

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER Stonehenge of Cedar City		STREET ADDRESS, CITY, STATE, ZIP CODE 333 West 1425 North Cedar City, UT 84721	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>19354</p> <p>Based on staff interview, review of medical records, and review of the policy and procedures, facility staff did not report to the State Agency bruising of unknown origin for 1 resident in the sample of 5. (Resident identifier: 1.)</p> <p>Findings include:</p> <p>A nursing note, dated January 27, 2025, for resident 1, noted that staff found bruising to the neck, back and sides. On 2/5/2025, the licensor interviewed Admin 1. Admin 1 stated the bruising to resident 1 ' s back and sides were present at the time of admission to the facility. Admin 1 stated that resident 1 was assessed and that the bruising to the anterior neck was caused by a shirt that resident 1 was wearing. Admin 1 stated that resident 1 was admitted to the hospital with a new diagnosis of hemophilia, which contributed to the bruising. Admin 1 stated because of the shirt and new diagnosis, resident 1 did not have an injury of unknown origin and that a critical incident was not reported to the State Agency within one business day as required.</p> <p>The licensor reviewed the facility ' s Abuse Reporting Policy which indicated that the state licensing/certification agency responsible for surveying/licensing the facility was to be notified within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.</p> <p>On 2/5/2025 at 9:40 AM, the licensor conducted an interview with Admin 1. Admin 1 stated that the incident of unknown bruising was not reported to the office.</p>

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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