STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465182	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonehenge of Ogden	5648 South Adams Avenue Washington Terrace, UT 84405

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on interview and record review it was determined, for 2 of 27 sampled residents, that the facility did not ensure that residents remained free from abuse, neglect, and misappropriation of property. Specifically, there were residents in a relationship that had not been evaluated to have the capacity to consent. Resident identifiers: 13 and 151. Findings include: A. Resident 151 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included vascular dementia, unspecified severity, with agitation, acquired absence of right leg below knee, acquired absence of left leg below knee, occlusion and stenosis of bilateral carotid arteries, and duodenal ulcer, without hemorrhage or perforation. Resident 151's medical records were reviewed between 6/24/24 and 6/27/24. An admission Minimum Data Set (MDS) dated [DATE] revealed that resident 151 had a Brief Interview of Mental Status (BIMS) score of 7 which indicated severely impaired cognition. A review of resident 151's care plan initiated on 12/13/23, revealed a focus area that, Sometimes I have paranoid thoughts or delusions: ie having bed made oversease [sic] that will grow his legs back, medications and treatments. The goal is, I do not want to be fearful or paranoid. Approaches included Avoid power struggles and If my delusions or hallucinations do not distress me and are not harmful, do not medicate me or try to make them go away. On 2/5/24 at 1:13 PM, a social work progress note revealed the following, Social Service Worker (SSW) notified daughter of newfound friendship with a female peer. On 2/15/24 at 6:30 PM, a nursing progress note revealed the following, Pt [patient] is sitting at bedside in wheelchair with [resident 13] from room [ROOM NUMBER]A resting in his bed with a shirt on wearing no briefs. I knocked and pt [patient] wants to be left alone with her and requested that I leave as soon as possible and shut the door. Instruction given to staff to make sure they are knocking first before entering the room. 2030 (8:30 PM) Pt [patient] stated that he was really concerned that [resident 13] wanted him to lift her from off the bed tonight, Education given to pt [patient] to always call for assistance from CNAs (certified nursing assistants) and not attempt transfers himself. Provider notified. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/15/24 at 9:00 PM, a nursing progress note revealed the following, CNA [name removed] reported that pt [patient] in room had his garments on and no bottoms. Social work notified to follow up. A review of resident 151's care plan initiated on 2/16/24 revealed a focus area that Resident has a special friend the resident likes to spend time with. The goal being that 'Resident will show affection towards their special friend only in private. Approaches included Remind resident to limit showing ffection [sic] in public to holding hands, Remind residents that if the residents want private time together, the resident must find a place that will not disturb their roommates, and Remind staff that if the door is closed to knock and allow a few extra seconds before entering the room. On 2/16/24 at 11:42 AM, a social work progress note revealed the following, SSW and [Director of Nursing] DON Spoke with resident regarding relationship with peer. Resident reports that he enjoys spending time with his friend. they enjoy watching movies and talking. Resident denies that him and peer have been intimate. Resident reports that things are good with him and his friend. On 3/26/24 at 10:18 AM a social work progress note revealed the following, resident continues to verbalize paranoid statements he continues to believe that people are out to get him. He continues to verbalize statements that do not make sense. He continues to report that he is building things, and that he needs to get to places and take care of business but is unable to report where he needs to go and what he needs to accomplish. He also continues to describe people that had an altered physical appearance with one eye telescopic mask, and people that are coming to get him and take him from them. He continues to believe that people are out to get him and then he wants to get with a lady and get married and then get away from the people that are out to get him. SSW reassured him he is safe and if strange people come to visit him to let us know and that the staff will help him with the situation. On 5/4/24 at 7:03 PM, a nursing progress note revealed the following, resident 151 was becoming agitated while in the dining room. I gave resident 0.25mg (milligrams) Lorazepam to help with his agitation and left the dining room. Approximately 15 minutes later, my aid wheeled the resident to me. I wheeled the resident back to his room and another resident, who he often visits with, was in his room. She was attempting to calm him down, as he was still agitated. She offered him two warmed blankets that he had requested. The resident accepted the blankets and then started speaking in nonsensical terms. He then threw the blankets on the floor. On 5/4/24 at 8:30 PM, a nursing progress note revealed the following, CNA reported that pt [patient] was in his wheelchair headed looking for a female resident 'to meet his needs.' He went into room [ROOM NUMBER]. On 5/4/24 at 9:00 PM, a nursing progress note revealed the following, Night medications given at the med (medication) cart. Agitated when attempt made to give him meds in his room. Pt [patient] requesting if he can 'have a little sex.' I changed the subject. He is confused and believes that it is morning. Agitated when he was told it was night time. Continue to monitor with 15 minute bed checks. