STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A064	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Creek Rehabilitation and Nursing	876 West 700 South Salt Lake City, UT 84104

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility did not use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Specifically, the facility did not always have a registered nurse at least 8 consecutive hours on certain weekends.Findings Included: Findings Included:The facility's staffing schedules from September 2025 to October 2025 were reviewed.-There was no RN scheduled on 9/14/25.-There was no RN scheduled on 9/28/25.On 10/8/25 at 2:58 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that they did not need to have a registered nurse scheduled on every shift. The DON stated that they did not do admissions on the weekends and if the residents needed an assessment completed the nurse would call her. On 10/8/25 at 3:21 PM, an interview was conducted with the Administrator (Admin). The Admin stated if the residents needed intravenous therapy or a wound vacuum then they would send them out. The Admin stated they were not sure if it was necessary to have a registered nurse on every shift based on the type of facility they were and that they were trying to get guidance on whether they needed to have a registered nurse work 8 hours a day. On 10/8/25 at 3:47 PM, a follow up interview was conducted with the Admin who stated that there was only a Licensed Practical Nurse working on the 14th and the 28th of September, no Registered Nurse worked in the facility on those days.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that the resident's transfer or discharge was documented in the resident's medical record and the information was communicated to the receiving provider to ensure a safe and effective transition of care. Specifically, for 3 out of 23 sampled residents, the resident's medical record did not contain documentation of what information was sent to the receiving provider and the transfer or discharge was not documented. In addition, a resident that was discharged to the hospital was not provided with a bed hold notice. Resident identifiers: 31, 33, and 38. Findings included: 1. Resident 31 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, paranoid schizophrenia. Resident 31's medical record was reviewed. A discharge return not anticipated Minimum Data Set (MDS) assessment dated [DATE], documented that resident 31's discharge status was short-term general hospital. Resident 31's medical record revealed no documentation of a transfer/discharge summary, what information was sent to the receiving provider, a bed hold notice at the time of transfer, and there was no documentation regarding where resident 31 was transferred or discharged to. 2. Resident 33 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema. Resident 33's medical record was reviewed. A discharge return anticipated MDS assessment dated [DATE], documented that resident 33's discharge status was nursing home. On 8/8/25 at 5:06 PM, an Orders - Administration Note documented House Supplement two times a day for poor oral intake related to UNSPECIFIED PROTEIN-CALORIE MALNUTRITION Encourage resident to drink, document %m [percent] of intake discharged to other facility. Resident 33's medical record revealed no documentation of a transfer/discharge summary, what information was sent to the receiving provider, and there was no documentation regarding where resident 33 was transferred or discharged to. 3. Resident 38 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease. Resident 38's medical record was reviewed. Resident 38's face sheet revealed a date of discharge of 5/15/25. Resident 38's medical record revealed no documentation of a transfer/discharge summary, what information was sent to the receiving provider, and there was no documentation regarding where resident 38 was transferred or discharged to. On 10/8/25 at 9:08 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated if a resident needed to go to the hospital she would make sure the resident was stable and call emergency services. LPN 1 stated she would print a face sheet and medication list. LPN 1 stated she would give the paramedics report when they arrived. LPN 1 stated she would document the hospital transfer in the medical record. On 10/8/25 at 10:21 AM, an interview was conducted with the Director of Nursing (DON). The DON stated if a resident discharged home the provider would see the resident to make sure they were safe or needed any services. The DON stated the Social Worker would set up any services and would notify the Ombudsman. The DON stated if the transfer was an emergency staff would call the doctor, print a face sheet, medication order summary, and call emergency services. The DON stated the staff should complete a discharge summary report and make a progress note. The DON stated a bed hold notice was provided to the residents on admission and when they were transferred to the hospital. The DON stated that the three residents were discharged to sister facilities. The facility Bed Hold Policy and Notification policy revised on 5/24/2023, documented It is the policy of this facility to provide any resident that is transferred to a general acute care hospital the right to exercise the bed hold provision. The resident or resident's representative has the right to exercise the bed hold provision of three (3) days. Medicaid will not cover the cost of the bed hold. Insurance plans may or may not cover for bed hold. Residents will be liable for the cost of the bed hold days. Upon transfer to a general acute care hospital the resident or (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident representative shall notify the facility within twenty-four (24) hours after being informed of the right to have the bed held, if the resident desires the bed hold. If the resident's attending physician notifies the facility in writing that the resident's stay in the general acute care hospital is expected to exceed three (3) days, the facility shall not be required to maintain the bed hold.