

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 465167	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER STONEHENGE OF OREM			STREET ADDRESS, CITY, STATE, ZIP CODE 435 WEST CENTER STREET OREM, UT 84057		
(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 755 SS=D	<p>Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility did not provide pharmaceutical services (including procedures that assure the accurate acquiring,</p>	F 755 PoC Accepted GB 3/27/2024	<p>F755</p> <p>Resident 129: On 03/18/2024 Residents narcotic card(s) were audited with no further concerns associated with this deficiency.</p> <p>Resident 130: On 03/18/2024 Residents narcotic card(s) were audited with no further concerns associated with this deficiency.</p> <p><u>Corrective action for residents that may be affected by this deficiency:</u></p> <p>All residents have the potential to be affected. Beginning 03/18/2024 an audit was performed by the Director of Nursing to ensure all medication cards with a medication placed back into the card and taped have been wasted and documented on the narcotic sheet. No further concerns have been noted.</p> <p><u>Measures that will be put into place to ensure this deficiency does not recur:</u> <u>Beginning 03/14/2024 the nursing staff were educated.</u></p> <p>All narcotic medications popped from a medication card that were dropped, popped out the wrong medication or refused by the resident would be wasted by two nurses and documented on the bottom of the narcotic sheet with the reason and signed by two nurses.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator

3/20/24

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.

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F 755	<p>Continued From page 1</p> <p>receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. Specifically, the facility did not have a process in place to destroy narcotics when not administered to the residents. Resident identifiers: 129 and 130.</p> <p>Findings included:</p> <p>On 3/13/24 at 8:30 AM, an observation was made of the facility medication cart located on the South hallway with Licensed Practical Nurse (LPN) 1. The following medications were observed inside:</p> <p>a. A multi dose medication card which held Oxycodone 5 mg (milligram) had the back of pocket number 23 was opened with tape now closing it, there was no medications observed in the pocket. The bottom of the narcotic card, under the waste section, had a note written by a staff member that documented, the Oxycodone had been taped closed back into pocket number 23 after the resident refused it.</p> <p>b. A multi dose medication card which held Hydrocodone - APAP (Acetaminophen) 5-325 mg had the back of pocket number 2 was opened with tape now closing it, there was no medication observed in the pocket. No information was documented under the waste section of the form to explain what happened to the narcotic.</p> <p>c. A multi dose medication card which held Oxycodone 10 mg had the back of pocket number 25 was opened with tape now closing it, there was no medication observed in the pocket. No information was documented under the waste section of the form to explain what happened to the narcotic.</p>	F 755	<p>If only one nurse is on shift the narcotic will be placed in a pill pouch or cup and locked in the narcotic drawer until another nurse arrives. The two nurses would verify the medication being wasted. Document the bottom of the narcotic sheet with the reason and signed by both nurses.</p> <p><u>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:</u></p> <p>Director of Nursing or designee will audit the North and South medication carts to ensure all narcotic medication cards do not have any tape or taped medications replaced in card. All wasted medications are documented on the narcotic sheet and signed by two nurses. Starting the week of 03/25/2024 audits will be done weekly for 4 weeks, monthly for 2 months, then quarterly thereafter if needed.</p> <p>A report will be submitted to the Quality Assurance Performance Improvement (QAPI) committee monthly for 3 months. The QAPI committee will make recommendations and determine if continued monitoring is necessary.</p> <p>The Director of Nursing is responsible for on-going monitoring and compliance.</p> <p>Date of Compliance: 03/25/2024</p>	03/25/2024	

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F 755	Continued From page 2 On 3/13/24 at 8:30 AM, an interview was conducted with LPN 1. LPN 1 stated when a narcotic needed to be discarded it was done by two nursing staff, if available. And the narcotic was put in the sharps container. If two staff were not available LPN 1 stated they had been told that it was okay to tape the narcotic back in the the medication card for future use. LPN 1 stated the staff would circle the number on the narcotic sheet of the pill that was taped back in. LPN 1 stated the medication would then be used when the resident needed that medication again. LPN 1 stated she was unsure how future staff would know if the correct medication had been placed back into the medication card or if the medication was kept clean by the previous nurse. LPN 1 stated she was unsure what the correct process was. On 3/13/24 at 9:00 AM, an interview was conducted with Registered Nurse (RN) 1. RN 1 stated two nurses would dispose of a narcotic and sign it out in the narcotic book. RN 1 stated she did not know what to do if there was only one nurse on duty and a narcotic needed to be wasted. RN 1 stated, "you would need to keep it right, and put it back in?" RN 1 then stated she just did not know because she had not been faced with that or been told what to do in that situation. On 3/13/24 at 10:16 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the staff were expected to sign out a narcotic when they get it from the cart. The DON stated when the nurses waste a narcotic they were supposed to waste it with another nurse, if another nurse is not available then the	F 755			

