2's wound care by Licensed Practical Nurse (LPN) 1. LPN 1 was observed to perform hand hygiene, don a disposable gown, gloves, and mask prior to initiating wound care. LPN 1 was observed to remove resident 2's old dressing from the left foot and discard them. LPN 1 did not doff the dirty gloves, perform hand hygiene and don new clean gloves prior to continuing with wound care. LPN 1 then obtained a sterile 4 x 4 gauze pad that was soaked in normal saline from the bedside table and cleaned resident 2's left foot dorsum surgical incision, left lateral foot surgical (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465186	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Springs Senior Living	350 East 2200 North North Logan, UT 84341

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incision, and the left heel pressure ulcer. All three wound sites were cleaned with a new gauze pad. An immediate interview was conducted with the LPN 1 upon exit of resident 2's room. LPN 1 stated that she switched out gloves and performed hand hygiene when placing ointment or cream on the wound bed. LPN 1 stated that she should have doffed her dirty gloves and performed hand hygiene after removing resident 2's old dressing and prior to cleaning the wound bed. On 2/25/26 at 11:32 AM, an interview was conducted with the DON. The DON stated that staff should reduce the risk of infection with wound care by performing hand hygiene, having all equipment prepped prior to initiation, and following wound care orders.