STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465130	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonehenge of Springville	909 West 450 South Springville, UT 84663

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on interview, and record review, for 3 of 24 residents sampled, the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, were reported immediately, but not later than 2 hours after the allegation was made, to the State Survey Agency. Specifically, a resident had an assisted fall out of bed during cares, the same resident had a fall which resulted in a bilateral femur fractures, a resident threatened another resident with physical harm, and a resident choked on a plastic ring and the State Survey Agency was not notified after the allegation was identified. Resident identifiers: 5, 28, 35, Findings include: 1. Resident 35 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's disease with late onset, lymphedema, morbid obesity, abnormalities of gait and mobility, chronic pain, and epilepsy. Resident 35's medical record was reviewed 3/4/25 through 3/5/25. An incident report dated 1/12/25 documented, [Resident 35] was turned on her left side in bed for CNA [certified nursing assistant] to change her chuck, as the CNA was pulling on the chuck, her right leg moved forward towards the edge of the bed. CNA was able to go to the other side of the bed and hold her legs until assistance arrived to assist [resident 35] to the floor. She was placed in sling and lifted via hoyer lift back into bed. Only her legs were coming off the bed. Due to her weight it was safer for [resident 35] and staff to lower her to the floor and put her back in bed with the hoyer lift. My leg slipped. No injuries were documented on the incident report. An incident report dated 1/17/25 documented, [Resident 35] was calling out for help, when aide entered the room she was on her knees at the side of the bed holding onto the and position bar. She had a bowel movement and urinated. Additional staff came in to assist her to the floor. She was layed down on the hoyer sling and assisted back into bed. On 3/4/25 a review of resident 35's physician progress note dated 1/18/25 revealed the following, patient with fall from bed, yesterday, during cares. subsequently sent to the ER [emergency room] for evaluation where she was found to have bilateral femoral fractures . (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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no additional information regarding the incident or an investigation into the incident provided. On 3/5/25 at 3:32 PM, an interview was conducted with the Administrator (ADM). The ADM stated he was the abuse coordinator for the facility and the staff reported allegations of abuse or neglect to the nurse and then it was reported to him. The ADM stated if there was not a signifiant injury then the allegation would not necessarily be reported to him. The ADM stated he would report any allegations of abuse or neglect to the State Survey Agency. The ADM stated with the assisted fall he would not have expected them to report it to him because they knew exactly what had happened and the CNA was with the resident. The ADM stated with the second fall, it was the exact same thing that happened with the first fall except staff were not in the room. The ADM stated resident 35 liked to be left alone, so the CNAs would place her on her side and leave the room. The ADM stated those who were in the room deem whether the incident would be reported to him or not, if it was reported to him then we talk about it. The ADM stated he did not think these incidents were reportable. The ADM stated we just knew there was not abuse or neglect because it was the way it had always been done. On 3/10/25 at 10:00 AM, a conference call was conducted with the ADM, Director of Nursing (DON), and the Regional Nurse Consultant (RNC). The RNC stated because there was a fracture it was reported to red cap and not to the State Survey Agency because it was not abuse. The ADM stated there was no cause for concern and they knew exactly what happened. The RNC stated within the investigation, if there was a concern, then they would report it. The RNC stated an investigation was completed for interventions but not to determine if there was abuse or neglect. The ADM stated the CNA's were interviewed on 3/6/25. It should be noted on 3/6/25 the CNA's were interviewed and the incident took place on 1/12/25 and 1/17/25. 