STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, interviews and record review, the facility failed to ensure care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect, in full recognition of his or her individuality for two (#16 and #28) of two residents reviewed for respect and dignity out of 29 sample residents. Specifically, the facility failed to: -Ensure Resident #16 had privacy when he slept in a brief; and, -Ensure Resident #28 was dressed appropriately and not exposed in the dining room. Findings include: I. Facility policy and procedure The Resident Rights Dignity and Respect policy, revised November 2023, was provided by the director of nursing (DON) on 7/12/24 at 11:45 a.m. It read in pertinent part, It is the policy of this facility that all residents be treated with kindness, dignity and respect. Residents will be appropriately dressed in clean clothes arranged comfortably on their persons, and well groomed. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passers-by. Violations of the resident's right to dignity and respect should be promptly reported to the DON and/or the administrator. II. Resident #16 A. Resident status Resident #16, age less than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included personal history of a traumatic brain injury, dependence on respirator and persistent vegetative state (disordered state of consciousness). (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/1/24 minimum data set (MDS) assessment revealed the resident was unable to be understood and unable to participate in the brief interview for mental status (BIMS) for a cognitive score. The MDS assessment indicated Resident #16 had a memory problem and was severely impaired through staff assessment. Resident #16 was dependent upon staff for all activities of daily living (ADLs). B. Observations During a continuous observation on 7/10/24, beginning at 10:55 a.m. and ending at 12:55 p.m., the following was observed: At 10:55 a.m. Resident #16 was lying in bed wearing a brief. The resident's brief and the entire right side of his body was exposed and the resident's bedroom door was completely open. At 12:03 p.m. licensed practical nurse (LPN) #2 entered Resident #16's room and administered his medication through his feeding tube. There was a sheet that covered Resident #16's left leg exposing the rest of his body and his brief. -LPN #2 did not cover Resident #16 and left the room at 12:07 p.m. The resident's door was left completely open. At 12:45 p.m. an unidentified respiratory therapist (RT) entered Resident #16's room. The unidentified RT suctioned the resident's tracheostomy. The RT exited the room at 12:49 p.m. and left the resident's room without covering the resident. The RT left the resident's door completely open. At 12:55 p.m. a staff member entered Resident #16's room and provided incontinence care. The staff member covered Resident #16 with a sheet when he left the room. -However, the facility failed to cover the resident for two hours. The resident's door was left open and he was exposed to individuals who passed by in the hallway. C. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 7/10/24 at 1:17 p.m. CNA #1 said after a resident was changed or repositioned the staff covered the resident with a sheet or their clothing. CNA #1 said if the resident refused to be covered the staff closed the door or pulled the privacy curtain. The DON was interviewed on 7/12/24 at 3:17 p.m. The DON said if a resident wanted to lay in their bed in their underwear or a brief the staff respected the resident's wishes. She said the staff needed to close the bedroom door or pull the privacy curtain if they chose to lay in bed without clothing. The DON said she was not sure why the staff left Resident #16 exposed. She said the staff should have covered Resident #16's legs, closed the door or pulled the privacy curtain to prevent Resident #16 from being exposed to individuals passing by his room. III. Resident #28 A. Resident status (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28, age 69, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included morbid obesity due to excessive calories, undifferentiated schizophrenia (a psychotic disorder that was a subtype of schizophrenia with a broad range of symptoms), muscle weakness and abnormal posture. The 4/17/24 MDS assessment revealed Resident #28 was cognitively intact with a BIMS score of 13 out of 15. Resident #28 had no impairment to his upper or lower extremities and used a wheelchair. It indicated the resident refused care offered. B. Observations On 7/10/24 at 12:37 p.m. Resident #28 was in the main dining room in his wheelchair. His shirt was raised over his stomach just below his chest and his pants were down low which exposed his intergluteal cleft to the residents and staff in the dining room. -No staff members offered to adjust the resident's clothing so the resident was not exposed in the dining room. On 7/11/24 at 12:21 p.m. Resident #28 was in the main dining room in his wheelchair wearing the same clothes from 7/10/24. His shirt was raised over his stomach just below his chest and his pants were down low which exposed his intergluteal cleft to the residents and staff in the dining room. -No staff members offered to adjust the resident's clothing so the resident was not exposed in the dining room. On 7/12/24 at 5:04 p.m. Resident #28 was in the main dining room in his wheelchair wearing the same clothes from 7/10/24. His shirt was raised over his stomach just below his chest and his pants were down low which exposed his intergluteal cleft to the residents and staff in the dining room. -No staff members offered to adjust the resident's clothing so the resident was not exposed in the dining room. C. Resident interview A resident, who wished to remain anonymous, was interviewed on 7/10/24 at 3:00 p.m. The resident said when the weather was hot the staff often placed residents in their wheelchairs with only a brief and shirt or just a brief on in the dining room. The resident said a lot of residents walked around exposed and Resident #28 often had his clothes not positioned properly to prevent exposure. D. Staff interviews The DON was interviewed on 7/12/24 at 3:17 p.m. The DON said Resident #28 often sat in the dining room partially exposed because he was a bigger resident and his clothes did not fit well. She said the staff encouraged him to fix his clothing placement or offered to help him, but the resident often refused. The DON said the facility offered to purchase the resident bigger clothes and Resident #28 refused. -However, staff were not observed offering to reposition Resident #28's clothing so he was not exposed in the dining room during the survey (see observations above). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she had not heard of any concerns from residents regarding other residents being exposed during meal times. The DON said she understood why it was a concern.

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51160

Based on observations, record review, and interviews the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming and personal and oral hygiene for six (#10, #16, #14, #6, #24 and #9) of 13 residents reviewed for ADLs out of 29 sample residents.

Specifically, the facility failed to:

-Ensure Resident #10, #16 and #14 received timely repositioning and toileting/incontinence care while in bed;

-Ensure Resident #6 and #24 received timely repositioning and toileting/incontinence care; and,

-Ensure Resident #9 received assistance with meals.

Findings include:

I. Professional reference

According to the Basic Nursing third edition, Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022), page 1214 read in pertinent part, Healthy people regularly shift position to maintain comfort. However, many patients are unable to move without assistance. They require a change of position at least every two hours to prevent skin breakdown, muscle discomfort, damage to superficial nerves and blood vessels, and contractures.

II. Facility policy

The Activity of Daily Living/Maintain Abilities policy and procedure, revised October 2022, was provided by the director of nursing (DON) on 7/10/24 at 5:28 p.m. It documented in pertinent part, Residents who are unable to carry out activities of daily living (ADL) will receive necessary services or support from staff. ADLs will be care planned to reflect the resident specific needs

The Activities of Daily Living (ADL) policy, undated, was provided by the DON on 7/12/24 at 11:45 a.m. It documented in pertinent part, Care and services will be provided for the following activities of daily living: bathing, dressing, grooming and oral care, transfer and ambulation, toileting, eating, to include meals and snacks. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.

