STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465178	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonehenge of American Fork	538 South 500 East American Fork, UT 84003

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, the staff wore hairnets incorrectly, cell phones were in the food preparation area, a dirty rag was used to clean a plate that was used for a resident's lunch, a spoon was repeatedly touched with dirty gloves then placed on the food. Findings included:On 7/23/25 at 12:18 PM, the following were observed during lunch service: At 12:03 PM, an observation was made of the Cook. The cook wore a hat with a hairnet over the top of it that was not covering her hair. The cook's hair had fallen out of the hat and was not covered by the hairnet.At 12:05 PM, an observation was made of a kitchen aide who had her hair clipped up in the back. The hair net was observed to only be covering the hair in the hair clip not on her scalp.At 12:07 PM, the cook was observed to touch the face of the plates with gloved hands that had touched her face and hair. At 12:08 PM, the dietary manager was observed to enter the cooking area with no hair net in place. At 12:11 PM, a cell phone was observed to be in the cooking area, near the plate warmers. At 12:12 PM, the tongs that had been used in the cheese container were laid on the counter then placed back into the shredded cheese container. At 12:16 PM, the cook was observed to touch the food on the plate with dirty gloves.At 12:19 PM, the spoon that was used to serve the parmesan cheese was touched by dirty gloves then fell back into the cheese. At 12:27 PM, a rag that had been used to wipe the counter and open the oven door was observed to be used to wipe away excessive food on a plate that was given to a resident.On 1/23/25 at 2:58 PM, an interview was conducted with the Dietary Manager (DM). The DM stated all of the staff should have hair coverings that cover all of the hair. The females should have their hair up in their hats, not strands hanging down. The DM stated that the staff should not have a cell phone anywhere in the food area. The DM stated the staff should not be wiping the face of the plates with a dirty rag or touching the face of the plates with dirty gloves. The DM stated that a utensil should not touch dirty gloves or other surfaces and then be placed back into the food for use.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents had the right to make choices about aspects of his or her life in the facility that were significant to the resident. Specifically, 1 out of 37 sampled residents, a resident was not administered medications timely. Findings included:Resident 18 was admitted to the facility on [DATE] with diagnoses which included chronic diastolic congestive heart failure, morbid obesity, major depressive disorder, weakness, acquired absence of left leg above knee, and essential hypertension.On 7/21/25 at 11:14 AM, an interview was completed with resident 18. Resident 18 stated that she did not receive her nighttime medications until around 11:00 PM, and that was just too late to get them. Resident 18 stated the staff had woken her up last night to administer the medications and it was close to or after midnight. Resident 18 stated that it did not happen with every nurse but it did happen quite a bit. Resident 18 stated she did not want to be woken up to get her medications when they were supposed to be given at a certain time before bedtime. Resident 18 stated it happened during the day and that was also bothersome. Resident 18 stated that they should be able to get their medications on time.Resident 18's medical record was reviewed on 7/21/25 through 7/23/25.The June and July 2025 Medication Administration Record was reviewed and revealed the following dates and times that medications were administered late.a. Gabapentin 300 milligrams (mg) was ordered to be given three times daily.On 6/3/25, due at 2:00 PM given at 5:00 PM.On 6/9/25, due at 7:00 AM given at 11:06 AM.On 6/12/25, due at 2:00 PM given at 5:12 PM.On 6/14/25, due at 7:00 AM given at 12:15 PM.On 6/14/25, due at 2:00 PM given at 4:14 PM.On 6/21/5, due at 7:00 AM given at 11:45 AM.On 6/21/25, due at 7:00 PM given at 11:25 PM.On 6/27/25, due at 7:00 AM given at 11:42 AM.On 7/8/25 due at 2:00 PM and given at 4:07 PM.On 7/10/25 due at 7:00 AM and given at 11:00 AM and administered again at 2:43 PM. It should be noted that this dose was given with only three hours in between the doses.On 7/12/25, due at 7:00 PM and given at 11:01 PM.On 7/16/25, due at 7:00 AM and given at 11:31 AM.On 7/16/25, due at 2:00 PM and given at 3:23 PM.On 7/17/25, due at 7:00 AM and given at 11:21 AM. On 7/17/25, due at 7:00 PM and given at 10:47 PM.On 7/19/25, due at 7:00 AM and given at 12:42 PM.On 7/19/25, due at 2:00 PM and given at 3:23 PM.On 7/20/25, due at 7:00 AM and given at 11:06 AM.B. Lidocaine external patch 4% was ordered to be administered to the left thigh topically two times a day for pain.On 7/20/25, due at 7:00 PM and given at 11:04 PM.C. Trazadone 50 mg by mouth at bedtime.On 7/20/25, due at 7:00 PM and given at 11:04 PM.On 7/22/24 at 2:00 PM, an interview was conducted with Registered Nurse (RN) 2. RN 2 stated that medications that were due at 7:00 AM, could be administered to the residents between 6:00 and 8:00 AM. RN 2 stated if a medication was not administered during the time frame the doctor should be contacted for further instruction. RN 2 stated that gabapentin should not be given any closer than every eight hours as it could cause problems for the resident. RN 2 stated the doctor should be contacted if the medication was not administered within the appropriate time frame. On 7/22/25 at 2:03 PM, an interview was conducted