STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46A070	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyonland Care Center	390 West Williams Way Moab, UT 84532

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. (continued on next page)

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that for 1 of 18 sampled residents, that the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice. Specifically, the facility did not maintain documentation that a resident's primary care provider had been notified of a resident's change in condition. Resident Identifier: 34 Findings Included: Resident 34 was admitted [DATE], and discharged [DATE] with diagnoses including other frontotemporal neurocognitive disorder, personal history of transient ischemic attack and cerebral infarction without residual deficits, other recurrent depressive disorders, atrioventricular block first degree, age-related osteoporosis without current pathological fracture, hypothyroidism unspecified, essential (primary) hypertension, and hypokalemia. Resident 34's medical record was reviewed from 11/3/25 through 11/5/25. A progress note dated 1/15/25 at 10:51 PM stated, CNA's [sic] reported that resident had a LG [large] bowel movement after dinner that was black, tarry and putrid smell [sic]. Resident drank evening ensure with evening meds, however, did not eat dinner. This note was documented by Licensed Practical Nurse (LPN) 1. A progress note dated 1/16/25 at 11:51 AM stated, [Resident 34] continues to have black tarry stools. She has remained in bed d/t (due to) increased weakness. She is infertile [sic] at this time. This noted was documented by LPN 2. There were no other progress notes regarding Resident 34's tarry, black stools. There were no progress notes or documentation that showed that Resident 34's primary care provider had been notified of her change in condition. On 11/5/25 at 11:09 AM, a voicemail was left for LPN 1. LPN 1 no longer worked at the facility. LPN 1 did not return the voicemail. On 11/5/25 at 1:54 PM, an interview was conducted with LPN 2. LPN 2 stated that she could not remember the incident with resident 34. LPN stated that if a resident had a change in condition, she would call the resident's physician to notify them and write a progress note in the resident's medical record. On 11/5/25 at 9:23 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that when a resident had a change in condition, the facility would notify the resident's primary care provider and document that the provider was notified as a progress note in the resident's electronic medical record. RN 1 stated that this would not be documented anywhere else in the medical record. On 11/5/25 at 12:35 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that if a resident had a change in condition, the facility should notify the resident's family and the resident's primary care provider, update the resident's care plan, update the resident's alert charting, and assess the resident. The DON stated that if a resident had a change in condition, the nurse on shift should write a progress note in the resident's medical record. The DON stated that she was unsure why there was no documentation in resident 34's medical record that resident 34's primary care provider was not notified of her change in condition. The DON stated that a check box that stated Show on MD[Medical Doctor]/Nursing Communications Report on the two progress notes that mentioned resident 34's tarry, black stools should have been checked in the medical record, but the box was not checked on these two progress notes. The DON stated that if the check box had been checked, the progress notes would have been carried over to a report that is printed out for the facility's physician each morning.