

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Stonehenge of Ogden		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, gloves were not changed and hand hygiene was not performed after touching dirty surfaces in the kitchen prior to touching food while plating the lunch meal. Findings included: On 6/30/26 at 11:33 AM, an observation and simultaneous interview were conducted with [NAME] 1 during the lunch meal service. [NAME] 1 stated that she had prepared a chicken salad sandwich with apples and celery for lunch. The Dietary Manager (DM) washed hands with soap and water and donned gloves. The DM placed the fruit container containing cantelope, honeydew, pineapple, orange, and grapes on a rolling cart on top of a cutting board. The DM moved and repositioned the cart and touched the cart handle with gloved hands. The DM then proceeded to touch the fruit with the same gloved hands while cutting the fruit into bite size pieces. [NAME] 1 washed her hands and donned new gloves. [NAME] 1 started the tray line and touched the croissant with gloved hands while placing a scoop of chicken salad inside. [NAME] 1 closed the refrigerator door with gloved hands and then proceeded with the next sandwich preparation. [NAME] 1 obtained a second bowl of chicken salad from the fridge and stated that this bowl did not contain celery or apples. [NAME] 1 washed her hands and donned new gloves. [NAME] 1 obtained a second box of croissants from the original packing box and removed the saran wrap. The original packing box and saran wrap were handled with [NAME] 1's gloved hands. [NAME] 1 returned to sandwich preparation without changing her gloves. On 6/30/26 at 12:11 PM, [NAME] 1 obtained cold plates from the refrigerator and the door was closed with gloved hands. [NAME] 1 returned to sandwich preparation without changing her gloves. On 6/30/26 at 12:15 PM, [NAME] 1 doffed gloves, washed hands and donned new gloves. [NAME] 1 obtained a new box of croissants from the original packing box and removed the saran wrap. [NAME] 1 touched the rolling cart containing the plate lids with gloved hands. [NAME] 1 obtained a stack of cold plates from the refrigerator and the door was closed with gloved hands. [NAME] 1 returned to sandwich preparation without changing her gloves. On 6/30/26 at 12:21 PM, [NAME] 1 was handed a meal ticket from a Certified Nursing Assistant (CNA) who had delivered a tray to room [ROOM NUMBER]. The CNA reported that the resident had requested a croissant and did not receive one. [NAME] 1 touched the meal ticket with gloved hands and then returned to sandwich preparation without changing her gloves. On 6/30/26 at 12:28 PM, [NAME] 1 obtained a stack of cold plates from the refrigerator and closed the door with gloved hands. [NAME] 1 returned to sandwich preparation without changing her gloves. On 6/30/26 at 12:29 PM, a delivery man came into the kitchen stating he had a delivery. The delivery driver proceeded to show the DM the invoice while holding it over the food prep area. On 6/30/26 at 12:31 PM, [NAME] 1 obtained a container of cottage cheese from the refrigerator and served a portion. The refrigerator and (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cottage cheese container were handled with gloved hands. [NAME] 1 returned to sandwich preparation without changing her gloves. On 6/30/26 at 12:35 PM, [NAME] 1 obtained a stack of cold plates from the refrigerator and closed the door with gloved hands. [NAME] 1 returned to sandwich preparation without changing her gloves. On 6/30/26 at 12:42 PM, [NAME] 1 obtained a package of hamburger buns and stated she ran out of croissants. [NAME] 1 returned to sandwich preparation without changing her gloves. On 6/30/26 at 1:39 PM, an interview was conducted with the DM. The DM stated that hand hygiene should be performed when they changed a task or started the day. The DM stated that hand hygiene should be performed prior to touching food items. The DM stated that if the [NAME] walked away from the food preparation area they should wash their hands and don new gloves upon their return to food preparation. The DM stated that hand hygiene should be performed and gloves changed if the [NAME] touched other surface areas that may contaminate the food. The DM stated that they would need to educate the delivery staff to stand at the red line and not enter the food preparation area.