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 _____	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF OGDEN	5648 SOUTH ADAMS AVENUE WASHINGTON TERRACE, UT 84405

(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 42 CFR 483.73 K6 PLAN APPROVAL: 2013 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: A one (1) story, 2013, Type V (111), protected combustible construction. The building has complete coverage by an automatic (wet) sprinkler system and a total of there (3) smoke compartments. A Comparative Federal Monitoring Survey was conducted on 8/23/24, following a State Agency Annual Survey on 7/3/24, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Stonehenge of Ogden was found to not 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, 483.73 et seq. (Emergency Preparedness).	E 000	Preparation and submission of this plan of correction by, Stonehenge of Ogden does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. Reviewed by Erik Wilhelm Ascellon Corporation 11/20/24 ACCEPTABLE	
E 035 SS=F	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws	E 035	E 035 1. No residents were affected by this finding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 09/13/2024

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
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E 035	Continued From page 1 and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to develop and maintain an Emergency Preparedness (EP) communication plan that complies with Federal, State and local laws and includes a method for sharing information from the emergency plan, that the facility has determined as appropriate with residents and their families. The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility has a capacity for 52 beds with a census of 36 on the day of the survey. The findings include: Records review of the facility's EP communications plan on 8/23/24 at 1:34 p.m. revealed the facility had no documentation of a method for sharing information from the emergency plan, that the facility has determined as appropriate with residents and their families. The facility failed to develop and maintain an EP	E 035	2. A document was created titled " Stonehenge of Ogden Emergency Plan Fact Sheet" explaining that the facility does have an emergency plan in place in the event of a major incident or natural disaster. The fact sheet includes the types of events that are outlined in the emergency preparedness manual and a contact number for the resident or their families to call if they would like to see the manual or would like more details about the emergency preparedness plan. The document was placed inside a welcome binder that is provided in every patient room. The welcome binder includes information on key personnel in the facility, services that are offered at the facility, our mission statement, a map of the facility with evacuation routes, and other information. 3. The maintenance director or designee will do an audit of five random rooms monthly to ensure that thte Emergency Plan Fact Sheet is included in the welcome binders. The maintenance director or designee will bring the results of the audit to the monthly Quallity Assurance Performance Improvement (QAPI) Meeting monthly for three months and then quarterly for reporting and review.	

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E 035	Continued From page 2 plan that complies with Federal, State and local laws and includes a method for sharing information from the emergency plan, that the facility has determined as appropriate with residents and their families. Interview on 8/23/22 at 1:34 p.m. with the Administrator and Maintenance Director revealed the facility was unaware of the requirement to develop and maintain a method for sharing information from the emergency plan that the facility has determined as appropriate with residents and their families. The census of 36 was verified by the Director of Nursing on 8/23/24 at 10:21 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 8/23/24 at 1:55 p.m.	E 035	4. The maintenance director or designee is responsible for on-going monitoring and compliance. Date of Compliance: 9/5/2024	

STONEHENGE

Of Ogden
Emergency Plan Fact Sheet

The mission of Stonehenge of Ogden in respect to all-hazards emergency preparedness is to plan, prepare, and respond to emergency situations and disaster scenarios; to ensure that casualties and property damage are minimized; to restore normal operations; to assist other facilities that may be stricken by an emergency situation or disaster scenario with available capabilities and resources; and to coordinate all emergency management activities with the Weber County Emergency Management agency as well as with other local emergency response agencies. The administrator or assigned designee will be the incident commander during emergency situation and will work with local and regional authorities during that time to restore normal operation. A public relations officer will be available to contact in regards of love ones during an emergency at 801-475-0500.