III. Failure to ensure timely repositioning in bed and toileting/incontinence care for Resident #10, #16 and #14

A. Resident #10

1. Resident status

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #10, age less than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included anoxic brain damage, persistent vegetative state, muscle wasting and atrophy, contracture of muscle (right ankle and foot), contracture (right elbow, left elbow, right wrist, left wrist), swan-neck deformity of (right fingers, left fingers), chronic respiratory failure, and dependence on respirator (ventilator) status. The 5/27/24 minimum data set (MDS) assessment revealed the resident was in a persistent vegetative state with no discernible consciousness and was unable to complete a brief interview for mental status (BIMS). The resident was dependent on two staff members for all ADLs. 2. Observations During a continuous observation on 7/10/24, beginning at 10:37 a.m. and ending at 1:12 p.m., the following observations were made: At 10:55 a.m. Resident #10 was lying in bed, positioned with his right arm off-loaded by a wedge cushion. At 12:03 p.m. licensed practical nurse (LPN) #2 entered the resident's room. LPN #2 completed a medication administration for the resident and then left the room. Resident #2 was not repositioned. At 12:24 p.m. Resident #10 remained lying in the same position in bed, positioned with his right arm off-loaded by the wedge cushion. At 12:55 p.m., two staff members entered the resident's room. The staff members performed incontinence care with the resident's roommate, however, Resident #10 was not repositioned. -Resident #10 was not repositioned or provided toileting/incontinence care during the two hour and 18 minute continuous observation. 3. Record Review Review of the Kardex (a tool utilized for providing consistent care for residents) for Resident #10 revealed the resident required the total participation of two staff members to reposition and turn in bed. The resident was to be repositioned at least every two hours Resident #10's ADL care plan, revised 3/7/24, revealed the resident was totally dependent for all ADLs related to his vegetative state. Interventions included total staff participation of two staff members to reposition and turn the resident in bed. B.Resident # 16 1. Resident status Resident #16, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included traumatic brain injury and dependence on respirator (ventilator) status. The 4/29/24 MDS assessment revealed the resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was in a persistent vegetative state with no discernible consciousness and was unable to complete a BIMS. The resident was dependent on two staff members for all ADLs. The assessment revealed the resident had a feeding tube. 2. Observations During a continuous observation on 7/10/24, beginning at 10:37 a.m. and ending at 1:12 p.m., the following observations were made: At 10:55 a.m. Resident #16 was lying in bed turned to the right side with his left arm and left hip off-loaded by wedge cushions. The resident's heel protector boots rested next to his feet on the right hand side of the bed and his heels were not off-loaded. The resident was wearing only a brief. Resident #16's left leg and left hip were covered by a flat sheet. The resident's door was open to the hallway. At 12:03 p.m. LPN #2 entered the room and provided care to Resident #16's roommate. Neither resident was repositioned. Resident #16 remained in just a brief with his left leg covered by a sheet. The resident's left hip had become exposed. At 12:24 p.m. Resident #16 remained in the same position. The wedge cushions placed to off-load the resident's weight remained on the resident's left side. The resident's heels were laying on the mattress next to his heel protector boots. The resident was wearing only a brief with just his left leg covered by a sheet and the resident's door was open fully. At 12:45 p.m. a respiratory therapist (RT) entered Resident #16's room. The RT performed tracheostomy care and suctioning with the resident and exited the room at 12:49 p.m. The resident remained in the same position with his left leg partially covered by the sheet. At 12:55 p.m. two staff members entered the resident's room and performed incontinence care with Resident #16. The resident was repositioned with the wedge cushions on the right side of his body and he was covered with a sheet and no longer exposed. -However, Resident #16's heel protector boots remained next to his feet on the right hand side of the bed and the resident's heels were not off-loaded. -Resident #16 was not repositioned or provided toileting/incontinence care for two hours and 18 minutes during the continuous observation. 3. Record Review Review or the Kardex for Resident #16 revealed the resident required the assistance of one to two staff members. -The Kardex did not document how frequently the resident should be repositioned. Resident #16's ADL care plan, revised 2/20/24 revealed the resident needed assistance to turn/reposition and his heels were to be floated as the resident tolerated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident # 14 1. Resident status Resident #14, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included need for assistance with personal care, anoxic brain injury, quadriplegia, contracture of muscle (right ankle and foot), contracture (left shoulder, left elbow, left wrist, right elbow, right wrist, right hand), muscle wasting and atrophy, and dependence on respirator (ventilator) status. The 6/17/24 MDS assessment revealed the resident was rarely/never understood and was unable to complete a BIMS. The resident was dependent on two staff members for all ADLs. 2. Observations During a continuous observation on 7/10/24, beginning at 10:37 a.m. and ending at 1:12 p.m., the following observations were made: At 11:03 a.m. Resident #14 was lying in bed, positioned with his left arm off-loaded with a pillow. At 11:12 a.m. Resident #14's family member was observed adjusting the positioning of the resident's feet and the bed linens. At 12:14 p.m. LPN #2 entered the resident's room. LPN #2 administered medications to the resident and exited the room at 12:19 p.m. Resident #14 was not repositioned and remained lying in bed with the pillow under his left arm. -Resident #14 was not repositioned or provided toileting/incontinence care during the two hour and 18 minute continuous observation. 3. Record Review Review of the Kardex for Resident #14 revealed the resident was totally dependent on two staff members for repositioning and turning in bed. The resident's heels were to be floated as tolerated or he was to wear pressure relieving boots as tolerated. Review of Resident #14's ADL care plan, revised 2/20/24, revealed the resident was totally dependent on two staff members for repositioning and turning in bed and his heels were to be floated as tolerated. D. Staff interviews Certified nurse aide (CNA) #7 was interviewed on 7/10/24 at 1:12 p.m. CNA #7 said Resident #14 and Resident #16 were to be repositioned and toileted or changed every two hours and more frequently if needed. CNA #1 was interviewed on 7/10/24 at 1:17 p.m. CNA #1 said residents were repositioned and toileted or changed every two hours (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #1 said he provided care for Resident #10 and Resident #16. He said he checked the residents every two hours. He said some residents were checked more frequently if they required more frequent incontinence care. CNA #6 was interviewed on 7/12/24 at 10:48 a.m. CNA #6 said dependent residents should be turned/repositioned every two hours. He said staff was not always able to reposition residents every two hours. CNA #6 said his current shift required him to complete eight showers during his shift. He said when a resident was being showered, it required one CNA to be off the floor while the CNA was in the shower room. CNA #6 said some dependent residents were difficult to reposition related to their contractures or preferred position. Physical therapist assistant (PTA) #1 was interviewed on 7/12/24 at 10:56 a.m. PTA #1 said each resident received an individualized evaluation which included recommendations for positioning PTA #1 said the recommendations could be restorative, preventative, or maintenance measures. 51163 IV. Failure to ensure timely repositioning and toileting/incontinence care for Resident #6 and #24 A. Resident #6 1. Resident status Resident #6, age 84, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included hemiplegia and hemiparesis (conditions that cause weakness or paralysis on one side of the body) following cerebral infarction (type of stroke) affecting left non-dominant side, vascular dementia unspecified severity, senile degeneration of brain not elsewhere classified, benign prostatic hyperplasia (increased cell production in a normal tissue or organ) without lower urinary tract symptoms. The 4/22/24 MDS assessment revealed the resident was rarely or never understood, had short-term and long-term memory problems and his daily decision making was severely impaired. He was dependent on staff for personal hygiene, dressing, bathing and toileting and needed substantial or maximal assistance for oral hygiene. He needed setup and clean-up for meals and he was dependent on staff for wheelchair and bed mobility. 2. Observations During a continuous observation on 7/10/24, beginning at 9:35 a.m. and ending at 1:30 p.m., the following observations were made: At 9:35 a.m. Resident #6 was in the common area with a group of other residents and activities assistant (AA) #1 who were hitting and throwing a large ball. Resident #6 was tilted in his wheelchair at approximately a 45 degree angle and he was leaning to his left side. At 10:25 a.m. the resident continued to participate in the activity. There were no changes to his positioning. At 11:54 a.m. Resident #6 was assisted into the dining room for lunch by a CNA. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The CNA positioned the resident's wheelchair at approximately a 90 degree angle at the table, however, the resident was not repositioned in the wheelchair and continued to lean to his left side. -Resident #6 was not offered toileting or incontinence care prior to being taken to the dining room for lunch. -At 12:35 p.m., after eating lunch, Resident #6 was assisted back to the common area by a CNA. -The CNA positioned the resident's wheelchair at approximately a 45 degree angle, however, the resident was not repositioned in the wheelchair and continued to lean to his left side. -Resident #6 was not offered toileting or incontinence care prior to being taken back to the common area after lunch. At 1:06 p.m. the resident was heard asking an unknown CNA to lay down because he had urinated himself. At 1:11 p.m. the resident was assisted to his room and assisted by two staff members to lay down in bed and have his brief changed. -Resident #6 was not repositioned or provided toileting/incontinence care during the three hour and 36 minute continuous observation. 3. Record review Resident #6's ADL care plan, initiated 8/13/23, revealed the resident had ADL self care performance deficits due to lack of safety awareness, end stage dementia and impaired mobility. The care plan indicated that the resident was dependent on one to two staff members with toilet use, transfers to and from wheelchair, bathing, bed mobility, personal hygiene, oral care and dressing. The care plan further revealed Resident #6 was at risk for bowel and bladder incontinence. Pertinent interventions included checking the resident as required for incontinence. B. Resident #24 1. Resident status Resident #24, age 70, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included other sequelae of cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarction affecting non-dominant side, cerebrovascular disease (condition affecting blood flow and blood vessels in the brain and spinal cord) unspecified, unspecified dementia, abnormal posture, muscle weakness generalized, contracture of left elbow, and contracture of muscle left upper arm. The 6/17/24 MDS assessment revealed the resident had a severe cognitive impairment with a BIMS score of seven out of 15. He was dependent on staff assistance with oral hygiene, toileting, bathing, dressing upper and lower body, putting on footwear, personal hygiene, transfers to and from his wheelchair and bed mobility. He needed supervision or touching assistance with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observations During a continuous observation on 7/10/24, beginning at 9:35 a.m. and ending at 1:30 p.m., the following observations were made: At 9:35 a.m. Resident #24 was in the common area with a group of other residents and AA #1 who were hitting and throwing a large ball. Resident #24 was tilted in his wheelchair at approximately a 45 degree angle and was not actively participating in the activity. At 10:25 a.m, Resident #24 remained in the common area in his wheelchair in the same position. -At 11:57 a.m. the resident was assisted to the dining room for lunch by a CNA. -The CNA positioned the resident's wheelchair at approximately a 90 degree angle at the table, however, the resident was not repositioned in the wheelchair. -Resident #24 was not offered toileting or incontinence care prior to being taken to the dining room for lunch. At 12:40 p.m., after eating lunch, Resident #24 was assisted back to the common area by a CNA. The resident was sliding down in his wheelchair. -The CNA positioned the resident's wheelchair at approximately a 45 degree angle, however, the resident was not repositioned in the wheelchair despite the resident noticeably sliding down in his wheelchair. -Resident #24 was not offered toileting or incontinence care prior to being taken back to the common area after lunch. - At approximately 12:45 p.m. Resident #24 was wheeled to his room to be provided with incontinence care. At 1:01 p.m. the resident was transferred to bed and provided with incontinence care. -Resident #24 was not repositioned or provided toileting/incontinence care during the three hour and 26 minute continuous observation. 3. Record review Resident #24's ADL care plan, initiated 10/6/23, revealed the resident had an ADL care performance deficit due to his weakness and left sided deficits due to his cerebrovascular accident. The care plan indicated the resident was dependent on one to two staff members with toilet use, transfers to and from the wheelchair, bathing, bed mobility, personal hygiene, oral care, and dressing. The care plan further revealed Resident #24 was at risk for bowel and bladder incontinence. Pertinent interventions included checking the resident as required for incontinence. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Rock Canyon Respiratory and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2515 Pitman Pl Pueblo, CO 81004	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Staff interviews LPN (licensed practical nurse) #1 was interviewed on 7/10/24 at 12:45 p.m. LPN #1 said residents should be toileted every two to three hours and should be toileted before going to lunch. She said residents should be repositioned every two hours. LPN #1 said Resident #6 and Resident #24 were incontinent and were at risk for skin issues. CNA #3 was interviewed on 7/10/24 at approximately 1:20 p.m. CNA #3 said Resident #6 should be checked for incontinence every two hours unless he asked to be changed more frequently. She said the resident could reposition himself in his wheelchair. -However, observations revealed the resident did not attempt to reposition himself (see observations above). CNA #5 said residents should be repositioned and have their briefs checked for incontinence every two hours. She said Resident #6 and Resident #24 were incontinent. V. Failure to ensure Resident #9 received assistance with meals A. Resident #9 1. Resident status Resident #9, age 82, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included Alzheimer's disease, cognitive communication deficit and need for assistance with personal care. The 5/1/24 MDS assessment revealed the resident was rarely or never understood through staff assessment. She had short-term and long-term memory deficits and was severely impaired in daily decision-making through staff assessment. She required set up and clean up assistance for meals and was dependent on staff for all other ADLs. 2. Observations On 7/9/24 at 5:10 p.m. Resident #9 was assisted to the dining room. The resident was served her meal which consisted of four chicken nuggets, french fries and four apricot halves. She instantly picked up a french fry to eat. At 5:13 p.m. Resident #9 stood up and ate half an apricot half. She then proceeded to leave the table. -No staff members attempted to redirect the resident back to the table as she walked away from the dining room or offer the resident a hand held food item to take with her while she walked. At 5:15 p.m. the resident returned to the dining room. She took her plate of chicken nuggets and french fries with her as she left the dining room again. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 5:19 p.m. Resident #9 was walking the hall and had blankets in her arms. She did not have the food plate with her and the plate of food was not in sight in the hallway. At approximately 5:30 p.m. an unidentified CNA passed the resident walking in the hallway. The unidentified CNA asked another CNA if Resident #9 had eaten. The other CNA said the resident had eaten. -However, Resident #9 had not eaten (see observations above). On 7/10/24 at 8:35 a.m. Resident #9 was sitting at a dining room table with her meal in front of her. The resident was sleeping. At 8:45 a.m. the resident continued to sit at the table asleep. She had not touched her food. -No staff members attempted to wake the resident up or provide encouragement for her to eat. -On 7/10/24 at 11:00 a.m. Resident #9's plate of chicken nuggets and french fries from the dinner meal on 7/9/24 were found in another resident's drawer. The plate still contained the four chicken nuggets and french fries. 3. Record review Resident #9's nutrition care, initiated 4/26/24, revealed the resident had a nutritional problem. Pertinent interventions were to provide the diet as ordered. Resident #9's ADL care plan revealed the resident required set up and supervision with eating. The 5/2/24 initial nutritional evaluation documented the resident ate in the dining room and required set up assistance with her meal. B. Staff interviews Registered nurse (RN) #1 was interviewed on 7/11/24 at 4:00 p.m. RN #1 said Resident #9 was able to feed herself but she needed to receive cueing and encouragement to eat. RN #1 said the resident did get up and leave the table but she should be encouraged to come back to the dining room and she should be provided a hand held food to take with her if she would not come back to the dining room. The dietary manager (DM) was interviewed on 7/12/24 at 10:00 a.m. The DM said the kitchen had bread and other items and a hand held sandwich could be made for Resident #9 to take with her when she was walking. CNA #3 was interviewed 7/12/24 at 11:45 a.m. CNA #3 said residents who needed meal assistance could vary each day and she observed the dining room to see which residents needed assistance. The registered dietitian (RD) was interviewed on 7/12/24 at 2:00 p.m. The RD said Resident #9 would benefit from a hand held meal because she tended to walk around during meals. She said the resident should always be offered an alternative if she was not eating.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to ensure the resident environment remained as free from accident hazards as possible for one (#20) of four residents reviewed for accident hazards out of 29 sample residents. Resident #20, who had severely impaired daily decision-making skills, was admitted on [DATE]. The facility determined the resident to be at risk for falls upon her admission and implemented a care plan with generalized fall risk interventions that were not individualized for Resident #20. Resident #20 sustained falls with minor injuries on 5/3/24, 5/10/24 and 5/16/24. Per interviews during the survey (from 7/12/24 to 7/16/24), the facility added fall interventions following each of the falls, however, the facility failed to update the interventions on the resident's care plan or ensure staff were consistently implementing the identified fall interventions for the resident. The facility additionally did not evaluate the fall interventions to determine if the interventions were effective. On 7/8/24, Resident #20 sustained another fall, which resulted in the resident being transferred to the hospital for further evaluation, where it was discovered that she had sustained a fractured nose from the fall. Observations during the survey revealed the resident was not always wearing appropriate footwear (non-skid socks or shoes), as had been identified as a fall intervention. Additionally, the resident did not have a call light in her room, despite one of the fall interventions instructing staff to ensure the call light was within reach of the resident. Due to the facility's failures to identify and consistently implement individualized person-centered fall interventions, and update the resident's care plan with new fall interventions that were identified, Resident #20 sustained four falls within a three month period between 4/25/24 and 7/8/24, with the last fall on 7/8/24 resulting in a fracture to the resident's nose. Findings include: I. Facility Policy The Falls Monitoring and Management policy, undated, was provided by the director of nursing (DON) on 7/10/24 at 5:28 p.m. The policy read in pertinent part, Residents are assessed and evaluated to identify risks for injury due to falls. Residents receive necessary treatment and monitoring after a fall and interventions are implemented to minimize risks for injury due to falls. II. Resident status (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #20, age greater than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included neurocognitive disorder with Lewy bodies, cognitive communication deficit and diabetes. The 5/1/24 minimum data set (MDS) assessment revealed the resident was rarely/never understood and had short-term and long-term memory problems and her daily decision-making was severely impaired. She was dependent on staff for personal hygiene, dressing, bathing, toileting and oral hygiene. She also needed setup and clean-up for meals. She was dependent on staff for bed mobility, and needed supervision or touching assistance for walking and sitting to standing, while needing substantial assistance with transferring from chair to bed and bed to chair. She was frequently incontinent of bladder and always incontinent of bowel. III. Observations On 7/10/24 at 11:00 a.m., Resident #20 was observed getting up from her chair and beginning to walk. The brakes on the resident's wheelchair were not locked. The resident's representative was in the room and asked for the resident to sit down. The resident did not sit back down until she was encouraged to sit back down. She did have non-slip socks on. On 7/11/24 at 11:35 a.m., the resident was sitting in her wheelchair. She was self propelling with her feet. -Resident #20 had socks on her feet, however they were not non-slip socks. Certified nurse aide (CNA) #3 said the resident was at risk for falls and staff needed to ensure she had proper footwear on, which would be non-slip socks or shoes. On 7/11/24 at 2:00 p.m. Resident #20's room was observed. -There was no call light in the resident's room, however, ensuring the call light was within reach was one of the resident's care planned fall interventions (see record review below). On 7/12/24 at approximately 5:00 p.m. the resident was sitting in her wheelchair. -Resident #20 had socks on her feet, however, they were not non-slip socks. CNA #2 was interviewed on 7/12/24 at approximately 5:00 p.m. CNA #2 said the resident was at risk for falls and staff needed to ensure she had proper footwear on, which would be non-slip socks or shoes. IV. Resident representative interview (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #20's representative was interviewed on 7/10/24 at 11:41 a.m. The representative said Resident #20 had resided at the facility since April 2024. She said since the resident had resided at the facility, she had fallen four times. She said Resident #20 fractured her nose during her most recent fall on 7/8/24. The representative said the resident had been at risk for falling prior to her admission to the facility and the facility was aware of the resident's fall history. She said the resident was not always toileted timely and that could be a contributing factor to the falls. The representative said the facility had just placed a lipped mattress on the resident's bed after the fall on 7/8/24. The representative said the Resident #20 was not on a walking program, but she frequently would stand up and try to walk on her own. -The lipped mattress was not added to Resident #20's care plan. V. Record review The fall care plan, initiated on 4/29/24, identified Resident #20 was at risk for falls related to the resident's confusion and impaired safety awareness. Pertinent interventions included to ensure the call light was within reach, resident to wear proper footwear when ambulating or wheeling in wheelchair and to maintain a clear pathway. -There were no interventions added to the resident's care plan following the resident's falls on 5/3/24, 5/10/24, 5/16/24 or 7/8/24. The Kardex (a tool utilized for providing consistent care for residents), dated 7/12/24, documented the safety interventions which in place for Resident #20 were to provide frequent checks and ensure the resident was wearing appropriate footwear when walking or wheeling her wheelchair. Review of Resident #20's fall risk assessments revealed the following: -On 4/25/24, Resident #20's fall risk score was documented as an eight, which indicated she was a medium fall risk; -On 5/3/24 Resident #20's fall risk score was documented as a 13, which indicted she was a high fall risk; -On 5/11/24 Resident #20's fall risk score was documented as a 13, which indicted she was a high fall risk; -On 5/16/24 Resident #20's fall risk score was documented as a nine, which indicted she was a medium fall risk; and, -On 7/8/24 Resident #20's fall risk score was documented as a 13, which indicted she was a high fall risk. -Resident #20 was incorrectly assessed as a medium hall risk on 5/16/24 despite the resident sustaining falls on 5/3/24, 5/10/24 and 5/16/24. A. Fall #1 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 5/3/24 fall investigation documented Resident #20 fell on [DATE] and was found laying on her right side in the hall. The resident sustained a large hematoma (an injury which causes blood to pool under the skin) forming on the back right side of her head. The investigation documented the resident was confused, drowsy, incontinent and ambulating without assistance. The investigation further documented the predisposing psychological factors were confusion, drowsy, incontinence and impaired memory. The predisposing situation factors were ambulating without assistance and being a wanderer. -The investigation failed to document if the resident was wearing appropriate footwear (no-slip socks or shoes) at the time of the fall. A nurse progress note dated 5/3/24 at 5:18 a.m. documented the registered nurse (RN) heard a loud thud and noted the resident laying on the floor on her right side. The resident had been walking in the hallway. A CNA was walking toward the resident with the resident's wheelchair when the fall occurred.The RN assessed the resident and found a large hematoma forming on the back right side of her head. The resident was assisted up into a waiting wheelchair and brought to the nurses station. Neurological checks were started on the resident. The 5/3/24 post fall interdisciplinary team (IDT) note documented the resident was found on the floor. She could not explain what happened. The note documented more frequent checks were to be provided when the resident was in her room. -However, the intervention for more frequent checks was not added to the resident's care plan. B. Fall #2 The 5/10/24 fall investigation documented the resident was refusing to sit down and Resident #20 was found laying on the floor on her right side in the common area living room. She had a small one millimeter (mm) by two mm bruise to her eye and a bruise on her leg. The investigation documented the resident was ambulating without assistance. The investigation further documented the predisposing psychological factors were confusion, gait imbalance, recent change in medication and impaired memory The predisposing situation factor was ambulating without assistance. -The investigation failed to document if the resident was wearing appropriate footwear (no-slip socks or shoes) at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse progress note dated 5/11/24 at 1:03 a.m. documented the resident fell on [DATE]. The resident had been refusing to go to her room or sit in her wheelchair and was wide awake. The resident was on the other side of a wall. A RN who was nearby heard a noise and went to assess. Resident #20 was found laying in front of her wheelchair on her right side on the floor. The RN assessed the resident and found bruises on the resident's right lateral eye orbit, left side of her face near the temple area and her right lower leg. The resident was alert and able to follow simple directions. The resident was assisted to stand by a CNA and the RN, placed into her wheelchair and positioned within view of the nurses station. Neurological checks were started on the resident. -Review of Resident #20's electronic medical record (EMR) revealed there was no documentation to indicate the IDT reviewed the resident's 5/10/24 fall or that new fall interventions were implemented. C. Fall #3 The 5/16/24 fall investigation documented the resident slid to the floor from her wheelchair. The resident did not sustain any injuries. The investigation documented the predisposing psychological factor was confusion. The predisposing situation factor was she was a wanderer. -The investigation failed to document if the resident was wearing appropriate footwear (no-slip socks or shoes) at the time of the fall. A nurse progress note dated 5/16/24 at 8:25 p.m. documented Resident #20 was in the front entrance hallway of the facility and was observed sliding from her wheelchair to the floor in a seated position and then laying herself flat on her back. There were no injuries observed and neurological checks and vital signs were initiated. The 5/17/24 post fall IDT note documented the resident slid from her chair near the front door. Frequent checks and an occupational therapy wheelchair evaluation were documented as prior fall interventions. The new fall intervention added was for the occupational therapist to screen for adding dycem (a non-slip material used under wheelchair cushions) to the resident's wheelchair. -However, the interventions for frequent checks and dycem to the wheelchair were not added to the resident's care plan. D. Fall #4 The 7/8/24 fall investigation documented Resident #20 was face down on the floor bleeding from her nose and the right side of her head. The resident was sent to the emergency department. The resident had facial grimacing. The fall happened in the hallway. The investigation documented the predisposing psychological factors were gait imbalance, impaired memory and confusion. The predisposing situation factor was she was a wanderer. -The investigation failed to document if the resident was wearing appropriate footwear (no-slip socks or shoes) at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse progress note dated 7/8/24 at 11:33 p.m. documented the resident was observed on the floor face down bleeding from the bridge of her nose and the right side of her head. She had bruising and swelling noted to her face and her pupils were unequal. The resident was sent to the hospital for further evaluation and treatment. A nurse progress note dated 7/9/24 at 3:33 a.m. documented the resident had returned from the hospital. A nurse progress note dated 7/9/24 at 3:48 a.m. documented the resident had a fractured nose with swelling and bruising noted. The 7/8/24 post fall IDT note documented the resident had been found in her room laying on the floor with a fractured nose. The prior interventions listed were for occupational therapy to screen for wheelchair safety and dycem and frequent checks. The current new intervention was to lay the resident down when she appeared fatigued. -However, none of the interventions were added to the resident's care plan. VI. Staff interviews RN #1 was interviewed on 7/12/24 at 11:30 a.m. RN #1 said the resident had memory impairments and dementia. He said the resident could walk with assistance but she was not on a walking program. RN #1 said the resident's dementia was worse later in the day and the interventions the facility used to keep her safe were keeping an eye on her and ensuring she was wearing proper footwear. -However, observations during the survey revealed the resident was not consistently wearing non-slip socks or shoes (see observations above). The DON was interviewed on 7/12/24 at 3:42 p.m. The DON said residents were assessed for fall interventions upon admission, quarterly and after each fall. She said the falls were to be analyzed the day of or the day after a fall in the facility's morning meetings and as a IDT they talked about what interventions had worked to prevent falls and which ones had not. The DON said the IDT came up with new interventions and implemented them after the falls. The DON said Resident #20 was found laying on her right side on 5/3/24 and that she had a hematoma on her head. She said they implemented frequent checks. -However, the intervention was not added to the resident's care plan. The DON said the resident fell on [DATE] in front of her wheelchair. She said she received a laceration on her eye. She said that the resident's representative did not want to move her room. She said the occupational therapist screened for a new wheelchair. However, she said the resident's family did not wish to change the chair. -However, the intervention was not added to the resident's care plan and there was no documentation the resident's family had declined a room move or a new wheelchair for the resident. (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51163

