STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465176	A. BUILDING _____ B. WING _____	03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF SOUTH JORDAN, LLC	1371 WEST SOUTH JORDAN PARKWAY SOUTH JORDAN, UT 84095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was completed from 3/27/23 through 3/28/23. No non-compliance was identified and no deficiencies were cited.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Lindley	Administrator	4/6/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465176	A. BUILDING 01 B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF SOUTH JORDAN, LLC	1371 WEST SOUTH JORDAN PARKWAY SOUTH JORDAN, UT 84095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Emergency preparedness E-000 Initial Comments: Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 03-27-2023 in the presence of the Administrator and the facility manager are found in 42 Code of Federal Regulations, Section 483.73 The facility was found to be in compliance with the requirements for participation in Medicare and Medicaid.	E 000	Cole Julian Approved 05-01-2023 POC Date 05-19-2023	
K 000	INITIAL COMMENTS K-000 Initial Comments. Statutory and regulatory authority for this Life Safety Code survey that was conducted on 03-27-2023 in the presence of the Administrator and the facility manager are found in 42 Code of Federal Regulations, Section 483.70, (a) and the 2012 Edition, NFPA 101 Life Safety Code including NFPA publications referenced therein. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) Life Safety from fire.	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345	**K 345** **Corrective action for resident found to have been affected by this deficiency:** No specific residents were cited or named as having been directly affected by this deficiency. **Corrective action for residents that may be affected by this deficiency:** All residents have potential to be affected by not having the proper inspections of the riser tamper switches and water valves not being inspected. **Measures that will be put into place to ensure this deficiency does not recur:** A new contract has been made between Stonehenge of South Jordan and AAA Fire. AAA Fire schedules semiannual inspections of the fire riser control valve tamper switches. AAA Fire is scheduled to come out and will have us back in compliance by 5/19/2023 **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Administrator and Maintenance Director will regularly do audits of the facility life safety binder to ensure proper testing and maintenance has been done on the fire sprinkler system, specifically the riser control valve and tamper switches.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erin Embley	Administrator	4/20/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465176	A. BUILDING 01 B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF SOUTH JORDAN, LLC	1371 WEST SOUTH JORDAN PARKWAY SOUTH JORDAN, UT 84095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 1 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: K-345 Based upon observation made during the record review in the presence of the Administrator and facility manager on 03-27-2023, it was determined that the facility did not maintain the fire alarm system in accordance with NFPA 101 19.3.4.4 & 9.6.3.1.; and NFPA 72. Table 14.4.5 (6) (3) This deficiency affected all control valve tamper switches. Findings include: 1-During the record review portion of the survey the facility failed to produce documentation that the riser tamper switch test was conducted two times in the last year. Valve supervisory alarm devices shall be tested semiannually in accordance with NFPA 101 19.3.4.2.1, 9.7.5. And NFPA 72 table 14.4.5. (15.I-1)	K 345	The Maintenance Director will be responsible for reporting monthly during our Quality Assurance Performance Improvement (QAPI) committee meeting. The QAPI committee will make recommendations and determine continued monitoring as necessary. The Maintenance Director is responsible for on-going monitoring and compliance. Date of Compliance: 5/19/2023	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353	**K 353** **Corrective action for resident found to have been affected by this deficiency:** No specific residents were cited or named as having been directly affected by this deficiency. **Corrective action for residents that may be affected by this deficiency:** All residents have potential to be affected by not having the proper inspections of the fire sprinkler systems not being inspected quarterly. **Measures that will be put into place to ensure this deficiency does not recur:** A new contract has been made between Stonehenge of South Jordan and AAA Fire. AAA Fire schedules quarterly inspections of the fire riser water flow alarm. AAA Fire is scheduled to come out and will have us back in compliance by 5/19/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465176	A. BUILDING 01 B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF SOUTH JORDAN, LLC	1371 WEST SOUTH JORDAN PARKWAY SOUTH JORDAN, UT 84095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 2 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: K-353 Based upon observations made in the presence of the administrator and the facility manager on 03-27-2023, it was determined that the facility did not maintain the fire sprinkler system in accordance with NFPA 25 and NFPA 101 9.7.5. This deficiency affected the fire riser testing. Findings include: During the record review it was determined that the facility failed to provide documentation that the fire risers water flow alarm test was conducted 4 times in the last year in accordance with NFPA 101 19.3.5.1; 9.7; 9.7.5; NFPA 72 Table 7-3.1. (2012 table 14.3.1)	K 353	**Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Administrator and Maintenance Director will regularly do audits of the facility life safety binder to ensure proper testing and maintenance has been done on the fire sprinkler system specifically the riser water flow alarm. The Maintenance Director will be responsible for reporting monthly during our Quality Assurance Performance Improvement (QAPI) committee meeting. The QAPI committee will make recommendations and determine continued monitoring as necessary. The Maintenance Director is responsible for on-going monitoring and compliance. Date of Compliance: 5/19/2023	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511	**K 511** **Corrective action for resident found to have been affected by this deficiency:** No specific residents were cited or named as having been directly affected by this deficiency. **Corrective action for residents that may be affected by this deficiency:** All residents have potential to be affected by not having the proper inspections of the fire and smoke damper being inspected every 4 years.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465176	A. BUILDING 01 B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF SOUTH JORDAN, LLC	1371 WEST SOUTH JORDAN PARKWAY SOUTH JORDAN, UT 84095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 3 This REQUIREMENT is not met as evidenced by: K-0521 Based upon observations made in the presence of the Administrator and the facility manager on 03-27-2023, it was determined that the facility did not install or maintain the buildings heating, ventilating and air conditioning systems in accordance with NFPA 101 19.5.2.1 and 9.2. This deficiency affected all of the fire dampers. Findings include: 1-During the record review the facility failed to provide an itemized list of fire/ smoke damper locations and the tests that were performed. All inspections and testing shall be documented, indicating the location of the fire damper, date(s) of inspection, name of inspector, and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected in accordance with NFPA 80 19.3.4	K 511	**Measures that will be put into place to ensure this deficiency does not recur:** A new contract has been made between Stonehenge of South Jordan and AAA Fire. AAA Fire schedules 4 year inspections of the fire and smoke dampers. AAA Fire is scheduled to come out and will have us back in compliance by 5/19/2023. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Administrator and Maintenance Director will regularly do audits of the facility life safety binder to ensure proper testing and maintenance has been done on the fire and smoke dampers. The Maintenance Director will be responsible for reporting monthly during our Quality Assurance Performance Improvement (QAPI) committee meeting. The QAPI committee will make recommendations and determine continued monitoring as necessary. The Maintenance Director is responsible for on-going monitoring and compliance.	