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, for 3 out of 23 sampled residents, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs. An unnecessary drug was defined as any drug when used in excessive dose; or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences. Specifically, blood pressure medications were administered outside of the physician's ordered parameters. Resident identifiers: 1, 4, and 6. Findings included: 1. Resident 1 was admitted on [DATE] and readmitted on [DATE] with diagnoses that included traumatic subarachnoid hemorrhage, chronic obstructive pulmonary disease, chronic respiratory failure, dementia, paranoid schizophrenia, and pleural effusion. Resident 1's medical record was reviewed 10/6/25 through 10/8/25. A physician's order dated 9/25/24 indicated, Midodrine HCl [hydrochloride] Oral Tablet (Midodrine HCl) Give 5 mg [milligrams] by mouth three times a day for hypotension Hold for Systolic [blood pressure] over 110. The Medication Administration Record for October 2025 indicated that resident 1 received Midodrine 9 times when it should have been held due to a systolic blood pressure (BP) of more than 110: On 10/4/25, resident 1 had a BP of 120/76 and a BP of 126/83 two times; On 10/5/25, resident 1 had a BP of 120/79 two times; On 10/6/25, resident 1 had a BP of 158/81 and a BP of 120/80; and On 10/7/25, resident 1 had a BP of 130/79 two times. It should be noted that resident 1 received Midodrine when it should have been held due to a systolic blood pressure of more than 110, 23 times in September 2025 and 17 times in August 2025. 2. Resident 6 was admitted on [DATE] with diagnoses that included dementia, hypertension, hyperlipidemia, and chronic respiratory failure. Resident 6's medical record was reviewed 10/6/25 through 10/8/25. A physician's order dated 6/3/25 indicated, Metoprolol Tartrate Oral Tablet (Metoprolol Tartrate) Give 12.5 mg by mouth two times a day for HTN [hypertension] Give 1 tablet by mouth one time a day for HTN hold for SBP [systolic blood pressure] under 110, HR [heart rate] under 60. The Medication Administration Record for October and September 2025 indicated that resident 1 received Metoprolol 9 times when it should have been held due to a systolic blood pressure of less than 110: On 10/5/25, resident 6 had a BP of 105/64; On 9/29/25, resident 6 had a BP of 97/59; (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/27/25, resident 6 had a BP of 99/60; and On 9/18/25, resident 6 had a BP of 94/67. On 10/8/25 at 9:39 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated Midodrine raised blood pressure and should have been given within the parameters. LPN 1 stated if the systolic blood pressure was above 110, it should have been held because it would make the blood pressure go even higher and that could be bad. On 10/8/25 at 10:00 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that the Certified Nursing Assistants (CNAs) obtained the blood pressures but the nurses would review them before giving blood pressure medications. The DON stated that nurses were expected to review the parameters in the order before giving the medication. On 10/8/25 at 10:08 AM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated the nurses may get confused with Midodrine because it raises the blood pressure instead of lowering it. The RNC stated that the parameters are very clear in the orders and that was something that they would need to educate nurses on. 3. Resident 4 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, seizures, asthma, hypertensive heart disease and chronic obstructive pulmonary disease. Resident medical record reviewed 10/7/25. A physician order dated 4/20/21 indicated, Propranolol HCl Tablet Give 20 mg by mouth two times a day related to EXTRAPYRAMIDAL AND MOVEMENT DISORDER, UNSPECIFIED Hold for SBP < [less than] 110 and/or Pulse < [less than] 60. The Medication Administration Record for August, September and October 2025 documented resident 4 received Propranolol 28 times when it should have been held for a systolic blood pressure less than 110. Propranolol was given out of parameters on the following dates: On 8/8/25 for B/P of 109/75 and 98/58 On 8/10/25 for B/P of 102/62 On 8/15/25 for B/P of 98/57 and 90/67 On 8/16/25 for B/P of 101/53 On 8/17/25 for B/P of 105/79 On 8/18/25 for B/P of 106/65 On 8/19/25 for B/P of 105/65 On 8/24/25 for B/P of104/79 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/25 for B/P of 100/69 On 9/3/25 for B/P of 108/63 On 9/12/25 for B/P of 107/67 On 9/13/25 for B/P of 109/53 On 9/14/25 for B/P of 100/70 and 102/60 On 9/15/25 for B/P of 105/96 and 106/78 On 9/18/25 for B/P of 102/68 and 99/67 On 9/22/25 for B/P of 105/71 On 9/26/25 for B/P of 105/69 9/30 109/85 On 10/2/25 for B/P of 101/60 On 10/3/25 for B/P of 89/47 On 10/5/25 for B/P of 100/65 On 10/6/25 for B/P of 102/68 On 10/7/25 for B/P of 109/86 This surveyor interviewed LPN 1, on 10/7/25 at 10:15 AM, who stated the nurse should check the orders and the resident's blood pressure before giving a blood pressure medication. This surveyor interviewed the DON, on 10/8/25 at 10:01 AM who stated the nurses were expected to review the parameters before they administer the medications. The DON stated they expected the nurses to follow those parameters, and they should have held the propranolol for resident 4 when it was below 110. This surveyor interviewed the RNC, who stated the doctor had tried to get rid of blood pressure medication parameters with the residents at the facility. The RNC stated there were dates where resident 4 was given the medication out of the ordered parameters.