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that residents who used psychotropic drugs received gradual dose reductions (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Specifically, for 2 out of 31 sampled residents, the facility did not attempt a GDR for psychotropic medications in two separate quarters (with at least one month between attempts) and clinical contraindications were not documented in the resident medical records. Resident identifiers: 30 and 31. Findings included: 1. Resident 31 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included major depressive disorder and insomnia. A physician's order dated 5/7/25, documented Auvelity Oral Tablet Extended Release 45-105 milligrams (mg) (Dextromethorphan Hydrobromide-Bupropion Hydrochloride), Give 1 tablet by mouth one time a day related to major depressive disorder for 3 days and then Give 1 tablet by mouth two times a day. The order was discontinued on 5/23/25. [It should be noted that Auvelity is classified as an anti-depressant.] A physician's order dated 5/23/25, documented Auvelity Oral Tablet Extended Release 45-105 mg, Give 1 tablet by mouth one time a day related to major depressive disorder for 3 days and then Give 1 tablet by mouth two times a day. The order was discontinued on 10/30/25. A physician's order dated 10/30/25, documented Auvelity Oral Tablet Extended Release 45-105 mg, Give 1 tablet by mouth two times a day related to major depressive disorder. The order was discontinued on 12/29/25. A physician's order dated 1/2/26, documented Auvelity Oral Tablet Extended Release 45-105 mg, Give 1 tablet by mouth two times a day for Depression. On 2/19/26, the Psychotropic Drug Review documented Auvelity 45-105 mg by mouth two times a day was initiated on 5/21/25. The form documented 11 episodes of verbalization of sadness. The form documented to review the medication again in 90 days and recommended no changes be made to the medication at that time. No documentation could be found that an attempt was made at a GDR for the Auvelity, and no documentation could be found with a rationale for a clinical contraindication for a GDR. On 6/30/26 at 7:36 AM, an interview was conducted with the Director of Nursing (DON). The DON stated that resident 31 was seen by a behavioral health provider and they ordered the Auvelity. The DON stated that she would look for a contraindication for a GDR form. On 6/30/26 at 11:24 AM, the DON provided a note from a behavioral health provider dated 6/30/26, that stated In my opinion, a decrease in any of their current psychiatric medications would result in deterioration. I strongly recommend that their psychiatric medications are not changed. No attempted GDR or clinical contraindication had been done prior to the State Survey Agency asking for this information. 2. Resident 30 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with diagnoses which included depression, generalized anxiety disorder, and insomnia due to other mental disorders. A physician's order dated 3/18/25, documented paroxetine hydrochloride oral tablet 30 mg. Give 30 mg by mouth one time a day. The physician order was discontinued on 5/21/25. [It should be noted that paroxetine hydrochloride is classified as an anti-depressant.] A physician's order dated 5/22/25, documented paroxetine hydrochloride oral tablet 30 mg. Give 30 mg by mouth one time a day. The physician order was discontinued on 10/30/25. A physician's order dated 11/1/25, documented paroxetine hydrochloride oral tablet 30 mg. Give 30 mg by mouth one time a day. The physician order was discontinued on 2/26/26. A physician's order dated 2/27/26, documented paroxetine hydrochloride oral tablet 20 mg. Give 20 mg by mouth one time a day. It should be noted that resident 30 did not receive a GDR in two separate quarters (with at least one month between the (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempts), unless clinically contraindicated. On 7/1/26 at 10:08 AM, an interview was conducted with the DON. The DON stated they tried to GDR resident 30's as needed lorazepam that was hardly ever used and it sent resident 30 into a panic attack. The DON stated the psychotropic team reviewed the short term residents monthly and the long term resident quarterly. The DON stated that herself, social services, the pharmacy consultant, and Medical Director would attend the meeting. The DON stated that she would prepare the paper work and would discuss with the team who was needing a medication dose reduction and she would make recommendations to the team. The DON stated that it was ultimately up to the provider if they wanted to GDR the medication.