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of resident 151's care plan initiated on 5/10/24, revealed a focus area of Aggression - Physical/Verbal The resident can be physically and/or verbally abusive at times. The goal being that The resident will be able to express themselves without becoming aggressive. Approaches included If the resident appears to be getting anxious or restless, take them for a walk, do something active with them to use up their energy and decrease their anxiety. and Redirect the resident away from any residents who upset them. On 5/19/24 at 1:10 AM, a nursing progress note revealed the following resident 151 has passed away. B. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes, age related osteoporosis with current pathological fracture vertebra, sequela, spondylosis, moderate protein-calorie malnutrition, essential hypertension, dysphasia, depression, muscle weakness, gastro-esophagela reflux disease, and history of falling. Resident 13's medical record was reviewed 6/24/24-6/27/24. A Minimum Data Set [MDS] dated 11/3/23 revealed that resident 13 had a Brief Interview of Mental Status [BIMS] score of 7 which indicated severely impaired cognition. A care plan Focus addressing delusions/ hallucinations initiated on 5/2/23, documented [Resident 13] sometimes has paranoid thoughts and believes that someone is trying to hurt me or do bad things to me. The interventions included: a. Be sure my M.D. [medical doctor] or psychiatrist review my meds [medications] regularly and adjust them as needed. If I have command hallucinations where I might do what my voices tell me and get hurt, start a safety plan and get to the ER [emergency room] if you cannot ensure my safety at the nursing home. b. If my delusions or hallucinations do not distress me and are not harmful, do not medicate me or try to make them go away. c. Listen to my feelings about what I am imagining and do not criticize A care plan Focus addressing relationship with special friend initiated on 2/16/24, documented resident has a special friend the resident likes to spend time with. The goal documented, resident will show affection towards their special friend only in private. The interventions included: a. Remind resident to limit showing affection in public to holding hands b. Remind residents that if the residents want private time together, the resident must find a place that will not disturb their roommates. c. Remind staff that if the door is closed to knock and allow a few extra seconds before entering the room. Review of resident 13's progress notes revealed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/24 at 9:00 PM, a behavior note documented, Pt [patient] states that she enjoyed having pt in room [room number redacted]. the man without legs cuddling with her previously. Denies anything physical contact was inappropriate. On 1/31/24 at 1:21 PM, a social work note documented, SSW [Social Service Worker] spoke with resident about information received [sic] that she had told staff that she had allowed a male peer to sit on her bed with her while they watched a movie together. [resident 13] reported that she has found a friend and they enjoy spending time together. On 2/5/24 at 1:26 PM, a social work note documented, SSW spoke with residents daughter and informed her that her mom has new found friend and that they enjoy spending time together and doing various activities together. On 2/15/24 at 6:30 PM, a behavior note documented, Pt is resting on the bed of room [number redacted] with a shirt on with no brief on. Denies any inappropriate behavior. She remained in the room until apx [approximately] 2030 [8:30 PM]. On 2/15/24 at 9:00 PM, a behavior note documented, CNA [name redacted] reported that pt from room [room number redacted] also had his garments on with no bottoms. [Resident 13] had her bottoms off resting in his bed. Social work notified. On 2/16/24 at 11:23 AM, a social work note documented, SSW notified that Resident and peer spent alone time together. Resident verbalized that she is happy with her current relationship with her peer. She reports that they are good friends and that nothing has happened that they enjoy spending time together in peers bed watching movies and talking. She reports that peer is kind to her and that they have not been intimate. On 6/25/24 at 11:36 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that she is not aware of any relationships between residents in the building either companions or