Emergency Preparedness Plan Includes

- Hazard Vulnerability Assessment
- Collaboration with local and regional Emergency Management Agencies
- Incident Command System
- Emergency food, water and supplies
- Local and long distant evacuation sites
- Evacuation procedures from Stonehenge
- Continuation of care for Stonehenge's residents
- Shelter-in-place consideration during emergencies
- Emergency procedures for the following:
    - Fire emergency
    - Missing resident
    - Sevier weather
    - Flooding
    - Earthquakes
    - Utility outage
    - Hazardous material incident
    - Armed intruder/Active shooter
    - Workplace violence
    - Nuclear attack or incident
    - Suspicious package
    - Bomb threat
    - Medical emergency
    - Epidemic/Pandemic episode
    - Terrorism attack
    - Post recovery procedures

The purpose of this plan is to provide an all-hazards approach to guide Stonehenge of Ogden in the event of an emergency, a crisis, or a disaster scenario that would affect the safety and well-being of our residents and employees as well as community members stricken by the situation. The desired outcome is to protect and preserve the residents, employees, and facility from such emergencies. Further information can be given upon request.

If you have any question, you can contact the facility at 801-475-0500.

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	465182	A. BUILDING 01 - STONEHENGE OF OGDEN, LLC B. WING _____	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEHENGE OF OGDEN	5648 SOUTH ADAMS AVENUE WASHINGTON TERRACE, UT 84405

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K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2013 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: A one (1) story, 2013, Type V (111), protected combustible construction. The building has complete coverage by an automatic (wet) sprinkler system and a total of three (3) smoke compartments. A Comparative Federal Monitoring Survey was conducted on 8/23/24, following a State Agency Annual Survey on 7/3/24, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Stonehenge of Ogden 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, 483.90 (a) et seq. (Life Safety from Fire).	K 000	Preparation and submission of this plan of correction by, Stonehenge of Ogden does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an	K 351	K 351 1. No residents were affected by this finding.	

Reviewed by Erik Wilhelm
Ascellon Corporation
11/20/24
ACCEPTABLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 09/13/2024

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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K 351	Continued From page 1 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the code. The deficient practice affected one (1) of three (3) smoke compartments, staff, and no residents. The facility has the capacity for 52 beds with a census of 36 on the day of survey. The findings include: Observation during a tour of the building on 08/23/24 at 10:25 a.m. revealed the spray pattern of two (2) of four (4) sprinkler heads in the administrative corridor were obstructed by 2-foot by 4-foot ceiling mounted fluorescent light fixtures. The light fixture was located approximately 4-inches from the sprinkler head and extended approximately 2-inches below the sprinkler deflector. The facility failed to install sprinkler heads free from obstructions to spray pattern development as required by sections 8.5.5.1, 8.5.5.2.1 and Table 8.6.5.1.1 of NAPA 13, Standard for the Installation of Sprinkler Systems	K 351	2. The lights in the administrative hallway that were identified as obstructing the spray pattern of the adjacent fire sprinklers were relocated further away from the fire sprinklers as to not obstruct their pattern or flow in the event that they are to be used. 3. An audit will be performed by the maintenance director or designee to identify other lights in the facility that are too close to the sprinklers and that could potentially disrupt the pattern and flow of the sprinkler. Any lights and sprinklers that are identified as being too close together will be remedied with appropriate action to achieve compliance. 4. The maintenance director or designee will bring the audit report with the to the monthly Quality Assurance Performance Improvement (QAPI) meeting and the facility will take appropriate action to achieve continued compliance. Date of Compliance: 9/5/24	

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K 351	Continued From page 2 Interview with the Maintenance Director on 08/23/24 at 10:25 a.m. revealed the facility was not aware the light fixtures were obstructing the sprinkler heads. The census of 36 was verified by the Director of Nursing on 8/23/24 at 10:21 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 8/23/24 at 1:55 p.m. Actual NFPA Standard: NFPA 101, Life Safety Code (2012) 19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. 9.7 Automatic Sprinklers and Other Extinguishing Equipment 9.7.1 Automatic Sprinklers. 9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation of Sprinkler Systems (2) NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes (3) NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height Actual NFPA Standard: NFPA 13, Standard for the Installation of Sprinkler Systems (2010) 8.5.5. Obstructions to sprinkler discharge. 8.5.5.1 * Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the	K 351		