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Specifically, staff were applying a PureWick external urinary catheter device without orders or training on how to use the device. Resident identifier: 28. Findings included: Resident 28 was admitted to the facility on [DATE] with diagnoses which included fracture around internal prosthetic right hip joint, muscle weakness, abnormality of gait and mobility, congestive heart failure, lymphedema, muscle wasting and atrophy. On 6/29/26 at 10:05 AM, an interview was conducted with resident 28. Resident 28 stated she wore a PureWick device at nighttime. Resident 28 stated that the facility was going to teach the staff how to use the PureWick device. Resident 28 stated that sometimes the staff did not plug the device into suction after they placed the device on her. Resident 28's physician orders were reviewed. No orders were found for the PureWick urinary device. Resident 28's June 2026 Medication Administration Record and Treatment Administration Record was reviewed. No documentation was found for the care, treatment, or monitoring of the PureWick device. On 3/10/26 at 1:04 PM the Nursing note documented, Pt [patient] cont [continued] on Doxycycline or [sic] UTI [urinary tract infection], tolerating well, no ASE [adverse side effects]. Pt using purewick this am [morning] while in bed. Pt encouraged to increase fluid intake. Voiding freely. On 6/21/26 at 9:24 AM, the progress note documented, . Genitourinary: Resident continent of bladder. Urine clear yellow. Denies urinary complaints. Genitourinary Note: wears a purewick at night. On 6/26/26 at 12:45 AM, the Provider note documented that the resident was prescribed Lasix 40 milligram by mouth at bedtime for edema . Pt wants in pm [after midday] after she goes to bed with purewick. On 10/31/25, resident 28 had a care plan initiated for at risk for incontinence related to history of urinary incontinence. An intervention identified on the care plan was Pt using own [NAME]-wick [sic] at bedtime. The intervention was initiated on 3/26/26. On 7/1/26 at 9:56 AM, an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated that resident 28 had a urinary device. CNA 1 stated that she turned off the suction in the morning, pulled off the sponge and discarded it, dumped the urine and rinsed the canister, and placed it in the closet for use again at night. CNA 1 stated that resident 28 wore the PureWick at night only and staff removed the device in the morning. CNA 1 stated that she was shown how to remove the device by another CNA and no other education was provided by the facility for the care and treatment of the PureWick device. CNA 1 stated that she was not instructed on how to apply the device safely but she was sure it was the same concept for removal. CNA 1 stated that she was not aware of resident 28 having a history of UTIs. On 7/1/26 at 10:06 AM, an interview was conducted with Registered Nurse (RN)1. RN 1 stated that resident 28 had a PureWick that was used at night. RN 1 stated that she did not have any orders for the PureWick device and she would think that they needed an order for it. RN 1 stated that the CNAs took care of the device in the morning by removing it and cleaning it. RN 1 stated that resident 28's family provided all the equipment for the PureWick. RN 1 stated that the PureWick was not documented on the Treatment Administration Record and there was no documentation of the care and treatment of the device. RN 1 stated that potential complications of the device were infection and skin breakdown. RN 1 stated she would expect to see orders for monitoring the device to ensure there were no signs and symptoms of infection or any skin breakdown. On 7/1/26 at 10:13 AM, an interview was conducted with the Director of Nursing (DON). The DON stated (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that resident 28 used a PureWick device. The DON stated that the family provided the device and the facility staff were responsible for the care and use of it. The DON stated resident 28 used the urinary device at nighttime and it was discarded each morning after use. The DON stated that resident 28 should have orders for the PureWick device. The DON confirmed that resident 28 did not have orders for the PureWick and there was no monitoring for the care and treatment of the device. The DON stated that complications of using the PureWick device were UTI, skin breakdown, and not promoting urinary continence. The DON stated that staff had not been provided training on the device. The DON stated that it was up to resident 28 to apply and place the device and staff turned on the suction. The DON stated that the CNAs should know how to properly apply and remove the device.		