sexual in nature. On 6/25/24 at 12:56 PM, an interview was conducted with the SSW. The SSW stated that she interviewed the residents in order to determine if the residents were able to consent to having a relationship. The SSW stated that there was the potential that these residents were engaged in physical contact. The SSW stated she went with the Director of Nursing to assess resident 13 for any harm. The SSW stated that she could not recall if the medical director was notified of the relationship the residents were having and it was typically the DON's responsibility to notify the medical doctor in regards to residents. The SSW stated that resident 13 was confused and said bizarre things at times. The SSW stated that she figured that the residents were both adults and they could consent to have a relationship with each other. The SSW stated that no formal assessment was done to determine if resident 13 was able to consent to have a relationship. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 9:59 AM, a second interview was conducted with the SSW. The SSW stated that resident 151 was typically very sweet and then suddenly, he became very agitated near the end of his life. SSW stated resident 151 did have delusions off and on, he would think he was doing business deals with people. The SSW stated that resident 151 and resident 13 would have meals and attend activities together, and that it was resident 151 that helped get resident 13 out of her shell and out of her room more. The SSW stated she did not see any public affection between resident 151 and resident 13, and that they were always very cordial. The SSW stated Stonehenge was not a behavioral health facility, so she was not much concerned when the two residents started showing signs of a closer relationship. The SSW stated that resident 151's daughter was in the process of gaining guardianship due to him having bad finances and making bad choices. The SSW stated that resident 151 and resident 13 would go back and forth into each other's beds. The SSW stated that it was told to her that resident 151 and resident 13 may have been unclothed at some point. The SSW stated that she went with the Director of Nursing (DON) and talked to both residents separately. The SSW stated that her and the DON asked the residents about consent and how to be safe and what it means. The SSW stated that she and the DON were satisfied with what the residents reported and informed the Administrator (ADM), and they proceeded to inform the residents' families. The SSW stated that resident 151's guardian liked that he had a special friend in the facility that he was able to spend time with. The SSW stated that she would put a progress note in the resident's chart when she talked to a resident about what the resident knows about consent, how to be safe when with a close friend, and if she has talked with family or a guardian. The SSW stated that it was determined to allow the relationship to continue by the interviews with resident 151 and resident 13. The SSW stated that she does not recall if the physician was ever notified of resident 151 and resident 13's relationship, and that it would have been the DON that would have contacted the physician. The SSW stated that since both residents were confused, she had initiated a care plan, and she also initiated a care plan in case the relationship progressed further. The SSW stated that when she spoke with resident 151 and resident 13, they both replied they liked being with each other. On 6/27/24 at 12:35 PM, an interview with the DON was conducted. The DON stated she was informed that resident 13 and resident 151 were found in bed together in a state of undress. The DON stated that she and the SSW went together to talk to the residents individually. The DON stated that resident 151 told her it was none of your damn business. The DON stated that both residents denied being undressed with each other, stating nothing happened, and they were just watching movies. The DON stated that she encouraged both residents to let staff know if anything did happen or may happen. The DON stated that during the investigation, due to the residents being under the blankets the Certified Nurse Assistant (CNA) thought they saw the residents without clothing on. The DON stated that resident 151 was alert to himself and was alert and oriented x 3 or 4. The DON stated that resident 151 was showing signs of terminal aggressions. The DON stated that the did not do any cognitive assessments on resident 13 or resident 151, and that the assessment was her and the SSW talking to the residents. The DON stated she is unsure if the incident between resident 13 and resident 151 went to an interdisciplinary team (IDT) meeting, and that she recalled it was her and the SSW that talked most about it. The DON stated that it would be the physician that would make the decision if a resident was able to give consent. The DON stated that either she or the SSW would contact the physician. The DON stated that resident 13 was not always alert and oriented, and this behavior tended to be worse at night. The DON stated if patients were alert and oriented then the facility had to respect their choices to have a relationship. The DON stated there was no policy in regards to residents and relationships that she was aware of. [Cross refer to F607] (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50200