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F 755	Continued From page 3 nurse could place the narcotic in a cup and save it to waste when the next nurse came on shift. The DON stated a wasted medication would be one that was dropped, the nurse popped out the wrong medication, or refused by the resident. The DON stated it would be a nursing judgement call whether the medication needed to be discarded. The DON stated she was unsure if the facility had a procedure for disposing of medications. The DON stated the medications could be taped back into the medication card and used again. The DON stated the nurses would have to trust the previous nurse who put the medication in the card that it was the correct medication and that is was kept clean. The DON stated the nurses were not expected to write anything on the narcotic sheet under the waste section if they taped it back into the card, only if they wasted the medication.	F 755			

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E 000	Initial Comments SNF/NF Emergency preparedness E-000 Initial Comments: Statutory and regulatory authority for this Emergency preparedness survey that was conducted on 03-12-2024 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 03-27-2024 POC Date:03-25-2024	
K 000	INITIAL COMMENTS SNF/NF K-000 Initial Comments. Statutory and regulatory authority for this Life Safety Code survey that was conducted on 03-12-2024 in the presence of 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 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

David [Signature]

Administrator 03/27/2024

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K 321	Continued From page 2 door to the dietary storage room was being held open with a mop bucket and 2 milk crates by passing the required door closure. The door is required to be self-closing or automatic closing to the latch position in accordance with NFPA 101 19.3.2.1.	K 321		
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 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 observations made in the presence of the facility manager on 03-12-2024, it was determined that the facility did not maintain the fire alarm system in accordance with NFPA 101 19.3.4.4. & 9.6.1.3.; and NFPA 72. This deficiency affected 1 of two required tests. Findings include: During the record review the facility failed to provide documentation that the fire alarm control panel batteries had been tested under load two times in the last year. There was documentation of one test. Batteries need to be tested semiannually in accordance with NFPA 101 19.3.4.1, 9.6.1.3 and NFPA 72 table 7.3.2. The plant manager confirmed these findings.	K 345	POC for tag K 345 <u>Corrective action taken to ensure compliance with section K 345:</u> Facility administrator spoke with the manager at AAA Fire Utah (facility contracted service provider) on 03/21/2024 and reviewed the facility contract as well as the requirements under K 345 for the semiannual testing of alarm control batteries. The manager reviewed the facility testing and confirmed that the testing was missed in August of 2023. And committed to maintain compliance moving forward. Facility testing was completed February 22, 2024 and the second semiannual test is to be completed on or before August of 2024. In addition, the facility is looking into the option of changing fire testing service providers if contracted company cannot support continued compliance with code. <u>Date of Compliance 03/25/2024</u>	<u>03/25/24</u>
K 353	Sprinkler System - Maintenance and Testing	K 353		

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K 353 SS=D	Continued From page 3 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 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 facility manager on 03-12-2024, it was determined that the facility did not maintain the fire sprinkler system in accordance with NFPA 101, 9.7.5. NFPA 13 This deficiency affected 6 of the required escutcheons. Findings include: 1-The fire sprinkler head assemblies located in resident rooms 211 rest room and 112 restroom were missing the required escutcheons that cover the annular space around the fire sprinkler head. 2- The fire sprinkler head located in resident room 102 closet was leaking.	K 353	POC for tag K 353 <u>Corrective action taken to reenter compliance with section K 353:</u> 1 – Escutcheons replaced in the restrooms of rooms 211 and 112. 2 – Facility administrator contacted AAA Fire Utah (facility contracted service provider) on 03/21/2024 to request sprinkler head in closet of room 102 to be replaced. <u>Measures that will be put into place to ensure compliance with K 353 moving forward:</u> The facility maintenance manager will conduct an initial audit of fire suppression systems the week of 3/25/2024 and create an accurate count and location detail of all fire suppression sprinklers to ensure accuracy of further audits. The facility maintenance manager, their assistant, or the administrator will perform quarterly fire suppression system visual inspections and promptly address any systems out of compliance. <u>Date of Compliance 03/25/2024</u>	<u>03/25/24</u>	

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K 712 SS=F	<p>Fire Drills CFR(s): NFPA 101</p> <p>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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: K-0712 Based upon observations made during the record review in the presence of the facility manager on 03-12-2024, it was determined that the facility did not verify the transmission of the fire alarm signal during the conducted fire drills that were held at unexpected times under varying conditions at least quarterly on each shift in accordance with NFPA 101 19.7.1.2.</p> <p>This deficiency affected all required fire drills.</p> <p>Findings include: 1- During the record review the facility failed to provide documentation that the drill included the verification for the transmission of the fire alarm signal and simulation of emergency conditions per NFPA 101 19.7.1.4 The plant manager confirmed these findings.</p>	K 712	<p>POC for tag K 712</p> <p><u>Corrective action taken to ensure compliance with section K 712:</u></p> <p>Upon inspection of system and communication with AAA Fire of Utah, it was realized that transmissions are not sent when fire drills utilize the "Drill" button to trigger a response.</p> <p>With this information, it was decided that the facility will now trigger fire alarms from pull stations or smoke detectors, quickly silencing the audible alarm if needed, moving forward and call to verify transmission as well as request documentation be provided with proof of transmission.</p> <p>Facility maintenance manager will provide documentation of completion for 2024 Q1 and Q2 required fire drills to the life safety committee at their monthly life safety meeting for review.</p> <p><u>Date of Compliance 03/25/2024</u></p>	<u>03/25/24</u>	