Based on record review and interviews, the facility failed to ensure two (#23 and #1) of nine residents reviewed for weight loss out of 29 sample residents received the care and services necessary to meet their nutrition and hydration needs and to maintain their highest level of physical well-being

Resident #23, admitted at nutritional risk and lost 14 pounds in six weeks. While nutritional interventions were initiated on admission (supplements three times a day) and again when a significant weight loss was identified on 6/20/24 (fortified foods), observations revealed the facility failed to promote the resident's nutritional status by encouraging, cueing and assisting the resident at mealtime, documenting his intake of snack and supplement, and addressing his agitation in the dining room at mealtime. No new interventions were considered when the resident continued to lose weight.

Additionally, the facility failed to weigh Resident #1 upon admission to create a baseline to assess the resident's weight and nutritional status.

Findings include:

I. Facility policy and procedure

The Weights policy, revised May 2017, was provided by registered dietitian consultant (RDC) #1 on 7/12/24 at 12:20 p.m. It read in pertinent part,

It is the policy of this facility to obtain an accurate weight as part of the resident's assessment upon admission and at least monthly thereafter.

Nursing will be responsible for the initial determination of each individual's weight. Admission weights will be obtained. This will be included in the admission process and documented in the medical record. If hospital weight is entered, it should be listed as'type of scale used. '

The facility is responsible for obtaining correct weights on a regular basis, and for keeping accurate records. This includes having adequate weight scales, lift scales and/or wheelchair scales as needed. Erroneous (incorrect) weights may be struck out when determined inaccurate.

Reweighs may be requested if a discrepancy is presumed or if a significant weight change is noted to assure accuracy of the weight.

Individuals with unplanned significant or severe weight loss may receive nutrition interventions to prevent further weight loss, stabilize weight and/or assist to regain weight as appropriate.

II. Resident #23

A. Resident status

(continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident #23, age 84, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included senile degeneration of the brain, anxiety, hyperglycemia (high blood sugar), protein-calorie malnutrition, dysphagia oropharyngeal phase (difficulty swallowing), muscle weakness, muscle wasting and atrophy multiple sites (partial or complete wasting of the muscles). The 5/28/24 minimum data set (MDS) assessment revealed the resident was rarely or never understood through staff assessment. The resident had short-term and long-term memory deficits and was severely impaired in daily decision-making through staff assessment. The resident required set up and clean up assistance for meals and was dependent for all other activities of daily living (ADL). The assessment revealed the resident had complaints of difficulty or pain of swallowing, was on a mechanically altered diet and showed none or had unknown weight loss or weight gain. B. Observations On 7/9/24 at approximately 5:06 p.m., an unidentified staff member served Resident #23 dinner. Resident #23 was able to eat approximately 25% of his dinner and drink 100% of his beverages. -Resident #23 was not encouraged, cued or assisted by staff. -No alternates, refills or seconds were offered to Resident #23 before he was assisted out of the dining room. On 7/10/24 at approximately 12:05 p.m. Resident #23 was served his lunch meal. He was eating his lunch with no issues. -Resident #23 was not encouraged, cued or assisted by staff. At approximately 12:15 p.m. Resident #23 accidentally knocked his plate over the side of the table which spilled his plate of food down the front of himself and onto the floor. Resident #23 had consumed less than 25% of his meal. The resident was assisted out of the dining room and into the common area. -The resident was not offered a new meal after his lunch spilled on the ground. C. Record Review The nutrition care plan, dated 5/23/24, revealed the resident had a nutritional problem related to the diagnoses of dementia and hyperglycemia. The care plan documented the resident was malnourished and had a history of weight loss based on hospitalization s prior to admission to the skilled nursing facility. Pertinent interventions included honoring his right to make dietary choices, monitoring and reporting signs and symptoms of decreased appetite and unexpected weight loss to the physician, monitoring weekly weights for four weeks, monitoring intake and the registered dietitian (RD) would monitor the resident's ongoing nutritional status. -Resident #23's care plan did not identify weight loss was expected for the resident and there were no updates made to the care plan when significant weight loss was identified (see record review below). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rock Canyon Respiratory and Rehabilitation Center	2515 Pitman Pl Pueblo, CO 81004

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The July 2024 CPO revealed the resident had a physician's order to receive MedPass 2.0 (nutritional supplement) 120 ml (millileters) three times a day, ordered 5/24/24. The June 2024 and July 2024 medication administration records (MAR) revealed that MedPass 2.0 120 ml was being given to the resident three times a day and the resident was consistently consuming 100% of the supplement. -However, the amount of the supplement was not increased or another nutritional supplement added when the resident continued to lose weight until 6/25/24 when the RD added fortified foods. Resident #23's weights were documented in the resident's electronic medical record (EMR) as follows: -On 5/22/24, the resident weighed 153.5 lbs; -On 6/5/24, the resident weighed 150 lbs; -On 6/13/24, the resident weighed 147.5 lbs; -On 6/20/24, the resident weighed 142 lbs; -On 6/24/24, the resident weighed 140.5 lbs; and, -On 7/1/24, the resident weighed 139.0 lbs. -The resident lost 14.5 lbs (9.5%) from 5/22/24 to 7/1/24, in 40 days, which was considered significant. The 5/23/24 mini nutritional assessment (MNA) score was a six, which indicated that he was malnourished upon admission. The 5/24/24 admission nutritional assessment documented the resident's weight was 153.5 lbs upon admission. It documented his mini nutritional assessment risk score was a six, which indicated the resident was malnourished. The RD documented the resident was consuming 75-100% of most meals. The RD recommended starting 120 ml MedPass 2.0 three times a day, which would provide 720 calories and 30 grams protein per day. The assessment documented the RD would continue to monitor and follow up as needed. The 6/25/24 RD progress note documented the RD spoke to the resident's representative about the resident's weight loss and recommended fortified meals to help reduce further weight loss. The resident's representative agreed with the intervention. (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

The 6/25/24 nutrition at risk committee documented the resident's current weight was 140.5 lbs. The committee reviewed the resident's weight loss, which was down 13 lbs from the admission weight. The committee determined the resident's weight loss might have been related to fluctuating intake at meals and the disease progression. The resident's representative said the resident enjoyed peanut butter and honey. The note documented the recommendation was to assist the resident at meals to help reduce further weight loss. The physician was notified of the weight loss and was requested to evaluate for a possible appetite stimulant.

The 7/1/24 progress note revealed the resident was placed on hospice with the diagnosis of senile degeneration of the brain.

A review of Resident #23's intake meal record on 7/11/24 at 11:37 a.m., revealed the amount the resident had consumed of his meals from 6/12/24 to 7/11/24 was as follows:

-25% of meals on 23 occasions;

-50% of meals on 21 occasions;

-75% of meals on 12 occasions;

-100% of meals on 28 occasions;

- refusal noted one time; and,

- no documentation on two occasions.

A decline in the resident's meal intakes was noted between 7/5/24 and 7/11/24, following the resident's admission to hospice.

D. Staff interviews

Registered nurse (RN) #1 was interviewed on 7/11/24 at 4:00 p.m. RN #1 said Resident #23 should have been given another meal when he had spilled his first one. He said the resident was able to feed himself. RN #1 said Resident #23 required encouragement and oversight with eating.

RN #1 said the certified nurse aides (CNA) were responsible for documenting the amount each resident consumed at meals.