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47431 Based on interview and record review, the facility did not develop and implement written policies and procedures that; prohibit and prevent abuse, neglect, and exploitation of residents. In addition, the facility did not established polices and procedures to investigate any such allegations. Specifically, for 2 out of 27 sample residents, investigations and evaluations of ability to consent were not conducted after two residents were found to be in bed together. Resident identifiers: 13 and 151. Findings included: The facility's Abuse Prohibition Policies, dated 2024, was reviewed and documented the following information: The Provider Code of Conduct is to protect vulnerable clients (residents) from abuse, neglect, maltreatment and exploitation . Abuse, sexual-abuse and sexual exploitation, neglect, exploitation, and maltreatment are prohibited. A. No .individual . shall abuse, sexually abuse or sexually exploit, neglect, exploit or maltreat any client . 1. No person shall cause physical Injury to any client. All Injury to clients (explained or unexplained) shall be documented in writing and immediately reported to supervisory personnel. 2. No person by acting, failing to act, encouragement to engage In [sic], or failure to deter from will cause any client to be subject to abuse, sexual abuse or sexual exploitation, negleh, [sic] exploitation, or maltreatment. 3. No person shall engage any client as an observer or participant in sexual acts. 4. No person shall make unjust or Improper [sic] use of a client or their resources for profit or advantage. B. Failure to comply with this Code of Conduct may result in corrective action, probation, suspension, and/or termination of contract, license or certification, in accordance with administrative procedures act and Department of Human Services' regulations. POLICY: Our facilities will not condone any form of client/resident abuse or neglect. To assist In abuse prevention, all, csonnel[sic] are to report any signs and symptoms of abuse/neglect to their supervisor or to the Administrator .,mediately[sic]. A. Abuse of clients may include, but is not limited to: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Harm or threatened harm, meaning damage or threatened damage to the physical or emotional health and welfare of a client. 8. Sexual abuse and sexual exploitation will include, but not be limited to: 1. Engaging in sexual Intercourse with any client. 5. Committing or attempting to commit acts of sodomy or molestation with a client. REPORTING REQUIREMENTS POLICY . contracted, licensed or certified agency, Individual, or employee ls [sic] responsible to document and report abuse, . abuse and sexual exploitation . as outlined in this code and cooperate fully in any resulting investigation. 1. Any person will immediately report abuse, sexual abuse or sexual exploitation to the Administrator. 2. All other types of reports (meaning reports of an event that does not result in serious bodily injury to a patient) must be reported within 24 hours after forming the suspicion. The report must be made with the State Survey Agency and the Local Law Enforcement. The facility may not retaliate against an Individual who lawfully reports a reasonable suspicion of a crime. 3. All reports and documentation made regarding situations of abuse, sexual abuse and sexual exploitation, neglect, and exploitation will be made available upon request, or with court order when required by federal regulations, to appropriate Department of Human Services' personnel and law enforcement. A. Resident 151 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included vascular dementia, unspecified severity, with agitation, acquired absence of right leg below knee, acquired absence of left leg below knee, occlusion and stenosis of bilateral carotid arteries, and duodenal ulcer, without hemorrhage or perforation. Resident 151's medical records were reviewed between 6/24/24 and 6/27/24. An admission Minimum Data Set (MDS) dated [DATE] revealed that resident 151 had a Brief Interview of Mental Status (BIMS) score of 7 which indicated severely impaired cognition. A review of resident 151's care plan initiated on 12/13/23, revealed a focus area that, Sometimes I have paranoid thoughts or delusions: ie having bed made oversease [sic] that will grow his legs back, medications and treatments. The goal is, I do not want to be fearful or paranoid. Approaches included Avoid power struggles and If my delusions or hallucinations do not distress me and are not harmful, do not medicate me or try to make them go away. On 2/5/24 at 1:13 PM, a social work progress note revealed the following, Social Service Worker (SSW) notified daughter of newfound friendship with a female peer. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/15/24 at 6:30 PM, a nursing progress note revealed the following, Pt [patient] is sitting at bedside in wheelchair with [resident 13] from room [ROOM NUMBER]A resting in his bed with a shirt on wearing no briefs. I knocked and pt [patient] wants to be left alone with her and requested that I leave as soon as possible and shut the door. Instruction given to staff to make sure they are knocking first before entering the room. 2030 (8:30 PM) Pt [patient] stated that he was really concerned that [resident 13] wanted him to lift her from off the bed tonight, Education given to pt [patient] to always call for assistance from CNAs (certified nursing assistants) and not attempt transfers himself. Provider notified. On 2/15/24 at 9:00 PM, a nursing progress note revealed the following, CNA [name removed] reported that pt [patient] in room had his garments on and no bottoms. Social work notified to follow up. A review of resident 151's care plan initiated on 2/16/24 revealed a focus area that Resident has a special friend the resident likes to spend time with. The goal being that 'Resident will show affection towards their special friend only in private. Approaches included Remind resident to limit showing ffection [sic] in public to holding hands, Remind residents that if the residents want private time together, the resident must find a place that will not disturb their roommates, and Remind staff that if the door is closed to knock and allow a few extra seconds before entering the room. On 2/16/24 at 11:42 AM, a social work progress note revealed the following, SSW and [Director of Nursing] DON Spoke with resident regarding relationship with peer. Resident reports that he enjoys spending time with his friend. they enjoy watching movies and talking. Resident denies that him and peer have been intimate. Resident reports that things are good with him and his friend. On 3/26/24 at 10:18 AM a social work progress note revealed the following, resident continues to verbalize paranoid statements he continues to believe that people are out to get him. He continues to verbalize statements that do not make sense. He continues to report that he is building things, and that he needs to get to places and take care of business but is unable to report where he needs to go and what he needs to accomplish. He also continues to describe people that had an altered physical appearance with one eye telescopic mask, and people that are coming to get him and take him from them. He continues to believe that people are out to get him and then he wants to get with a lady and get married and then get away from the people that are out to get him. SSW reassured him he is safe and if strange people come to visit him to let us know and that the staff will help him with the situation. On 5/4/24 at 7:03 PM, a nursing progress note revealed the following, resident 151 was becoming agitated while in the dining room. I gave resident 0.25mg (milligrams) Lorazepam to help with his agitation and left the dining room. Approximately 15 minutes later, my aid wheeled the resident to me. I wheeled the resident back to his room and another resident, who he often visits with, was in his room. She was attempting to calm him down, as he was still agitated. She offered him two warmed blankets that he had requested. The resident accepted the blankets and then started speaking in nonsensical terms. He then threw the blankets on the floor. On 5/4/24 at 8:30 PM, a nursing progress note revealed the following, CNA reported that pt [patient] was in his wheelchair headed looking for a female resident 'to meet his needs.' He went into room [ROOM NUMBER]. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/4/24 at 9:00 PM, a nursing progress note revealed the following, Night medications given at the med (medication) cart. Agitated when attempt made to give him meds in his room. Pt [patient] requesting if he can 'have a little sex.' I changed the subject. He is confused and believes that it is morning. Agitated when he was told it was night time. Continue to monitor with 15 minute bed checks. A review of resident 151's care plan initiated on 5/10/24, revealed a focus area of Aggression - Physical/Verbal The resident can be physically and/or verbally abusive at times. The goal being that The resident will be able to express themselves without becoming aggressive. Approaches included If the resident appears to be getting anxious or restless, take them for a walk, do something active with them to use up their energy and decrease their anxiety. and Redirect the resident away from any residents who upset them. On 5/19/24 at 1:10 AM, a nursing progress note revealed the following resident 151 has passed away. B. Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included type 2 diabetes, age related osteoporosis with current pathological fracture vertebra, sequela, spondylosis, moderate protein-calorie malnutrition, essential hypertension, dysphasia, depression, muscle weakness, gastro-esophagela reflux disease, and history of falling. Resident 13's medical record was reviewed 6/24/24-6/27/24. A Minimum Data Set [MDS] dated 11/3/23 revealed that resident 13 had a Brief Interview of Mental Status [BIMS] score of 7 which indicated severely impaired cognition. A care plan Focus addressing delusions/ hallucinations initiated on 5/2/23, documented [Resident 13] sometimes has paranoid thoughts and believes that someone is trying to hurt me or do bad things to me. The interventions included: a. Be sure my M.D. [medical doctor] or psychiatrist review my meds [medications] regularly and adjust them as needed. If I have command hallucinations where I might do what my voices tell me and get hurt, start a safety plan and get to the ER [emergency room] if you cannot ensure my safety at the nursing home. b. If my delusions or hallucinations do not distress me and are not harmful, do not medicate me or try to make them go away. c. Listen to my feelings about what I am imagining and do not criticize A care plan Focus addressing relationship with special friend initiated on 2/16/24, documented resident has a special friend the resident likes to spend time with. The goal documented, resident will show affection towards their special friend only in private. The interventions included: a. Remind resident to limit showing affection in public to holding hands b. Remind residents that if the residents want private time together, the resident must find a place that will not disturb their roommates. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Remind staff that if the door is closed to knock and allow a few extra seconds before entering the room. Review of resident 13's progress notes revealed the following: On 1/29/24 at 9:00 PM, a behavior note documented, Pt [patient] states that she enjoyed having pt in room [room number redacted]. the man without legs cuddling with her previously. Denies anything physical contact was inappropriate. On 1/31/24 at 1:21 PM, a social work note documented, SSW [Social Service Worker] spoke with resident about information received [sic] that she had told staff that she had allowed a male peer to sit on her bed with her while they watched a movie together. [resident 13] reported that she has found a friend and they enjoy spending time together. On 2/5/24 at 1:26 PM, a social work note documented, SSW spoke with residents daughter and informed her that her mom has new found friend and that they enjoy spending time together and doing various activities together. On 2/15/24 at 6:30 PM, a behavior note documented, Pt is resting on the bed of room [number redacted] with a shirt on with no brief on. Denies any inappropriate behavior. She remained in the room until apx [approximately] 2030 [8:30 PM]. On 2/15/24 at 9:00 PM, a behavior note documented, CNA [name redacted] reported that pt from room [room number redacted] also had his garments on with no bottoms. [Resident 13] had her bottoms off resting in his bed. Social work notified. On 2/16/24 at 11:23 AM, a social work note documented, SSW notified that Resident and peer spent alone time together. Resident verbalized that she is happy with her current relationship with her peer. She reports that they are good friends and that nothing has happened that they enjoy spending time together in peers bed watching movies and talking. She reports that peer is kind to her and that they have not been intimate. On 6/25/24 at 11:36 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated that she is not aware of any relationships between residents in the building either companions or sexual in nature. On 6/25/24 at 12:56 PM, an interview was conducted with the SSW. The SSW stated that she interviewed the residents in order to determine if the residents were able to consent to having a relationship. The SSW stated that there was the potential that these residents were engaged in physical contact. The SSW stated she went with the Director of Nursing to assess resident 13 for any harm. The SSW stated that she could not recall if the medical director was notified of the relationship the residents were having and it was typically the DON's responsibility to notify the medical doctor in regards to residents. The SSW stated that resident 13 was confused and said bizarre things at times. The SSW stated that she figured that the residents were both adults and they could consent to have a relationship with each other. The SSW stated that no formal assessment was done to determine if resident 13 was able to consent to have a relationship. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 9:59 AM, a second interview was conducted with the SSW. The SSW stated that resident 151 was typically very sweet and then suddenly, he became very agitated near the end of his life. SSW stated resident 151 did have delusions off and on, he would think he was doing business deals with people. The SSW stated that resident 151 and resident 13 would have meals and attend activities together, and that it was resident 151 that helped get resident 13 out of her shell and out of her room more. The SSW stated she did not see any public affection between resident 151 and resident 13, and that they were always very cordial. The SSW stated Stonehenge was not a behavioral health facility, so she was not much concerned when the two residents started showing signs of a closer relationship. The SSW stated that resident 151's daughter was in the process of gaining guardianship due to him having bad