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K 351	Continued From page 3 hazard. (See Figure A.8.5.5.1.) 8.5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 8.5.5.2.1 Continuous or noncontinuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 8.5.5.2. 8.5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special requirements of Section 8.6 through Section 8.12 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. 8.6.5 Obstructions to Sprinkler Discharge (Standard Pendent and Upright Spray Sprinklers). 8.6.5.1 Performance Objective. 8.6.5.1.1 Sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.6.5.2 and 8.6.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. 8.6.5.1.2* Sprinklers shall be arranged to comply with one of the following arrangements: (1) Subsection 8.5.5.2, Table 8.6.5.1.2, and Figure 8.6.5.1.2(a). (2) Sprinklers shall be permitted to be spaced on opposite sides of obstructions not exceeding 4 ft (1.2 m) in width, provided the distance from the centerline of the obstruction to the sprinklers does not exceed one-half the allowable distance permitted between sprinklers. (3) Obstructions located against the wall and that are not over 30 in. (762 mm) in width shall be permitted to be protected in accordance with Figure 8.6.5.1.2(b). 8.6.5.2 Obstructions to Sprinkler D 8.6.5.2 Obstructions to Sprinkler Discharge Pattern Development. 8.6.5.2.1 General. 8.6.5.2.1.1 Continuous or noncontinuous	K 351		

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K 351	Continued From page 4 obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 8.6.5.2. 8.6.5.1.2 Where the distance from sprinkler head to the side of obstruction of less than 1 foot, the maximum distance of deflector above obstruction is 0 inches in accordance with Table 8.6.5.1.2.	K 351		
K 712 SS=F	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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected three (3) of three (3) smoke compartments, staff, and all residents. The facility had the capacity for 52 beds with a census of 36 on the day of survey. The findings include: Records review, on 8/23/24, at 11:36 a.m., revealed that no documentation was present that indicated the facility had conducted a fire drill on the second shift (2:00 p.m., to 10:00 p.m.) during the fourth quarter (January, February, or March) of 2023; on the third shift (11:00 p.m., to 7:00	K 712	K712 1. No residents were affected by this finding. 2. In October 2023, the new maintenance director started at the facility and noticed that the fire drills were not happening once per shift per quarter, but that there were only two fire drills per quarter. Starting in November of 2023, the fire drills were corrected and were being performed as required, once per shift per quarter. This was also noticed in the life-safety survey performed on 7/3/24. 3. The immediate resolution for the fire drills was implemented in October 2023 and has stayed consistent to the requirement since then and up to the life-safety survey on 7/3/2024, and then again for the second life-safety survey on 8/23/24. Administrator reviewed the fire drill logs with the maintenance director and educated him on continuing to follow the fire drill schedule as required by CMS.	

