

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  465176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/18/2024
NAME OF PROVIDER OR SUPPLIER  Stonehenge of South Jordan		STREET ADDRESS, CITY, STATE, ZIP CODE  1371 West South Jordan Parkway South Jordan, UT 84095	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview or record review it was determined, for 1 of 15 sampled resident, the facility did not ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice, the comprehensive person-centered plan, the residents' goals and preferences. Specifically, a residents was assisted to bed and his oxygen was not turned on. Resident identifier: 74.</p> <p>Findings include:</p> <p>Resident 74 was admitted to the facility on [DATE] with diagnoses which included right pubis fracture, congestive heart failure (CHF) and chronic respiratory failure.</p> <p>On 12/16/24 at 12:53 PM, an interview was conducted with resident 74. Resident 74 stated he needed oxygen all the time. Resident 74 stated he did not think his oxygen was on. Resident 74 stated he needed to have his oxygen turned on. At 1:05 PM, an observation was made of Certified Nurses Assistant (CNA) 1. CNA 1 was observed to place a pulse oximeter on resident 74 and then went into resident 74's bathroom and turned on his oxygen concentrator. Resident 74's oxygen was at 88% after a minute.</p> <p>Resident 74's medical record was reviewed.</p> <p>A physician's order dated 12/7/24 revealed O2 [oxygen] 1-4 L [liters] per NC [nasal cannula]</p> <p>PRN [as needed] to keep Sat [saturations] &amp;gt; [greater than] 90% until stable RA [room air] every shift.</p> <p>A care plan dated 12/7/24 revealed I use Oxygen Therapy: CHF, Respiratory illness. The goal was I will have no s/sx [signs and symptoms] of poor oxygen absorption during my stay. The interventions included Change oxygen cannula and humidification bottle (if used) weekly; Give medications as ordered; Monitor for s/sx of respiratory distress and report to MD [medical doctor] PRN: Respirations, Pulse oximetry, Increased heart rate (Tachycardia), Restlessness, Diaphoresis, Headaches, Lethargy, Confusion, Atelectasis, Hemoptysis, Cough, Pleuritic pain, Accessory muscle usage, Skin color; Position resident to facilitate ventilation/perfusion matching: Use upright, high Fowlers position when possible to allow for optimal diaphragm use, When on side, the good side should be down (e.g., damaged lung should be up); and Provide reassurance and allay anxiety if in distress. Stay with patient during episodes of respiratory distress.</p> <p>(continued on next page)</p>

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/17/24 at 2:38 PM, an interview was conducted with CNA 2. CNA 2 stated resident 74 was on continual oxygen using 3 to 4 liters. CNA 2 stated when a resident required oxygen a portable oxygen tank was used when the resident was being transported. CNA 2 stated resident 74 was not able to go without oxygen. CNA 2 stated when a resident was connected to a different oxygen tank or concentrator, she always checked to make sure the tubing was hooked up and the oxygen was on.</p> <p>On 12/17/24 at 3:25 PM, an interview was conducted with the Corporate Resource Nurse (CRN). The CRN stated if a resident required oxygen, then she would expect that the resident had the oxygen on at all times. The CRN stated a resident used a portable oxygen tank when the resident was not in their room. The CRN stated a resident used an oxygen concentrator when the resident was in their room.</p> <p>On 12/17/24 at 12:35 PM, an interview was conducted with CNA 1. CNA 1 stated she was not aware resident 74's oxygen concentrator was off. CNA 1 stated if she knew the oxygen concentrator was off she would have turned it on. CNA 1 stated the oxygen concentrator was usually turned off when a resident was not using it. CNA 1 stated she did not realize the concentrator was off.</p>		

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<p>F 0882</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home.</p> <p>Based on interview and record review, the facility did not designate one or more individuals as the infection preventionist (IP) who are responsible for the facility's infection control program. Specifically, the previous Director of Nursing (DON) was the facilities designated IP and did not work at least part time at the facility.</p> <p>Findings included:</p> <p>On 12/18/24 at 10:54 AM, an interview was conducted with the Corporate Resource Nurse (CRN). The CRN stated she was the facility DON. The CRN stated the previous DON was the IP.</p> <p>On 12/18/24 at 10:55 AM, an interview was conducted with the facility Administrator. The Administrator stated the previous DON was at the facility less than 10 hours per week.</p> <p>On 12/18/24 at 11:46 AM, an interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that the previous DON was the IP. LPN 1 stated that she was unsure how often the previous DON came to the facility. LPN 1 stated that she had not done the training to be the IP even though she signed and completed the infection surveillance for the facility.</p>		