finances and making bad choices. The SSW stated that resident 151 and resident 13 would go back and forth into each other's beds. The SSW stated that it was told to her that resident 151 and resident 13 may have been unclothed at some point. The SSW stated that she went with the Director of Nursing (DON) and talked to both residents separately. The SSW stated that her and the DON asked the residents about consent and how to be safe and what it means. The SSW stated that she and the DON were satisfied with what the residents reported and informed the Administrator (ADM), and they proceeded to inform the residents' families. The SSW stated that resident 151's guardian liked that he had a special friend in the facility that he was able to spend time with. The SSW stated that she would put a progress note in the resident's chart when she talked to a resident about what the resident knows about consent, how to be safe when with a close friend, and if she has talked with family or a guardian. The SSW stated that it was determined to allow the relationship to continue by the interviews with resident 151 and resident 13. The SSW stated that she does not recall if the physician was ever notified of resident 151 and resident 13's relationship, and that it would have been the DON that would have contacted the physician. The SSW stated that since both residents were confused, she had initiated a care plan, and she also initiated a care plan in case the relationship progressed further. The SSW stated that when she spoke with resident 151 and resident 13, they both replied they liked being with each other. On 6/27/24 at 12:35 PM, an interview with the DON was conducted. The DON stated she was informed that resident 13 and resident 151 were found in bed together in a state of undress. The DON stated that she and the SSW went together to talk to the residents individually. The DON stated that resident 151 told her it was none of your damn business. The DON stated that both residents denied being undressed with each other, stating nothing happened, and they were just watching movies. The DON stated that she encouraged both residents to let staff know if anything did happen or may happen. The DON stated that during the investigation, due to the residents being under the blankets the Certified Nurse Assistant (CNA) thought they saw the residents without clothing on. The DON stated that resident 151 was alert to himself and was alert and oriented x 3 or 4. The DON stated that resident 151 was showing signs of terminal aggressions. The DON stated that the did not do any cognitive assessments on resident 13 or resident 151, and that the assessment was her and the SSW talking to the residents. The DON stated she is unsure if the incident between resident 13 and resident 151 went to an interdisciplinary team (IDT) meeting, and that she recalled it was her and the SSW that talked most about it. The DON stated that it would be the physician that would make the decision if a resident was able to give consent. The DON stated that either she or the SSW would contact the physician. The DON stated that resident 13 was not always alert and oriented, and this behavior tended to be worse at night. The DON stated if patients were alert and oriented then the facility had to respect their choices to have a relationship. The DON stated there was no policy in regards to residents and relationships that she was aware of. [Cross refer to F600] (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50200

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50200 Based on observation, interview and record review it was determined, the facility did not ensure that residents who needed respiratory care were provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents goals, and preferences. Specifically, for 4 out of 27 sample residents the facility was not dating the change of oxygen tubing and nasal cannulas, nor ensuring there was a physician order for the use of oxygen for two residents (residents 7 and 8). Resident Identifiers: 7, 8, 19, and 20. Findings included: 1. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included viral intestinal infection, hypokalemia, hypercalcemia, unspecified protein-calorie malnutrition, dyspnea, essential hypertension, insomnia, generalized anxiety disorder, major depressive disorder, and gastro-esophageal reflux disease. Resident 7's medical record was reviewed 6/24/24-6/27/24. On 6/24/24 at 10:27 AM, an interview was conducted with resident 7. Resident 7 stated that she used nocturnal oxygen. Resident 7 stated that she had never seen her cannulas changed on either the concentrator or the portable oxygen. On 6/24/24 at 10:28 AM, an observation was made of the portable oxygen's nasal cannula which was yellowish in color and draped across the back of the wheelchair. An observation was made that there was no date on the cannula attached to the portable oxygen. An observation was made that there was no date on the nasal cannula attached to the concentrator. Review of resident 7's medical record revealed no order for oxygen therapy. 