with the South Unit Manager (SUM). The SUM stated the staff could administer a medication at the time it was due or within an hour of that time. The SUM stated if the administration was to go past when the medication was due the staff should contact the doctor. The SUM stated if gabapentin had been given at 12:00 PM and then again around 2:00 PM that was too close and the staff should have contacted the doctor. The SUM stated a medication could cause harm to the resident if given too close. On 7/22/25 at 2:11 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff have a flex time for the administration of medications, flex time means they have a time frame in which the medications could be administered. The DON stated they expected the staff to make the provider aware if the medications were to be administered late. The DON stated it was not appropriate to administer gabapentin at noon and then again around 2:00 PM. The DON stated she expected the staff to perform the same no matter what shift they were working on and ensure that there was enough time in between the ordered doses.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to inform each resident periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate. Specifically, for 1 out of 3 sampled residents, a resident did not receive a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) when the beneficiary intended to continue services that might not have been covered under Medicare. Resident identifier: 14.Findings included:A SNF Beneficiary Notification Review, completed by the Social Services Director (SSD) for resident 14, dated 7/23/25, indicated, Medicare Part A Skilled Services Episode Start Date: 01/31/25. Last covered day of Part A Service: 04/19/25. The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. It further indicated, 1. Was a SNF ABN, Form CMS [Centers for Medicare & Medicaid Services] 10055 provided to the resident? . No . Discussed with daughter via phone call, due to pt's [patient's] cognition. On 7/23/25 at 1:05 PM, an interview was conducted with the SSD. The SSD stated that the SNF ABN was discussed with resident 14's daughter, who was the resident representative, but it was not documented because it was done over the phone. The SSD stated resident 14's daughter came into the facility often and should have received the SNF ABN.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. The comprehensive care plan must describe the services that were to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. Specifically, for 1 out of 37 sampled residents, a resident's heels were observed to not be floated while in bed when it was indicated as needed on the care plan. Resident identifier: 88.Findings included:Resident 88 was admitted to the facility on [DATE] with diagnoses which included a second degree atrioventricular block, dementia, weakness, and hypertension.On 7/22/25 at 1:45 PM, an observation was made of resident 88 laying in bed on his back, his heels were not floated.Resident 88's medical record was reviewed on 7/21/25 through 7/23/25.An admission Nursing Comprehensive assessment dated [DATE] at 3:37 PM, indicated, right hip, open area red area to coccyx left elbow skin tear with dsg [dressing] on and two fingers on left hand taped together r/t [related to] recent fall with hairline fx [fracture] in fingers. It further indicated resident 88 required staff assistance for bed mobility, transfers, and walking and totally dependent on staff for locomotion.An admission Braden Scale assessment on 7/9/25 at 3:55 PM, indicated resident 88 was at risk of developing a pressure ulcer.A Weekly Skin Check dated 7/11/25 at 4:49 PM, indicated resident 88 had a left heel wound.A care plan Focus of I have impaired skin integrity and/or I am at risk for impaired skin integrity: Always incontinent of bowel, I require assistance with bed mobility.Date Initiated: 07/07/2025. It indicated a Goal of I will remain free from new areas of impaired skin throughout my stay Date Initiated: 07/09/2025 Target Date: 10/07/2025. It further indicated Interventions included:a. Administer treatments as ordered and monitor for effectiveness. Date Initiated: 7/9/25;b. Assist me with turning and repositioning every two hours. Date Initiated: 7/9/25;c. Educate me as to causes of skin breakdown; including: transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Date Initiated: 7/9/25;d. Float heels when in bed. Date Initiated: 7/9/25;e. Inform me of any new area of skin breakdown. Date Initiated: 7/9/25;f. Provide pressure relieving/reducing device as ordered. Date Initiated: 7/9/25; andg. Remind me to turn and reposition as needed. Date Initiated: 7/9/25.On 7/22/25 at 1:47 PM, a skin check of resident 88 was observed with Registered Nurse (RN) 1. RN 1 stated he was not aware of a wound on resident 88's heel. RN 1 asked resident 88 if he could look at his heels, resident 88 stated he had a wound on his left heel. RN 1 assessed resident 88's left heel, redness was observed on the skin that was blanchable but slow to return to color after pressure was applied. RN 1 stated he would call that, blanching redness. RN 1 told Certified Nursing Assistant (CNA) 1 to float his heels and that he was going to put in an order to float his heels and to apply a skin prep. CNA 1 was observed to put a pillow under resident 88's ankles to float his heels. RN 1 stated if the skin was not blanchable or if it was opened he would talk to the wound specialist.On 7/22/25 at 1:55 PM, an interview was conducted with CNA 1. CNA 1 stated resident 88 had to have his heels floated and that she had been floating his heels on her previous shifts this week.On 7/23/25 at 7:22 AM, an observation was made of resident 88 laying in bed on his back, his heels