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not prevent misappropriation of a resident's property. Specifically, for 1 out of 23 sampled residents, a resident gave a Nursing Assistant (NA) money and the NA did not return the money when the resident asked for the money back. Resident identifier: 38. Findings included: Resident 38 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, generalized anxiety disorder, and adjustment disorder with mixed disturbance of emotions and conduct. Resident 38's medical record was reviewed. The facility Incident Report Form was reviewed. On 3/4/25 at 1:37 PM, resident 38 reported that she had learned that the (Nursing Assistant) NA was having some struggles financially and resident 38 offered to give the NA $100.00 to help. After multiple attempts resident 38 finally forced the funds in the NA's pocket and the NA accepted the funds. After a few days resident 38 texted the NA asking for the $100.00 back so resident 38 could pay for some personal storage expenses. The NA did not respond to resident 38 and resident 38 reported the issue to two different staff members to ask for help. The facility Follow-up Investigation Report was reviewed. Resident 38 reported that she wanted to do something nice for the NA and felt bad for the NA's situation. Resident 38 reported that she gave the NA $100.00 and was not hearing back from the NA now. Resident 38 reported it was getting to the point where resident 38 really needed her money back and had not heard from the NA. The summary of interviews with staff documented that multiple staff members commented on how upset resident 38 was and how worried she was getting. Many staff members agreed that resident 38 felt bad for the NA in question and that resident 38 was trying to do the right thing to help the NA. The alleged perpetrator statement dated 3/4/25 at 1:00 PM, documented that the NA was talking to resident 38 about her financial situation and talking about life. After resident 38 found out that she was struggling a little bit, resident 38 offered her $100.00 to help get her by. The NA reported that she did not accept the money at first but after she kept pressing and put the money in her pocket she kept the money. The NA reported that she did not know it was not allowed. A staff interview documented Spoke to her [the resident] in tears about the situation. She was upset that she wasn't hearing back from [name redacted]. An additional staff interview documented I know she is really upset she doesn't have her funds. The employee was terminated and the facility verified the allegation.On 10/8/25 at 11:22 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that she did not currently work at the facility but she was the RA when she did. The RA stated that she was informed that resident 38 let a NA borrow $100.00, and the NA had not paid it back. The RA stated that resident 38 had no changes in behavior. The RA stated that she notified the Administrator (ADM) and Director of Nursing once she became aware of the incident. The RA stated that she did not help with investigating incidents. The RA stated that abuse training was provided to staff twice a year and the training included signs and symptoms of abuse, who to report allegations to, and the time frame of reporting. On 10/8/25 at 1:22 PM, an interview was conducted with the ADM. The ADM stated that he was not the ADM when the incident with resident 38 had occurred. The ADM stated he called the prior ADM and was told that he had not been completely in the loop regarding that incident. The ADM stated that the prior ADM spoke with corporate staff and was told to pay resident 38 back the money that was taken. The ADM stated that was all the prior ADM could say. The ADM stated that yes he would have called local law enforcement and reported the allegation. The ADM stated that he would investigate the allegation by speaking with the individual and the resident. The ADM stated that he would have assessed how the resident was doing. The ADM stated that he would have completed the typical investigation stuff and he would have asked for the money back from the individual that took it. The ADM stated that he had a curriculum of training that he presented at the all staff monthly meetings. The ADM stated that abuse was presented twice a year. The ADM stated if there was a unique case he would bring abuse up again. The ADM stated there was no training that he could find regarding the incident with resident 38.