2. Resident 8 was admitted to the facility on [DATE] with diagnoses which included wedge compression fracture of unspecified lumbar vertebra, history of falling, unspecified asthma, sepsis, major depressive disorder, generalized anxiety disorder, essential hypertension, chronic kidney disease stage 3, gastro-esophageal reflux disease, and cardiac murmur. Resident 8's medical record was reviewed 6/24/24-6/27/24. On 6/24/24 at 12:50 PM, an interview was conducted with resident 8. Resident 8 stated that she used nocturnal oxygen. Resident 8 stated she was unsure how often her cannulas were changed. On 6/24/24 at 12:52 PM, an observation was made of resident 8's oxygen cannula and tubing. It was observed that there was no date on the cannula or oxygen tubing. Review of resident 8's medical record revealed no order for oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 19 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease, heart failure, insomnia, obesity, adjustment disorder with anxiety, essential hypertension, gastro-esophageal reflux, and personal history of transient ischemic attack (tia), and cerebral infarction without residual deficits. Resident 19's medical record was reviewed 6/24/24-6/27/24. On 6/24/24 at 9:46 AM, an interview was conducted with resident 19. Resident 19 stated that she used nocturnal oxygen. Resident 19 stated that she was unsure when her cannulas got changed. On 6/24/24 at 9:50 AM, an observation was made of resident 19's oxygen cannulas. It was observed that there were no dates on the oxygen cannula or tubing. 4. Resident 20 was admitted to the facility on [DATE] with diagnoses which included chronic diastolic (congestive) heart failure, paroxysmal atrial fibrillation, thrombocytopenia, unspecified protein-calorie malnutrition, chronic respiratory failure with hypoxia, unspecified osteoarthritis, trigeminal neuralgia, pulmonary hypertension, peripheral vascular disease, and history of falling. Resident 20's medical record was reviewed 6/24/24-6/27/24. On 6/24/24 at 11:19 AM, an interview was conducted with resident 20. Resident 20 stated that she was not aware that her cannulas required changing. Resident 20 stated that she used a concentrator and portable oxygen. On 6/24/24 at 11:20 AM, an observation was made of resident 20's oxygen concentrator and portable oxygen. There were no dates on the nasal cannulas for the concentrator or portable oxygen. On 6/26/24 at 12:01 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated nurses were in charge of changing out residents' cannulas weekly. LPN 1 stated that cannulas were changed on Fridays and the date was written on tape and placed on the cannula. On 6/26/24 at 1:16 PM, an interview was conducted with the Director of Nursing [DON]. The DON stated that oxygen tubing was changed weekly and required a nurse to sign on the treatment administration record [TAR]. The DON stated that tubing was dated when it was replaced. The DON stated that in order for oxygen to be placed on a resident, an order from the doctor was required before it could be placed. The DON stated that there were standing orders for oxygen use in order to maintain oxygen levels above 90%, but the medical provider needed to be notified of this to ensure an order was written.

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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. 22992 Based on interview and observation, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, an employee was observed in the kitchen area without a hair net; and a refrigerator was observed to have spoiled, undated and unlabeled food. Findings include: 1. On 6/24/24 at 12:51 PM, the Maintenance Director (MD) was observed to enter the facility kitchen. The MD was observed to check several lights and sprinkler heads on the kitchen ceiling. At 12:52 PM, the MD left the kitchen, obtained a ladder that had been placed near the dining room entrance, and re-entered the kitchen. At no time was the MD observed to place a hair net over his hair. 2. On 6/24/24 at 12:57 PM, an observation was made of the refrigerator in the dining room. The following was noted: a. An open bag of grapes with no date or label b. A styrofoam container of what appeared to be leftovers. This container was not dated or labeled. c. An open bag of chips with no date or label d. What appeared to be an onion in a plastic bag. The onion was green, moldy, and slimy. There was liquid leaking from the bag onto the refrigerator surface. e. Five open plastic containers of soda with no date or label. f. Several areas with sticky spills and debris. On 6/24/24, at 1:00 PM, an interview was conducted with Housekeeper (HSK) 1. HSK 1 stated she thought that the refrigerator in the dining room was for both residents and employees, but was unsure. HSK 1 stated that it was the dietary department's responsibility to clean the refrigerator in the dining room. On 6/24/24 at 1:02 PM, an interview was conducted with the Dietary Manager (DM). The DM stated that she though that the refrigerator in the dining room was for both residents and employees, but that it was mostly the therapy department that used it. The DM stated that the dietary department and the housekeeping department took turns cleaning the refrigerator in the dining room.