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K 712	Date of Compliance: 5/19/2023 **K 712** **Corrective action for resident found to have been affected by this deficiency:** No specific residents were cited or named as having been directly affected by this deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465176	A. BUILDING 01 B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF SOUTH JORDAN, LLC	1371 WEST SOUTH JORDAN PARKWAY SOUTH JORDAN, UT 84095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 712	Continued From page 4 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: K-712 Based upon observations made during the record review in the presence of the Administrator and facility manager on 03-27-2023, it was determined that the facility did not conduct fire drills or training related to the current fire plan, they must be held at unexpected times under varying conditions at least quarterly on each shift in accordance with NFPA 101 19.7.1.4. Through 19.7.1.7. (ASC 21.7.1.4 through 21.7.1.7) This deficiency affected the fire drills. Findings include: During the record review the facility failed to provide documentation of the required 12 fire drills and or a documented orientation training program. The missing drills were the 1st quarter 3rd knock shift, 2nd quarter 2nd afternoon shift, 3rd quarter 1st day and 3rd knock shift, 4th quarter 2nd afternoon shift. Drills shall be held at unexpected time under varying conditions at least quarterly on each shift in accordance with NFPA 101 19.7.1.4. Through 19.7.1.7.	K 712	**Corrective action for residents that may be affected by this deficiency:** All residents have potential to be affected by not having educated the staff on proper procedures to take during a fire drill. **Measures that will be put into place to ensure this deficiency does not recur:** At the beginning of each month the Administrator and Maintenance Director will discuss what day and time we will be holding our monthly fire drill. We will compare with the last month and ensure that we are hitting all shifts at least quarterly. 2 check boxes will be added to the form; 1 to show that follow up action has been taken as needed with staff, and 1 to show that the monitoring company saw the drill and that we are back up and running. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Administrator and Maintenance Director will do quarterly audits of the facility life safety binder to ensure Fire drills are being done at the appropriate times and days to meet the standard. The Maintenance Director will be responsible for reporting monthly during our Quality Assurance Performance Improvement (QAPI) committee meeting. The QAPI committee will make recommendations and determine continued monitoring as necessary. The Maintenance Director is responsible for on-going monitoring and compliance. Date of Compliance: 5/19/2023	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465176	A. BUILDING 01 B. WING _____	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF SOUTH JORDAN, LLC	1371 WEST SOUTH JORDAN PARKWAY SOUTH JORDAN, UT 84095

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 914	Continued From page 5 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: K-914 Based on observations made in the presence the Administrator and the facility manager on 03-27-2023 it was determined that the facility did not perform Maintenance and testing on the receptacles at the patient bed locations for integrity, continuity, polarity, and retention force of the grounding blades in accordance with NFPA 99,2012,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4. This deficiency could affect all patients. Findings include: At the time of this facility tour it was observed that the receptacles at or near the resident beds and exam rooms were not hospital grade and were not being tested annually. All receptacles near resident beds and exam rooms shall be tested or a hospital grade receptacle in accordance with NFPA 99,2012 ,6.3.3.2.1, 6.3.3.2.2, 6.3.3.2.3, and 6.3.3.2.4.	K 914	**K 914** **Corrective action for resident found to have been affected by this deficiency:** No specific residents were cited or named as having been directly affected by this deficiency. **Corrective action for residents that may be affected by this deficiency:** All residents have potential to be affected by not properly completing the required inspections of electrical receptacles in and patient rooms and common areas. **Measures that will be put into place to ensure this deficiency does not recur:** All electrical outlets were tested on 03/27/2023 as per this regulation and all were found to be functional within the required limits. These tests were documented and are filed in our preventative maintenance binder. **Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:** The Administrator and Maintenance Director will regularly do audits of the facility life safety binder to ensure the electrical receptacles in patient rooms and common areas have been inspected at least annually. The Maintenance Director will be responsible for reporting monthly during our Quality Assurance Performance Improvement (QAPI) committee meeting. The QAPI committee will make recommendations and determine continued monitoring as necessary. The Maintenance Director is responsible for on-going monitoring and compliance. Date of Compliance: 5/19/2023	