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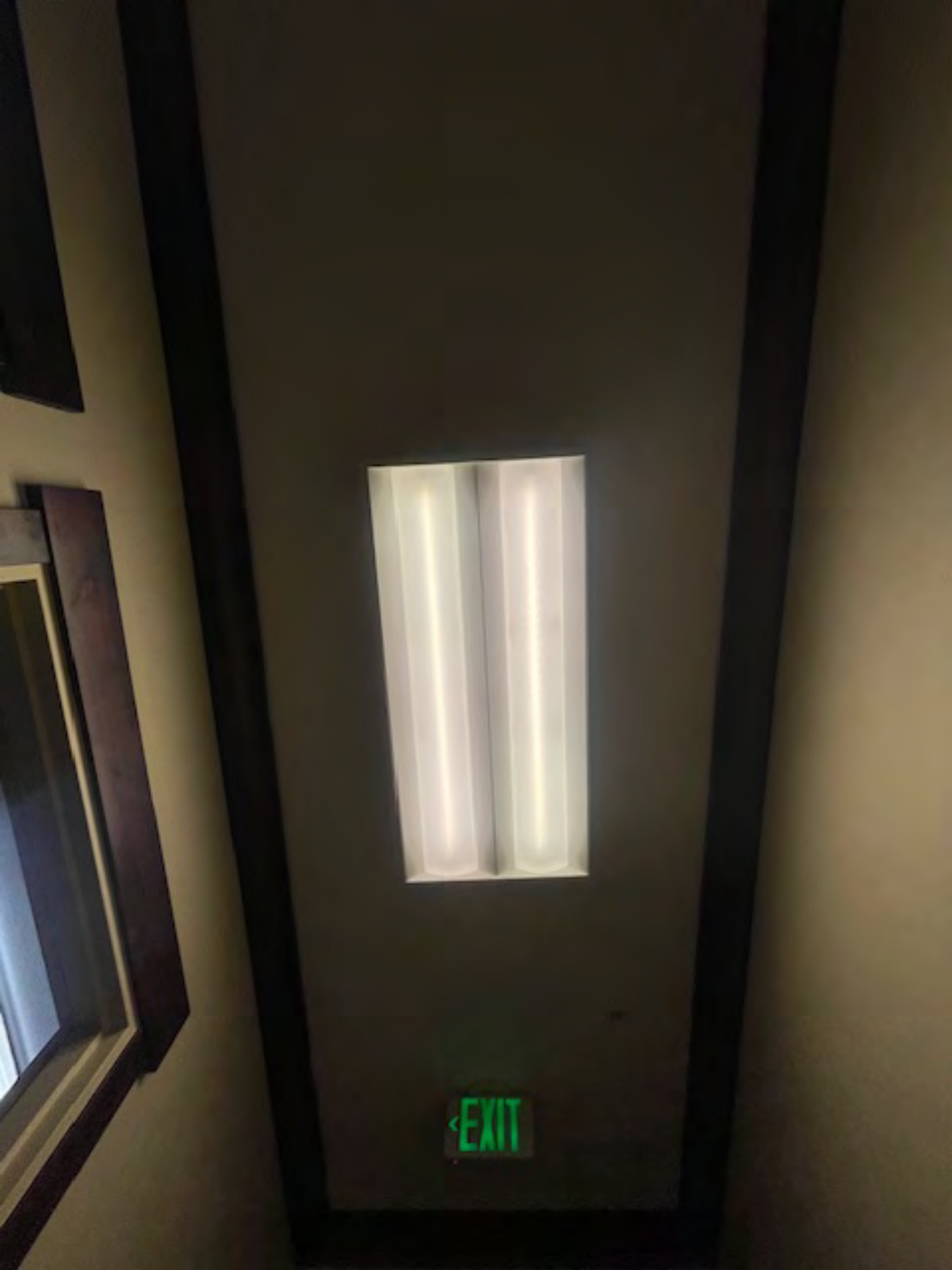
K 712	Continued From page 5 a.m.) during the second quarter (April, May, or June) of 2023; or on the third shift (11:00 p.m., to 7:00 a.m.) during the fourth quarter (October, November, or December) of 2023, as required by section 19.7.1.6 of NFPA 101, Life Safety Code. An interview with the Maintenance Director, on 8/23/24, at 11:36 a.m., revealed the facility was not aware of the missing fire drill. The census of 36 was verified by the Director of Nursing on 8/23/24 at 10:21 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 8/23/24 at 1:55 p.m. Actual NFPA Standard: NFPA 101 (2012) Life Safety Code 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. 19.7.1.7 When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.	K 712	4. The maintenance director or designed will bring the fire drill log to the monthly Quality Assurance Performance Improvement (QAPI) meeting monthly for reporting and review and the administrator will sign off on the fire drill report monthly. The maintenance director or designee is responsible for on-going monitoring and compliance. Date of Compliance: 8/30/2024	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