48709 2. Resident 28 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included intraductal carcinoma in situ of right breast, dysphagia, type 2 diabetes mellitus with diabetic neuropathy, aphasia, cerebral infarction, depression, acute kidney failure, and generalized anxiety disorder. Resident 28's medical record was reviewed 3/3/25 through 3/5/25. A Nurses Note, dated 3/2/25 at 5:30 PM, indicated, Pt [patient] threatened to throw a flower pot at another resident today in the dining hall during dinner. Staff intervened before any physical assault occurred. Residents were separated and taken back to their rooms. An annual Minimum Data Set (MDS) assessment, dated 2/13/25, indicated a Brief Interview for Mental Status (BIMS) score of 10. A BIMS score of 8-12 indicated a moderate cognitive impairment. Resident 6 was admitted to the facility on [DATE] with diagnoses which included generalized anxiety disorder, chronic kidney disease, major depressive disorder, hypertension, and intellectual disabilities. Resident 6's medical record was reviewed 3/3/25 through 3/5/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurses Note, dated 3/2/25 at 5:29 PM, indicated, Pt got into a verbal altercations [sic] with another pt in the dining hall where the other patient threatened to throw a flower pot at her. Pt stated 'go ahead'. Staff intervened before any physical assault occurred. Pt taken back to her room. A Quarterly MDS assessment, dated 1/29/25, indicated a BIMS score of 7. A BIMS score between 0-7 indicated severe cognitive impairment. On 3/5/25 at 11:24 AM, an interview was conducted with the Resident Advocate (RA). The RA stated that she was not aware of the incident that occurred between residents 28 and 6 and that it should have been reported to her but might have been reported to the DON. The RA stated that if it was reported to her she would have reviewed the care plans and make changes if needed. On 3/5/25 at 11:37 AM, an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated that she had heard about an incident that happened in the dining room where resident 28 got frustrated with resident 6 and that she picked up an object but that nothing happened and they were separated. On 3/5/25 at 12:11 PM, an interview was conducted with the DON. The DON stated it was reported to her that resident 6 was yelling a lot and resident 28 said that she was going to throw a centerpiece at resident 6, so staff separated them. The DON stated that is not typical behavior for resident 28 and seemed out of character. The DON stated she did not think anyone spoke to either of the residents after the altercation and that the RA should have followed up on that. The DON stated she would want to put an intervention into place after a resident-to-resident altercation to protect the resident. On 3/5/25 at 2:11 PM, a follow-up interview was conducted with the RA. The RA stated that if the resident-to-resident altercation was reported to her she would have met with both of the residents and make sure interventions were put into place to prevent any future incidents. On 3/5/25 at 2:58 PM, a follow-up interview was conducted with the DON. The DON stated that any suspicions of physical, sexual or verbal abuse, staff-to-resident or resident-to-resident needed to be reported to the Administrator immediately. On 3/5/25 at 3:47 PM, an interview was conducted with the Administrator (ADM). The ADM stated staff told him that resident 28 said that she was going to throw a vase at resident 6 and that staff separated them. The ADM stated he had first heard about the incident today. The ADM stated the staff that witnessed the incident deemed that this was not abuse and that he agreed so it did not need to be reported to the state agency. 30563 3. Resident 5 was admitted to the facility on [DATE] with diagnoses which included dementia, major depressive disorder, severe intellectual disabilities, dysphagia, and schizoaffective disorder. On 3/3/25 at 12:19 PM and 3/4/25 at 12:10 PM, observations were made of the resident 5. Resident 5 was observed to be sitting at a table by himself drinking thin liquids and coughing after each sip. Resident 5's medical record was reviewed 3/3/25 through 3/5/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 1/17/24 revealed regular, diet easy to chew textures, thin/regular liquids consistency. A nursing progress note dated 12/24/24 at 12:02 PM revealed, Patient was given a cupcake today during a Christmas activity. Patient began to choke on the cupcake. He got up and went to his room, CNA followed. Patient was struggling to breath. CNA performed the Heimlich maneuver, patient began coughing up and vomiting saliva. Patient began breathing normal, and wanted to lie down in bed. PA [Physician's Assistant] ., assessed lung sounds. Lung sounds are congested at this time. Patient breathing normal. Vital signs all within normal ranges for patient's baseline. Family notified of incident. The incident was not reported to the State Survey Agency. On 3/5/25 at 3:32 PM, an interview was conducted with the ADM. The ADM stated the incident with resident 5 chocking on the plastic ring was not reported to the SSA because there was no suspicion of abuse or neglect because they knew what happened.