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure all alleged violations involving abuse, including misappropriation of resident property, were reported immediately, but not later than two hours after the allegation was made, to Adult Protective Services (APS) and local law enforcement. Specifically, for 1 out of 23 sampled residents, an allegation of misappropriation of resident property was not reported to law enforcement and the report to APS was reported 17 days after the allegation. Resident identifier: 38. Findings included: Resident 38 was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, chronic obstructive pulmonary disease, generalized anxiety disorder, and adjustment disorder with mixed disturbance of emotions and conduct. Resident 38's medical record was reviewed. The facility Incident Report Form was reviewed. On 3/4/25 at 1:37 PM, resident 38 reported that she had learned that the (Nursing Assistant) NA was having some struggles financially and resident 38 offered to give the NA $100.00 to help. After multiple attempts resident 38 finally forced the funds in the NA's pocket and the NA accepted the funds. After a few days resident 38 texted the NA asking for the $100.00 back so resident 38 could pay for some personal storage expenses. The NA did not respond to resident 38 and resident 38 reported the issue to two different staff members to ask for help. The alleged perpetrator statement dated 3/4/25 at 1:00 PM, documented that the NA was talking to resident 38 about her financial situation and talking about life. After resident 38 found out that she was struggling a little bit, resident 38 offered her $100.00 to help get her by. The NA reported that she did not accept the money at first but after she kept pressing and put the money in her pocket she kept the money. The NA reported that she did not know it was not allowed. The employee was terminated and the facility verified the allegation. The APS report included with the facility investigation was submitted on 3/21/25 at 1:51 PM. The facility Alleged Resident Abuse/Neglect Investigation Checklist documented Notification of Police was not applicable. On 10/8/25 at 11:22 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that she did not currently work at the facility but she was the RA when she did. The RA stated that she was informed that resident 38 let a NA borrow $100.00, and the NA had not paid it back. The RA stated that resident 38 had no changes in behavior. The RA stated that she notified the Administrator (ADM) and Director of Nursing once she became aware of the incident. The RA stated that she did not help with investigating incidents. The RA stated that abuse training was provided to staff twice a year and the training included signs and symptoms of abuse, who to report allegations to, and the time frame of reporting. On 10/8/25 at 1:22 PM, an interview was conducted with the ADM. The ADM stated that he was not the ADM when the incident with resident 38 had occurred. The ADM stated he called the prior ADM and was told that he had not been completely in the loop regarding that incident. The ADM stated that the prior ADM spoke with corporate staff and was told to pay resident 38 back the money that was taken. The ADM stated that was all the prior ADM could say. The ADM stated that yes he would have called local law enforcement and reported the allegation. The ADM stated that he would investigate the allegation by speaking with the individual and the resident. The ADM stated that he would have assessed how the resident was doing. The ADM stated that he would have completed the typical investigation stuff and he would have asked for the money back from the individual that took it. The ADM stated that he had a curriculum of training that he presented at the all staff monthly meetings. The ADM stated that abuse was presented twice a year. The ADM stated if there was a unique case he would bring abuse up again. The ADM stated there was no training that he could find regarding the incident with resident 38.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined, for 1 of 23 sampled residents, that the facility did not arrange outside resources in a timely manner for residents. Specifically, a resident with a referral to see a neurologist for evaluation was not completed. Resident identifier: 14.Findings included: Resident 14 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, arthropathies or the left and right hips, schizoaffective disorder, peripheral neuropathy, and spondylosis. Resident 14's medical record was reviewed. On 10/6/25 at 3:20 PM, an interview was conducted with resident 14 who stated he had asked to see a doctor about the numbness in his left hand but that had not happened yet. A physician order dated 7/11/25 documented, Neurology consult for left hand weakness for EMG [electromyography] A progress note dated 6/25/25 documented, Physical exam: Notable for mild degenerative changes in the right elbow and an olecranon spur in the left elbow. He reports occasional pain in his left arm, despite normal x-ray findings, and is scheduled for a podiatry [sic] consultation. A progress note dated 7/23/2025 documented, L. [left] Elbow: Olecranon spur. A progress note dated 8/19/25 documented, Patient was seen in room in bed. He reports pain mainly in his left hand and requests topical Diclofenac for relief . xray negative. he is now treating symptomatically . Diagnostic Result: On Jun 14, 2025 L. Elbow: Olecranon spur and minro [sic] arthritic change. On 10/7/25 at 2:48 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated she was brand new so she did not know how it worked with referrals at the facility but she thought the doctor did those. LPN 1 stated she had not heard anything about resident 14 needing a referral. On 10/8/25 at 9:53 AM, an interview was conducted with the Director of Nursing (DON). The DON stated if there is an appointment that needed to be made usually the doctor would let her know and she would reach out and make the appointment. The DON stated the order for resident 14's referral was faxed over to the other facility but they had not heard back from them. The DON stated there was not a set time to follow up on things like that, they would just wait for the other place to let them know when they could get the resident in to be seen. The DON stated usually she would have followed up in 2 weeks and she did not remember doing that and she should have.