CNA #3 was interviewed on 7/12/24 at 11:45 a.m. CNA #3 said snacks were offered to the residents throughout the day. She said if a resident did not like something (snacks or meals), the staff would go and get them what they wanted.

CNA #3 said the CNAs would chart how much each resident ate after the resident was finished eating.

The dietary manager (DM) was interviewed on 7/12/24 at approximately 10:00 a.m. The DM said the satellite kitchen in the secured area had extra pureed food. The DM said the staff should have offered Resident #23 a new meal after he spilled his food.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	RDC #2 was interviewed on 7/12/24 at approximately 2:00 p.m. RDC #2 said Resident #23 had first experienced a three pound weight loss. She said because the resident did not have a significant weight loss, the facility did not implement a new intervention since he was already on the prescribed health shake upon admission. She said, on 6/20/24, the resident had experienced a significant weight loss. She said after the resident triggered for significant weight loss, the interdisciplinary team (IDT) began reviewing the resident in the nutrition at risk meetings. RDC #2 said the RD assessed the resident's nutritional status, spoke with the resident's family and observed the resident at lunch on 6/25/24. She said the RD spoke with the resident's representative about the fortified meal program and recommended fortified foods to help combat the resident's weight loss. RDC #2 said the resident often had increased agitation at meal times. She said the noise and amount of activity may have contributed to the agitation. She said the resident began hospice services on 7/1/24 with the diagnosis of senile degeneration of the brain. 48412 III. Resident #1 A. Resident status Resident #1, age less than 65, was admitted on [DATE] and discharged on [DATE]. According to the July 2024 computerized physician order (CPO), diagnoses included hemiplegia (paralysis on one half of the body), hemiparesis (muscle weakness on one half of the body) following a cerebral infarction (stroke) affecting right non-dominant side, quadriplegia (paralysis of all four limbs), tracheostomy status (opening from the outside of the windpipe to help oxygen reach the lungs), dysphagia oropharyngeal phase (inability to swallow food or fluids) and gastrostomy status (artificial opening to the stomach). The 5/2/24 minimum data set (MDS) assessment revealed the resident was unable to be understood and unable to participate in the brief interview for mental status (BIMS). The MDS assessment indicated the resident had no memory problems through staff assessment. The assessment documented Resident #1 had lost five percent or more of his body weight in the previous month or 10% or more of his body weight in the previous six months and he was not on a prescribed weight loss regimen. The assessment documented Resident #1 had a feeding tube and 100% of his nutrients were received through the feeding tube. B. Record review Resident #1's weights were documented in the resident's EMR as follows: On 2/22/24, Resident #1 weighed 103 lbs, this was struck out as an incorrect weight on 2/23/24. On 2/23/24, it was documented that Resident #1 weighed 152 lbs, which was obtained during his hospital stay. On 3/13/24, Resident #1's weight was 152 lbs, via the Hoyer scale (mechanical lift). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 3/28/24, Resident #1's weight was 104.5 lbs, via the Hoyer scale. Resident #1's nutritional care plan, revised 3/4/24, documented the resident had a nutritional problem or potential for a nutritional problem referring to his diagnoses. Interventions implemented were to provide the resident with Nutren 2.0 (tube feeding formula) at 35 milliliters (ml) an hour for 24 hours a day, enteral support regimen as ordered by the physician, staff monitoring for signs of intolerance to the tube feedings, staff monitoring for muscle wasting and significant weight loss and staff providing the resident his diet as ordered of nothing by mouth. Resident #1's tube feeding care plan, revised 3/6/24, documented the resident was dependent on tube feedings and water flushes and needed the RD to evaluate his needs quarterly and as needed to provide recommendations for changes to the tube feeding regimen. Review of nutritional assessments and IDT notes revealed the facility continued to use the resident's hospital weight and failed to weigh the resident to create a baseline for nutritional assessment until 3/28/24, 36 days after he was admitted to the facility, even though the RD requested the facility to obtain a weight on 2/23/24, in order to determine the correct amount of tube feeding the resident should be receiving (see RD nutritional summary below). The 2/23/24 nutritional summary documented Resident #1's hospital weight was entered into the facility's EMR. The RD requested for the facility to obtain a weight because the resident's weight history was undetermined. The 3/27/24 nutrition at risk meeting note documented the reason the resident was reviewed by the IDT was to adjust the resident's enteral feeding. The note documented Resident #1 weighed 152 lbs and often requested to have his feeding turned off because the resident felt full. The RD followed up with the resident and Resident #1 said the feedings caused the resident to feel full and made the resident nauseous. The resident said he had thrown up and the RD confirmed this in his chart. The RD spoke with the resident's family that the current feeding regimen was not enough to meet Resident #1's nutritional needs. The RD requested a follow-up weight and anticipated a weight decline because of a decrease in calories and a potential erroneous weight at the facility. The RD recalculated Resident #1's nutritional needs based on the resident's weight at home and adjusted the feeding regimen to match the weight of 103 lbs. C. Staff interviews The RD was interviewed on 7/11/24 at 10:14 a.m. The RD said the nursing staff weighed the residents upon admission. He said the facility preferred not to use the hospital weight because the facility was unsure if the weight was accurate. He said if a resident who received nutrition via a feeding tube experienced weight loss, he asked the nursing staff to re-weigh the resident to ensure the weight was accurate. The RD said when he noticed Resident #1 had lost weight he called the resident's family and the family said the resident typically weighed around 105 lbs and the family said the resident did not weigh 152 lbs. The RD said he questioned Resident #1's initial weight entered into the EMR, but the resident's weight was never confirmed. Registered dietitian consultant (RDC) #1 and RDC #2 were interviewed together on 7/12/24 at 10:19 a.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Actual harm Residents Affected - Few	RDC #1 said she and RDC #2 were dietary resources for the facility when help was needed. She said the hospital weight was not supposed to be entered into the resident's chart and the resident needed to be weighed on the facility's scale. RDC #1 said it was important to have an accurate weight because the facility needed to be able to provide the resident with the correct amount of calories he needed since he had a feeding tube. She said she and RDC #2 investigated any resident who experienced any type of weight loss. RDC #1 said the facility had documentation that Resident #1's family said the resident never weighed over 120 lbs and the facility knew the weight was incorrect. RDC #1 said the 152 lbs weight needed to be struck out as it was incorrect. She said the weight had not been struck out. She said when the resident was admitted to the facility, the hospital weight of 152 lbs was entered into Resident #1's EMR. RDC #1 said the resident's weight was documented as 103 lbs. She said the following day, on 2/23/24, the former RD struck out the 103 lbs and re-entered the 152 lbs as the resident's current weight. She said the current RD documented in the resident EMR that Resident #1's admitting weight was incorrect. She said the RD entered a progress note that indicated the weight of 152 lbs was incorrect should have been disregarded. The director of nursing (DON) was interviewed on 7/12/24 at 3:17 p.m. The DON said she had spoken to the staff member who documented Resident #1's admitting weight at 152 lbs. She said the staff member informed the DON she did not physically weigh the resident. The DON said the staff member who entered Resident #1's weight did not normally weigh residents The DON said the facility planned to have one staff member responsible for documenting the weights so someone was keeping track of any weight changes.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on observations, record review, and interviews the facility failed to ensure residents with percutaneous endoscopic gastrostomy (PEG) tubes received treatment and services to prevent complications for eight (#10, #25, #13, #15, #12, #14, #16 and #11) of nine residents reviewed for tube feeding management out of 29 sample residents. Specifically, the facility failed to: -Label Resident #10, Resident #25, Resident #13, Resident #15, Resident #12, Resident #14, Resident #16 and Resident #11's tube feeding containers with the residents' names, room number, date, start time, formula type, feeding rate and nurse initials; -Provide Residents #10, Resident #12, Resident #14, Resident #15, Resident #16 and Resident #25, with the prescribed formula as written in the computerized physician orders (CPO); -Provide Residents #10, Resident #25 and Resident #13 with water flushes at the prescribed rate as written in the CPO; and, -Ensure the feeding pumps were calibrated for Residents #13, Resident #15, Resident #12, Resident #14 and Resident #11. Findings include: I. Facility policy and procedure The Gastrostomy policy and procedure, dated March 2024, was provided by the director of nursing (DON) on 7/10/24 at 10:35 a.m. It read in pertinent part, Administer enteral feedings per prescriber orders. -The policy did not include how the formula bottle/bag should be labeled according to professional standards. The DON provided an undated resource poster that was typically hung in their medication room on 7/11/24 at 12:45 p.m. that indicated Jevity 1.2 could be substituted with Fibersource HN. The Food and Nutrition Services: Enteral Nutrition policy, dated August 2021, was provided by the registered dietitian consultant (RDC) on 7/12/24 at 10:17 a.m. The policy read in pertinent part, Nursing will administer enteral feeding per orders. Nursing will utilize formulary substitution sheets when the product is not readily available. Nursing will consult RD (registered dietitian) if the comparable formula (using substitution sheet) is not available. II. Professional reference (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022) Basic Nursing, Thinking, Doing and Caring, (Third edition), pages 2270-2277. Retrieved on 7/24/25. It read in pertinent part, Prior to administration, check the prescription for type of feeding, rate of infusion, and frequency of feeding. Label the container with the patient's name, room number, date, start time, formula type, feeding rate, and nurse initials. According to the Fibersource HN nutrition label, retrieved on 7/10/24 from https://www.nestlemedicalhub.com/products/fibersource-hn, Fibersource HN has 300 calories per 250 milliliters (ml) and 13.5 grams protein per 250 ml. According to the Jevity 1.2 nutrition label, retrieved on 7/10/24 from https://www.abbottnutrition.com/our-products/jevity-1_2-cal, Jevity 1.2 has 285 calories per 237 ml and 13.2 grams protein per 237 ml. According to the Jevity 1.5 nutrition label, retrieved on 7/25/24 from https://www.abbottnutrition.com/our-products/jevity-1_5-cal, Jevity 1.5 has 355 calories per 237 ml and 15.1 grams protein per 273 ml. III. Resident #10 A. Resident status Resident #10, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included gastrostomy status (surgical opening into the stomach for nutrition support), anoxic brain damage (lack of oxygen to the brain), chronic respiratory failure, disorders of diaphragm (muscle in the chest), disorders of electrolyte fluid imbalance, gastro-esophageal reflux disorder (GERD) and dependence on respirator (ventilator) status. The 5/27/24 minimum data set (MDS) assessment revealed the resident was in a persistent vegetative state with no discernible consciousness. The resident was dependent on two staff members for all activities of daily living (ADL). The assessment revealed the resident had a feeding tube. B. Observations On 7/9/24 at 6:10 p.m., the resident's feeding tube was connected to the tube feeding pump which was infusing Jevity 1.5 (tube feeding formula) at 83 ml per hour. The tube feeding pump automated water flush was programmed at 83 ml every two hours. -The CPO revealed the resident was supposed to receive Fibersource HN at 83 ml per hour, however, the resident was receiving Jevity 1.5, which was not an equivalent formula to Fibersource HN. -The tube feeding formula container did not have the time the formula was hung or the nurses'initials. On 7/10/24 at 9:30 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 83 ml per hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The CPO revealed the resident was supposed to receive Fibersource HN at 83 ml per hour, however, the resident was receiving Jevity 1.5. On 7/10/24 at 5:51 p.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 83 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 83 ml per hour, however, the resident was receiving Jevity 1.5. On 7/11/24 at 9:17 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 83 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 83 ml per hour, however, the resident was receiving Jevity 1.5. C. Record Review The July 2024 CPO revealed the following physician's order related to the resident's nutritional needs: Fibersource HN at 83 ml per hour for 20 hours via PEG tube, ordered 5/20/24. Free water flush every shift a 83 ml water auto flush every 20 hours via enteral support while feeding is running, ordered 4/29/24. -The physician's order indicated the resident was to receive 83 ml of water per day. However, the nutritional assessment indicated to provide 83 ml of water every two hours for 20 hours. The 5/21/24 nutritional summary documented the resident's nutritional needs were met with the enteral nutrition order of Fibersource HN at 83 ml per hour for 20 hours which the resident was observed not to be receiving. The free water was an auto flush of 83 ml every two hours while enteral feed was running. The 7/11/24 (during the survey) nutritional assessment documented due to shortage of Fibersource HN formula, Jevity 1.2 was used for substitution. -However, observations revealed the resident was receiving Jevity 1.5. IV. Resident #25 A. Resident status Resident #25, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included gastrostomy status, constipation, hyperkalemia (high potassium levels in the body), amyotrophic lateral scoliosis (ALS) and dependence on respirator status. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 7/8/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on two staff members for all ADLs. The assessment revealed the resident had a feeding tube. B. Observations On 7/10/24 at 9:30 a.m., the resident's feeding tube was connected to the tube feeding pump which was infusing Jevity 1.5 (tube feed formula) at 72 ml per hour. The water flush on the tube feeding pump was programmed at 72 ml every two hours. The formula type was identified by the manufacturer label on the bottle. -The CPO revealed the resident was supposed to receive Fibersource HN at 72 ml per hour, however, the resident was receiving Jevity 1.5. -Additionally, the CPO revealed the resident was supposed to receive 80 ml of water every two hours. On 7/10/24 at 5:51 p.m., the resident's feeding tube was connected to the tube feeding pump which was infusing Jevity 1.5 at 72 ml per hour. The tube feeding pump automated water flush was programmed at 72 ml every two hours. -The CPO revealed the resident was supposed to receive Fibersource HN at 72 ml per hour, however, the resident was receiving Jevity 1.5. -Additionally, the CPO revealed the resident was supposed to receive 80 ml of water every two hours. On 7/11/24 at 9:17 a.m., the resident's feeding tube was connected to the tube feeding pump which was infusing Jevity 1.5 at 72 ml per hour. The tube feeding pump automated water flush was programmed at 72 ml every two hours. On 7/11/24 at 9:30 a.m. (during the survey), licensed practical nurse (LPN) #3 adjusted the rate of the water on the feeding pump to match the ordered rate of 80 ml every 2 hours (see interview below). C. Record Review The July 2024 CPO revealed the following physician's order related to the resident's nutritional needs: Fibersource HN at 72 ml per hour for 20 hours via PEG tube, ordered 5/21/24. 