were not floated.On 7/23/25 at 12:28 PM, an interview was conducted with CNA 2. CNA 2 stated resident 88 had to have his heels floated but did not know why he had to have his heels floated. CNA 2 stated floating heels could help with comfort or leg swelling and was standard for most residents.On 7/23/25 at 1:08 PM, a follow-up interview was conducted with RN 1. RN 1 stated staff were supposed to notify him if a wound was identified and he would go assess it. RN 1 stated nobody notified him of a wound to resident 88's heal. RN 1 stated blanching redness would not indicate the need to see a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound specialist but a dressing or skin prep would be ordered to protect the skin from breaking down more. RN 1 stated if a resident had low mobility staff would float the heels when the resident was in bed. RN 1 stated he updated the care plans and that any time a care plan was updated it would put the intervention into the Kardex so CNA's would know of the changes and the nurses were also expected to tell the CNA's.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident received care, consistent with professional standards of practice, to prevent pressure ulcers and would not develop pressure ulcers unless the individual's clinical condition demonstrated that they were unavoidable. Specifically, for 1 out of 37 sampled residents, a resident who had blanchable redness on the left heel was observed to not have their heels floated when in bed. Resident identifier: 88.Findings included:Resident 88 was admitted to the facility on [DATE] with diagnoses which included a second degree atrioventricular block, dementia, weakness, and hypertension.On 7/22/25 at 1:45 PM, an observation was made of resident 88 laying in bed on his back, his heels were not floated.Resident 88's medical record was reviewed on 7/21/25 through 7/23/25.A physician's order dated 7/9/25 at 12:18 PM, indicated, Float Heels for protection of skin integrity .An admission Nursing Comprehensive assessment dated [DATE] at 3:37 PM, indicated, right hip, open area red area to coccyx left elbow skin tear with dsg [dressing] on and two fingers on left hand taped together r/t [related to] recent fall with hairline fx [fracture] in fingers. It further indicated resident 88 required staff assistance for bed mobility, transfers, and walking and totally dependent on staff for locomotion.An admission Braden Scale assessment on 7/9/25 at 3:55 PM, indicated resident 88 was at risk of developing a pressure ulcer.A Weekly Skin Check dated 7/11/25 at 4:49 PM, indicated resident 88 had a left heel wound.A care plan Focus of I have impaired skin integrity and/or I am at risk for impaired skin integrity: Always incontinent of bowel, I require assistance with bed mobility.Date Initiated: 07/07/2025. It indicated a Goal of I will remain free from new areas of impaired skin throughout my stay Date Initiated: 07/09/2025 Target Date: 10/07/2025. It further indicated Interventions included:a. Administer treatments as ordered and monitor for effectiveness. Date Initiated: 7/9/25;b. Assist me with turning and repositioning every 2 hours. Date Initiated: 7/9/25;c. Educate me as to causes of skin breakdown; including: transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Date Initiated: 7/9/25;d. Float heels when in bed. Date Initiated: 7/9/25;e. Inform me of any new area of skin breakdown Date Initiated: 7/9/25;f. Provide pressure relieving/reducing device as ordered. Date Initiated: 7/9/25; andg. Remind me to turn and reposition as needed. Date Initiated: 7/9/25.On 7/22/25 at 1:47 PM, a skin check of resident 88 was observed with Registered Nurse (RN) 1. RN 1 stated he was not aware of a wound on resident 88's heel. RN 1 asked resident 88 if he could look at his heels, resident 88 stated he had a wound on his left heel. RN 1 assessed resident 88's left heel, redness was observed on the skin that was blanchable but slow to return to color after pressure was applied. RN 1 stated he would call that, blanching redness. RN 1 told Certified Nursing Assistant (CNA) 1 to float his heels and that he was going to put in an order to float his heels and to apply a skin prep. CNA 1 was observed to put a pillow under resident 88's ankles to float his heels. RN 1 stated if the skin was not blanchable or if it was opened he would talk to the wound specialist.On 7/22/25 at 2:00 PM, a progress note indicated, Assessed L [left] heel with no open area noted at this time and blanching redness. Order in place for floating heels while in bed and skin prep OTA [open to air] bid [twice a day] to heel for blanching redness.On 7/22/25 at 2:07 PM, a new order note indicated, Skin prep to Blanching redness to L heel and leave OTA, apply bid until resolved. every day and night shift for Blanching redness notify wound team of any decline in heel tissue Start Date: 7/22/2025.On 7/23/25 at 7:22 AM, an observation was made of resident 88 laying in bed on his back, his heels were not floated.On 7/23/25 at 1:08 PM, a concurrent interview was conducted with RN 1 and the Director of Nursing (DON). RN 1 stated staff were supposed to notify him if a wound was identified and he would go assess it. RN 1 stated nobody notified him of a wound of resident 88's heel. RN 1 stated blanching redness would not indicate the need to see a wound specialist but a dressing or skin prep would be ordered to protect the skin from breaking down more. RN 1 stated if a resident had low mobility, staff would float the heels when the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was in bed. The DON stated a head to toe assessment was supposed to be completed weekly and if any wound was found they were supposed to notify RN 1 and the house physician.