80 ml free water flush every two hours via enteral support while the tube feeding was running, ordered 6/14/24. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	May substitute Jevity 1.2 for Fibersource HN at 72 ml per hour for 20 hours via peg tube, ordered 7/11/24 (during the survey). -However, observations revealed the resident was receiving Jevity 1.5. The 7/3/24 nutritional summary documented the enteral nutrition order as Fibersource HN at 72 ml per hour for 20 hours. The free water was an auto flush 80 ml every two hours while enteral feed was running. D. Staff interviews LPN #3 was interviewed on 7/11/24 at 9:17 p.m. LPN #3 said Resident #25 was being administered Jevity 1. 5. LPN #3 said Resident #25 was receiving 72 ml of water every two hours instead of 80 ml of water every two hours. LPN #3 said she recently started working at the facility. She said she knew the physician's orders for Fibersource HN were incorrect but, as a nurse, she did not question the physician's orders. She said the physician's order indicated to administer Fibersource HN, however the facility had been administering Jevity 1.5. She said a staff communication was sent on 5/29/24 by the director of staff development (DSD). She said the communication advised that Jevity would replace Fibersource HN during back order. She said the communication did not indicate which Jevity formula to utilize. V. Resident #13 A. Resident status Resident #13, age greater than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included gastrostomy status, GERD protein calorie malnutrition, hyper/hyposmolality, hyper/hyponatremia (high and low levels of sodium in the body), constipation and dependence on respirator status. The 5/20/24 MDS assessment revealed that the resident was rarely/never understood through staff assessment. The resident was dependent on two staff members for all ADLs. The assessment revealed the resident had a feeding tube. B. Observations On 7/9/24 at 6:10 p.m., Resident # 13 was lying in bed. The resident's feeding tube was connected to a feeding tube pump. The automated water flush was programmed at 115 ml every two hours. -However, the nutrition assessment indicated the resident needed 110 ml every two hours for 20 hours. -The container of tube feeding formula was not dated or initialed by the licensed nurse. On 7/10/24 at 9:30 a.m., the resident's feeding tube was connected to the tube feeding pump. An automated water flush was programmed at 115 ml every two hours. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-However, the nutrition assessment indicated the resident needed 110 ml every two hours for 20 hours. On 7/10/24 at 5:51 p.m., the resident's feeding tube was connected to the tube feeding pump. Nutren 2.0 (tube feed formula) at 65 ml per hour with an automated water flush programmed at 115 ml every two hours. -However, the nutrition assessment indicated the resident needed 110 ml every two hours for 20 hours. -The tube feed formula container was not dated. On 7/11/24 at 9:17 a.m., Resident #13 was lying in bed. The resident's feeding tube was connected to a feeding tube pump and was infusing Nutren 2.0 at a rate of 65 ml per hour. -The container was not dated with the time it was hung for administration or initialed by the administrating nurse. On 7/11/24 at 9:27 a.m., Resident #13 was lying in bed with Nutren 2.0 infusing at 65 ml per hour. The water auto flush was programmed at a rate of 115 ml every two hours. -However, the nutrition assessment indicated the resident needed 110 ml every two hours for 20 hours. -The tube feed formula container and the bag that contained the water flushes was not dated with the time it was hung on the pump to be administered or initialed with the administering nurse's signature. -The resident's tube feeding pump in Resident #13's room did not have a sticker indicating the pump had received annual calibration. C. Record Review The July 2024 CPO revealed the following physician's order related to the resident's nutritional needs: Nutren 2.0 at 65 ml per hour for 20 hours via PEG tube, ordered 5/21/24. 110 ml free water flush every two hours via enteral support while the tube feeding was running, ordered 3/22/24. 70 ml free water flush every two hours via enteral support while the tube feeding was running ordered 7/11/24 (during the survey). The 5/21/24 nutritional summary documented the enteral nutrition order as Nutren 2.0 at 65 ml per hour for 20 hours. The free water was an auto flush 110 ml every two hours while the enteral feed was running. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The physician's order indicated the resident was to receive 110 ml of water every two hours, however, observations revealed the resident was receiving 115 ml of water every two hours. D. Staff interviews LPN #3 was interviewed on 7/11/24 at 9:27 a.m. LPN #3 said the resident was receiving Nutren 2.0 formula through the feeding tube. LPN #3 confirmed the formula container was not dated or initialed. LPN #3 said the formula container was not labeled with the time it was hung to be administered or initialed. LPN #3 said Resident #13's water flush was running at 115 ml instead of the physician's order of 110 ml every two hours (see observations above). VI. Resident #15 A. Resident status Resident #15, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included gastrostomy status, type II diabetes mellitus, hyposmolality (low levels of nutrients, proteins and electrolytes in the blood), hyponatremia, anemia (low blood levels), vitamin D deficiency, cerebral infarction (stroke) and dependence on respirator status. The 5/6/24 MDS assessment revealed the resident had severe cognitive impairments with a mental status score of six out of 15. The resident was dependent on two staff members for all ADLs. The assessment revealed the resident had a feeding tube. B. Observations On 7/9/24 at 6:10 p.m., Resident #15 was lying in bed. The resident's feeding tube was connected to a feeding tube pump. The pump was infusing Jevity 1.5 at a rate of 90 ml per hour. The water flush bag was not labeled. -The CPO revealed the resident was supposed to receive Fibersource HN at 90 ml per hour, however, the resident was receiving Jevity 1.5, which was not an equivalent formula to Fibersource HN. -The tube feed formula container was not dated with the time or date it was hung on the pump to be administered or initialed with the administering nurse's signature. On 7/10/24 at 9:30 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 90 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 90 ml per hour, however, the resident was receiving Jevity 1.5, which was not an equivalent formula to Fibersource HN. On 7/10/24 at 5:51 p.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 90 ml per hour -The CPO revealed the resident was supposed to receive Fibersource HN at 90 ml per hour, however, the the resident was receiving Jevity 1.5. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/11/24 at 9:17 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 90 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 90 ml per hour, however, the resident was receiving Jevity 1.5. -On 7/12/24 at 2:51 p.m. The tube feeding pump in Resident #15's room did not have a sticker indicating the pump had received annual calibration. C. Record Review The July 2024 CPO revealed the following physician's order related to the resident's nutritional needs: Fibersource HN at 90 ml per hour for 20 hours via PEG tube, ordered 5/21/24. 90 ml free water flush every two hours via enteral support while the tube feeding was running, ordered 6/14/24. The 4/30/24 nutritional summary documented the enteral nutrition order as Fibersource HN at 90 ml per hour for 20 hours. The free water was an auto flush of 90 ml every two hours while the enteral feed was running. VII. Resident #12 A. Resident status Resident #12, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included gastrostomy status, GERD, gastroparesis (decreased stomach movement), traumatic brain injury, and dependence on respirator status. The 6/24/24 MDS assessment revealed the resident was rarely/never understood through staff assessment. The resident was in a persistent vegetative state with no discernible consciousness The resident was dependent on two staff members for all ADLs. The assessment revealed the resident had a feeding tube. B. Observations On 7/9/24 at 6:10 p.m., Resident # 12 was lying in bed. The resident's feeding tube was connected to a feeding tube pump. The pump was infusing Jevity 1.5 at a rate of 68 ml per hour. The automated water flush was programmed at 100 ml every two hours. -The CPO revealed the resident was supposed to receive Fibersource HN at 68 ml per hour, however, the resident was receiving Jevity 1.5. -The tube feed formula container was not dated with the time it was hung on the pump to be administered or initialed with the administering nurse's signature. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/10/24 at 9:30 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 at 68 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 68 ml per hour, however, the resident was receiving Jevity 1.5. On 7/10/24 at 5:51 p.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 68 ml per hour. On 7/11/24 at 9:17 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 68 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 68 ml per hour, however, the resident was receiving Jevity 1.5. On 7/11/24 at 9:27 a.m., Resident #12 was lying in bed and Jevity 1.5 was infusing at 68 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 68 ml per hour, however, the resident was receiving Jevity 1.5. -On 7/12/24 at 2:51 p.m. the tube feeding pump in Resident #12's room did not have a sticker indicating the pump had received annual calibration. C. Record Review The July 2024 CPO revealed the following physician's order related to the resident's nutritional needs: Fibersource HN at 68 ml per hour for 20 hours via PEG tube, ordered 6/25/24. 100 ml free water flush every two hours via enteral support while the tube feeding was running, ordered 6/14/24. May substitute Jevity 1.2 for Fibersource HN at 68 ml per hour for 20 hours via PEG tube, ordered 7/11/24 (during the survey). -However, observations revealed the resident was receiving Jevity 1.5. D. Staff interviews LPN #3 was interviewed on 7/11/24 at 9:27 a.m. LPN #3 said Resident #12 was being administered Jevity 1.5 at 68 ml per hour. She said the physician's order indicated to administer Fibersource HN. VIII. Resident #14 A. Resident status (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #14, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included gastrostomy status, GERD, constipation, anoxic brain injury and dependence on respirator status. The 6/17/24 MDS assessment revealed the resident was rarely/never understood through staff interview. The resident was dependent on two staff members for all ADLs. The assessment revealed the resident had a feeding tube. B. Observations On 7/9/24 at 6:10 p.m., the resident's feeding tube was connected to the tube feeding pump which was infusing Jevity 1.5 at 72 ml per hour. -The tube feed formula container was not dated with the time it was hung on the pump to be administered. On 7/10/24 at 9:30 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 72 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 72 ml per hour, however, the resident was receiving Jevity 1.5. On 7/10/24 at 5:51 p.m., Jevity 1.5 was infusing at 72 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 72 ml per hour, however, the resident was receiving Jevity 1.5. On 7/11/24 at 9:17 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 72 ml per hour with an automated water flush programmed at 72 ml every two hours. -The CPO revealed the resident was supposed to receive Fibersource HN at 72 ml per hour, however, the resident was receiving Jevity 1.5. -The water flush bag was not labeled with the time or date it was hung on the pump to be administered or initialed by the administrating nurse. On 7/12/24 at 2:51 p.m. the resident's feeding tube was connected to the tube feeding pump. Fibersource HN was infused at 72 ml per hour. -On 7/12/24 at 2:51 p.m. the tube feeding pump in Resident #14's room did not have a sticker indicating the pump had received annual calibration. C. Record Review The July 2024 CPO revealed the following physician's order related to the resident's nutritional needs: (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Fibersource HN at 72 ml per hour for 20 hours via PEG tube, ordered 5/21/24. 72 ml free water flush every two hours via enteral support while the tube feeding was running, ordered 4/9/24. May substitute Jevity 1.2 for Fibersource HN at 72 ml per hour for 20 hours via PEG tube, ordered 7/11/24 (during the survey). -However, observations revealed the resident was receiving Jevity 1.5. The 6/11/24 nutritional summary documented the enteral nutrition order as Fibersource HN at 72 ml per hour for 20 hours. The free water was an auto flush of 72 ml every two hours while the enteral feed was running. VIII. Resident #16 A. Resident status Resident #16, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included gastrostomy status, protein-calorie malnutrition, anemia, constipation, GERD, traumatic brain injury and dependence on respirator status. The 4/29/24 minimum data set (MDS) assessment revealed the resident was in a persistent vegetative state with no discernible consciousness. The resident was dependent on two staff members for all ADLs. The assessment revealed the resident had a feeding tube. B. Observations On 7/9/24 at 6:10 p.m., the resident's feeding tube was connected to the tube feeding pump which was infusing Jevity 1.5 at 105 ml per hour. The tube feed formula container had the name of the formula, however, was not timed when hung, and failed to have the nurses' initials. -The tube feed formula container bag was not labeled with the time it was hung on the pump to be administered or initialed by the administrating nurse. On 7/10/24 at 9:30 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 at 105 ml per hour. with an automated water flush programmed at 100 ml every two hours. -The CPO revealed the resident was supposed to receive Fibersource HN at 105 ml per hour, however, the resident was receiving Jevity 1.5. On 7/10/24 at 5:51 p.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 infused at 105 ml per hour. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The CPO revealed the resident was supposed to receive Fibersource HN at 105 ml per hour, however, the resident was receiving Jevity 1.5. On 7/11/24 at 9:17 a.m., the resident's feeding tube was connected to the tube feeding pump. Jevity 1.5 was infusing at 105 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 105 ml per hour, however, the resident was receiving Jevity 1.5. On 7/11/24 at 9:27 a.m., Jevity 1.5 was running through the pump at 105 ml per hour. -The CPO revealed the resident was supposed to receive Fibersource HN at 105 ml per hour, however, the resident was receiving Jevity 1.5. The tube feeding pump serial number: C14113939 had a sticker validating that annual calibration was required in March 2025. C. Record Review The July 2024 CPO revealed the following physician's order related to the resident's nutritional needs: Fibersource HN at 105 ml per hour for 20 hours via PEG tube, ordered 2/20/24. 100 ml free water flush every two hours via enteral support while the tube feeding was running, ordered 2/20/24. May substitute Jevity 1.5 for Fibersource HN at 105 ml per hour for 20 hours via PEG tube, ordered 7/11/24 (during the survey). May substitute Jevity 1.2 for Fibersource HN at 105 ml per hour for 20 hours via PEG tube, ordered 7/11/24 (during the survey). The 4/23/24 nutritional summary documented the enteral nutrition order as Fibersource HN at 105 ml per hour for 20 hours. The free water was an auto flush of 100 ml every two hours while the enteral feed was running. D. Staff interviews LPN #3 was interviewed 7/11/24 at 9:27 a.m. LPN #3 said Resident #16 was receiving Jevity 1.5 at 105 ml per hour. She said the physician's order indicated to administer Fibersource HN at 105 ml per hour. X. Resident #11 A. Resident status (continued on next page)

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F 0693

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Resident #11, age greater than 65, was admitted to the facility on [DATE]. According to the July 2024 CPO, diagnoses included gastrostomy status, GERD, type II diabetes mellitus with hypoglycemia, chronic idiopathic constipation, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction, aphasia following cerebral infarction, iron deficiency anemia and dependence on respirator status.

The 6/3/24 MDS assessment revealed the resident was rarely/never understood through staff interview. The resident was dependent on two staff members for all ADLs.

The assessment revealed the resident had a feeding tube.

B. Observations

On 7/9/2024 at 6:10 p.m., [NAME] Farms Peptide 1.5 (tube feed formula) was being administered at 59 ml per hour.

-The tube feed formula container bag had the formula type written on the bag, however, the writing was illegible. The container was not labeled with the time it was hung on the pump to be administered or initialed by the administrating nurse.

On 7/10/24 at 5:51 p.m., the resident's feeding tube was connected to the tube feeding pump. [NAME] Farm Peptide 1.5 was infused at 59 ml per hour with an automated water flush programmed at 100 ml every two hours.

-On 7/12/24 at 2:51 p.m., the tube feeding pump in Resident #11's room did not have a sticker indicating the pump had received annual calibration.

C. Record Review

The July 2024 CPO revealed the following physician's order related to the resident's nutritional needs:

[NAME] Farms Peptide 1.5 at 59 mla per hour for 20 hours via PEG tube, ordered 5/20/24.

100 ml free water flush every two hours via enteral support while the tube feeding was running, ordered 1/28/24.

The 5/28/24 nutritional summary documented the enteral nutrition order as [NAME] Farms Peptide 1.5 at 59 ml per hour for 20 hours. The free water was an auto flush of 100 ml water every two hours for 20 hours while the enteral feed was running.

XI. Additional record review

The nursing communication memo written by director staff development (DSD), dated 5/29/24 at 2:37 p.m., documented in pertinent part, The manufacturer of Fibersource tube feeding is back-ordered. They sent Jevity and can be used in its place.

-The nursing communication memo did not indicate which Jevity formula to use.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/12/24 at 3:45 p.m., the director of nursing (DON) provided a print out from a website called MedWrench. The print out read in pertinent part, A series of tests can be performed to verify pump performance. It is recommended that the evaluation procedure be run at least once per year. XII. Additional staff interviews Registered nurse (RN) #2 was interviewed on 7/9/2024 at 6:25 p.m. RN #2 said the tubing on a feeding tube pump must be changed every 24 hours. She said she changed them on the nightshift as her first task upon shift change. RN #2 said she wrote the resident's initials, date, and her first initial on each tube feed bottle. She said it was not important to label tube feeding formula bags or containers because the formula was used quickly. RN #2 She said that many of the residents in her assigned hallway had tube feeding sets that were not properly labeled related to a hectic shift the previous night. RN #2 observed Resident #15's infusing tube feed had no writing on the formula or water bag. RN #2 stated she had not hung it. She said the day shift hung it. She said the previous night shift had been extremely busy. The registered dietitian (RD) was interviewed via telephone on 7/11/24 at 10:14 a.m. The RD said when a resident was admitted to the facility he reviewed their medical record to determine which tube feeding formula they had been receiving prior to admission. The RD said he interviewed the residents and their representatives to determine the previous enteral feed regimens. The RD said he entered tube feeding related orders and the physician signed them. The RD said the physician's orders needed to be followed. The RD said there was communication with upper management and the nursing staff any time changes with the tube feeding orders had been made. The RD said Fibersource HN had been on backorder since May 2024. The RD said Jevity was being used as a temporary replacement for Fibersource HN. The RD said he was unaware that the physician's orders did not match the tube feeding formula that was hung for the residents. The RD said an incorrect auto water flush could cause a resident to become overhydrated, dehydrated, or to develop an electrolyte imbalance. The RD said he reviewed tube feed related orders with the expectation that the orders would not be altered by other staff members. The DON was interviewed on 7/11/24 at 11:29 a.m. The DON said she was not responsible for managing the tube feedings for the residents. She said the director of staff development (DSD) was responsible for ordering all tube feed formulas. The DON said the communication written by the DSD was not a valid physician's order and the actual orders should have been rewritten. She said the physician's order needed to match the tube feed formula that was infusing. She said the registered nurse supervisor (RNS) verified that the formulas that were infused through the tube feeding pumps matched the physician's orders. She said the RNS had been unable to complete the checks because he had been covering night shifts. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 48412 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life and quality of care. Findings include: I. Facility policy and procedure The Quality Assurance and Performance Improvement (QAPI) policy, revised 1/2022, was provided by the director of nursing (DON) on 7/12/24 at 6:23 p.m. The policy documented in pertinent part, The purpose of the QAPI plan and processes is to continually assess the facility's performance in all service areas, so that systems and processes achieve the delivery of person-centered care, and which maximizes the individuals' highest practicable physical, mental and social well-being. The committee will meet at least quarterly or more often as the facility deems necessary. The committee will maintain a record of the fates of all meetings and the names and titles of those attending each meeting. Committee functions include QAPI plan, identifying and prioritizing performance improvement plans (PIPs), implementing actions to correct quality issues and monitoring to ensure the corrective action implemented is being sustained. II. Repeat deficiencies Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies. F919 Resident call system During a recertification survey on 3/21/24, F919 was cited at an E level, no actual harm with potential for more than minimal harm that is not immediate jeopardy, pattern. During an abbreviated survey on 7/12/24, F919 was cited at an E level, no actual harm with potential for more than minimal harm that is not immediate jeopardy, pattern. F677 ADL (activities of daily living) Care Provided for Dependent Residents During a recertification survey on 12/15/22, F677 was cited at a D level, no actual harm with potential for more than minimal harm that is not immediate jeopardy, isolated. During an abbreviated survey on 8/10/23, F677 was cited at an E level, no actual harm with potential for more than minimal harm that is not immediate jeopardy, pattern. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065100	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/12/2024
NAME OF PROVIDER OR SUPPLIER: Rock Canyon Respiratory and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2515 Pitman Pl Pueblo, CO 81004	

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an abbreviated survey on 9/11/23, F677 was cited at a D level, no actual harm with potential for more than minimal harm that is not immediate jeopardy, isolated. During an abbreviated survey on 7/12/24, F677 was cited at an E level, no actual harm with potential for more than minimal harm that is not immediate jeopardy, pattern. III. Cross-referenced citations Cross-reference F692: The facility failed to ensure residents received the care and services necessary to meet their nutrition and hydration needs and to maintain their highest level of physical well-being. This failure resulted in actual harm with a severe weight loss and a G level citation, actual harm that is not immediate jeopardy, isolated. Cross-reference F693: The facility failed to administer tube feedings and water flushes accurately and according to physician orders. The facility failed to update physician orders when the tube feeding formula was on backorder and verbally informed staff to use a comparable tube feeding formula. This failure resulted in substandard care being provided to the residents due to eight out of eight residents having the incorrect formula administered. Cross-reference F677: The facility failed to provide activities of daily living (ADL) care to dependent residents. Cross-reference F689: The facility failed to implement effective interventions to prevent falls and bruises. Cross reference F919: The facility failed to install and maintain a working call light system. IV. Interviews The nursing home administrator (NHA) was interviewed on 7/12/24 at 5:52 p.m. The NHA said the interdisciplinary team (IDT) met once a month for QAPI. He said the QAPI team used the fishbone diagram (a tool used to identify root causes of a problem) once a specific area was identified as a concern. He said the facility had a spreadsheet to document each specific concern area identified. The NHA said the QAPI team discussed certain concerns if a grievance was filed about it. The NHA said tube feedings were not on the QAPI teams' areas of identified concerns within the past 90 days. The NHA said the registered dietician entered the residents' order for tube feedings and the nursing staff followed the orders. The NHA said he was unsure if the clinical staff were not hanging the formula bags correctly, however, he said the facility clearly did not have an effective process to ensure resident tube feedings were being appropriately monitored and managed. The NHA said falls was a topic covered in every QAPI meeting, which included discussion about interventions and active falls. The NHA said weight loss was discussed as part of the facility's nutritional program and the QAPI team investigated if the weight loss was desired or not and how to correct the problem. The NHA said he felt the registered dietician consultant needed to provide training to the facility to ensure everyone was on the same page regarding management of weight loss. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said the facility would be following up on how to proceed with the concern regarding the lack of an appropriate call light system in the memory care secure unit.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews the facility failed to adequately equip the residents to call for staff for two (#8 and #24) of three residents out of 29 sample residents and to provide a working call light system in the shower facilities. Specifically, the facility failed to: -Provide a working call light for Resident #24 and Resident #8; and, -Have a functioning call light system in the women's and men's shower areas. Findings include: I. Facility policy and procedure The Call Light/Bell policy and procedure, revised May 2007, was provided by the director of nursing (DON) on 7/12/24 at 11:54 a.m. It revealed in pertinent part, It is the policy of this facility to provide the residents a means of communication with nursing staff. II. Resident #24 A. Resident status Resident #24, age 70, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke), hemiplegia and hemiparesis following cerebral infarction affecting non-dominant side (limited or no movement of the resident's dominant side), cerebrovascular disease unspecified, unspecified dementia, abnormal posture, muscle weakness generalized, contracture of left elbow and contracture of muscle left upper arm. The 6/17/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. He was dependent on staff for oral hygiene, toileting, bathing, dressing upper and lower body, putting on footwear, personal hygiene, transfers and bed mobility. He required supervision or touching assistance with eating. B. Resident interview and observations On 7/9/24 at approximately 5:15 p m., Resident #24 was lying in his bed. His room was at the end of the hallway. Resident #24 was yelling for help and did not have a call light. On 7/10/24 at approximately 12:45 p.m. licensed practical nurse (LPN) #1 and certified nurse aide (CNA) #5 assisted Resident #24 with transferring from his wheelchair to the bed. Resident #24 did not have a call light in his room. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/12/24 at approximately 5:00 p.m. the resident had a yellow service bell. The resident had it on his chest. He said he was happy to have a call bell, however, he said when he rang it, the staff did not answer him. C. Record review The 4/11/24 call system assessment documented #24 was unable to demonstrate using a call bell. D. Staff interviews CNA #5 was interviewed on 7/10/24 at approximately 1:15 p.m. CNA #5 said Resident #24 was able to make his needs known. She said none of the residents who resided on the memory care unit had a call light. CNA #4 was interviewed on 7/11/24 at 9:30 a.m. CNA #4 said Resident #24 was not able to use a call light to make his needs known due to his forgetfulness. He said Resident #24 would be at risk for safety issues such as strangulation due to not understanding what it was for and playing with the long cord. The social services director (SSD) was interviewed on 7/11/24 at approximately 3:00 p.m. The SSD said she had recently taken over the call bell assessments. She said the assessments consisted of explaining and showing the call bell procedure to the resident. She said she would ask the resident to demonstrate the call bell procedure. She said if the resident could demonstrate the call bell procedure they left the call bell in their room. She said Resident #24 was unable to use the call bell on the last assessment but that she would reassess Resident #24 later that day (7/11/24). The social service director (SSD) was interviewed again on 7/11/24 at 4:04 p.m. The SSD said the resident was reassessed and it was determined Resident #24 could use a call bell. She said she gave the resident a yellow service bell (see above observations). III. Resident #8 A. Resident status Resident #8, age less than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included unspecified dementia, unspecified severity without behavioral disturbance, other amnesia (difficulty speaking), muscle weakness, contracture right knee, contracture left knee and rheumatoid arthritis (pain in the joints). The 5/8/24 MDS assessment revealed Resident #8 had moderate cognitive impairments with a BIMS score of eight out of 15. The MDS assessment revealed she had limited range of motion in both lower and upper extremities. Resident #8 was dependent on staff for eating, oral hygiene, toileting, showering, dressing lower and upper body, personal hygiene and bed mobility. B. Observations On 7/10/24 at 12:20 p.m. Resident #8 was in the dining room, another resident began to eat Resident #8's cake. Resident #8 told the other resident to stop eating her cake. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/24 at 12:00 p.m., the resident was at the medication cart. Registered nurse (RN) #1 was asking her medical questions and she was able to answer appropriately. C. Resident interview Resident #8 was interviewed on 7/12/24 at 3:00 p.m. Resident #8 said she was glad to have a call bell. She said she was able to use it when she needed to call for staff. D. Record review The 5/21/24 call system assessment documented Resident #8 was unable to demonstrate using a call bell. E. Staff interviews The SSD was interviewed on 7/11/24 at approximately 3:00 p.m. The SSD said Resident #8 scored an eight on her most recent BIMS assessment. She said because the resident scored an eight on the assessment, the SSD determined the resident was unable to use the call bell. The SSD said she would reassess the resident later in the day. The SSD was interviewed again on 7/11/24 at 4:04 p.m. The SSD said she reassessed the resident and determined the resident was able to use a call bell. She said she gave the resident a bell. IV. Shower rooms A. Observations and interviews On 7/10/24 at approximately 2:30 p.m., the men's and women's shower rooms on the memory care unit did not have a working call light system. There was a small red button on the men's side of the shower room which read emergency. However, when pushed, the red button did nothing. CNA #2 was interviewed on 7/10/24 at approximately 2:30 p.m. CNA #2 said the shower room call light initiated a light on a panel that was located across from the nurse's station. She tested the red button and the light on the panel did not light up. She said the facility did not have a different system in place to call for assistance. The maintenance supervisor (MS) was interviewed on 7/11/24 at 2:43 p.m. The MS said he had worked at the facility for four years. He said during that time there had never been call lights in the shower rooms on the memory care unit. He said the red button in the shower room was from an old call light system that no longer functioned. The MS was interviewed again on 7/11/24 at 3:15 p.m. The MS said he was able to put call lights into the shower rooms (on 7/11/24).