STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065108	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villas at Sunny Acres, The	2501 E 104th Ave Thornton, CO 80233

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52309 Based on record review and interviews, the facility failed to inform the resident's representative of the change in condition for one (#176) out of five residents reviewed out of 49 sample residents. Specifically, the facility failed to timely notify Resident #176's representative of a fall, the need for medical imaging (Xray) of her left hip, new orders for pain medication and an appointment for a diagnostic imaging procedure to show detailed internal images (CT) scan in a timely manner. Findings include: I. Facility policy and procedure The Change of Condition Reporting policy, revised October 2020, was provided by the nursing home administrator (NHA) on 4/3/25 at 10:30 a.m. The policy read in pertinent part, The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. All attempts to reach the physician and responsible party will be documented in the nursing progress notes. Documentation will include time and response. II. Resident #176 A. Resident's status Resident #176, age 89, was admitted to the facility on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included heart rhythm disorder (A-Fib), heart failure, history of transient ischemic attack (TIA) and cognitive communication deficit. The 1/23/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. B. Representative interviews (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #176's daughter-in-law was interviewed on 4/3/25 at 3:43 p.m. She said the resident's representative (Resident #176's son) was at the facility the morning of 2/11/25 to discuss discharging Resident #176 to the resident's home. The resident's representative was told by an unidentified case manager the resident had more insurance days and the team would discuss the discharge and call him back. The resident's representative spoke to a case manager later in the day and was only then notified there had been a change of condition due to a fall the night before (2/10/25) and the resident's condition had deteriorated. Resident #176's daughter-in-law said during the next several days they saw Resident #176 getting weaker and lying in bed. The daughter-in-law said the resident was not acting like herself because of the pain medication. Resident #176's daughter-in-law said prior to 2/10/25 there was a meeting with the family, resident, staff members including the case manager to discuss the passing of Resident #176's daughter and now the primary contact would be the resident's representative, her son. Resident #176's representative was interviewed on 4/3/25 at 5:11 p.m. He said he visited Resident #176 the morning of 2/11/25 and spoke to an unidentified case manager about discharging Resident #176 to her home that day. Resident #176's representative was told she still had insurance coverage and the team would discuss the discharge and call him back. He said there was no communication about the fall while he was there in the morning, He said Resident #176 was complaining of pain the morning of 2/11/25, which was new for her. He said he talked to a case manager later in the afternoon and was advised, because of Resident #176's change of condition, discharge was not recommended. He said he was then notified of the 2/10/25 fall and of the Xrays that were taken on 2/11/25. He said he had no prior notification from the facility regarding the fall or Xrays. He said he was told that the facility tried to call Resident's #176's daughter. He said the facility was aware that she passed away. He said there was a meeting for Resident #176 which included the case manager regarding the passing of the resident's daughter. He said he was listed as the first contact. He said he noticed a change in the resident and she was sleeping more, not getting out of bed and was told she was on pain medications after the medication was started. Resident #176's representative said he was not notified of the 2/20/25 CT scan appointment until the morning of 2/20/25 when he went to visit his mother and she was not at the facility. Resident #176's representative was then advised of the appointment. He said had been visiting sometimes up to three times a day prior to her rehospitalization . C. Record Review The nursing facility's face sheet listed Resident #176's representative, her son, as first emergency contact. There was no one listed as the resident's power of attorney (POA). There was only one contact listed. A progress note, dated 2/10/25 at 10:45 p.m., documented in pertinent part, the family member or representative was notified on 2/11/25 at 6:00 a.m. -The note did not specify which family member/representative was notified. A progress note, dated 2/10/25 at 11:03 p.m., documented in pertinent part, the nurse practitioner (NP), on-call nurse and POA were notified of the resident's fall. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note, dated 2/11/25 at 5:48 a.m., documented the writer attempted to call Resident #176's daughter and POA twice to notify her of the resident's fall. The phone went immediately to voicemail and the writer was unable to leave a message due to the mailbox being full. This was passed on to the dayshift nurse to try and contact the daughter again. -However, the facility was notified Resident #176's daughter passed away prior to 2/10/25, see interviews above. Resident's #176 daughter was not listed on the face sheet. A progress note, dated 2/11/25 at 12:26 p.m., documented an Xray of the left hip was completed due to a fall and were negative for a fracture. The Xray results were received and communicated to the physician. Review of the February 2025 CPO revealed the following physician's orders: Tramadol 50 milligram (mg) one tablet by mouth every six hours as needed for moderate and severe pain, ordered 2/11/25; and, Tylenol 1000 mg by mouth every eight hours as needed for pain, ordered 2/11/25. -Review of Resident #176's electronic medical record (EMR) failed to show the resident's representative (Resident #176's son) was notified of the 2/10/25 fall, the ordered Xrays or the addition of pain medication at the time when it occurred. D. Staff interviews The director of nursing (DON) and the regional clinical resource (RCR) were interviewed together on 4/2/25 at 5:15 p.m. The DON said the expectation was for the responsible party to be notified after a fall. Primary care physician (PCP) #1 was interviewed 4/3/25 at 2:50 p.m. PCP #1 said she had no contact with the family regarding the resident's fall or plan of care. PCP #1 said she asked the resident if she wanted to go to the hospital for tests or stay at the facility for Xrays. PCP #1 said the resident chose to stay at the facility. She said it was the facility's responsibility to contact the responsible party after a fall. III. Facility follow-up The NHA provided additional information on 4/4/25 at 12:43 p.m., after the exit. The NHA sent a screen shot of a phone and said it belonged to social worker's (SW) #1's phone. The screen shot revealed SW #1 called the resident's representative (son) phone on 2/11/25 at 2:43 p.m., lasting 34 seconds. Another screen shot revealed an incoming call from the resident's representative's phone number on 2/11/25 at 3:09 p.m. The NHA said SW #1 provided notification of the fall and Xray results at that time. -However, Resident #176 fell on [DATE] at approximately 10:15 p.m. and the resident's representative was not notified until 2/11/25 at 3:09 p.m., approximately 17 hours after the fall occurred, after Xrays were taken and medications were ordered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA provided a written statement from SW #1 on 4/4/25 at 12:43 p.m. The 4/4/25 statement read in pertinent part, SW #1 notified the resident's representative of the fall and Xray results during the phone conversation on 2/11/25 at 3:09 p.m.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 52045 Based on observations, record review and interviews, the facility failed to provide residents who were unable to carry out activities of daily living (ADL's) the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two (#326 and #8) of five residents out of 49 sample residents. Specifically the facility failed to -Offer repositioning to Resident #326 and Resident #8, who were dependent residents; and, -Provide assistance with toileting for Resident #326. Findings include: I. Observations During a continuous observation on 4/1/25, beginning at 8:38 a.m. and ending at 12:39 p.m., the following was observed: At 8:39 a.m. Resident #326 was lying in bed with her eyes opened. She was leaning to the right side of her bed. Resident #8, who resided in the same room, was sleeping in her wheelchair. At 9:15 a.m. Resident #326 was lying in bed with her eyes closed leaning to the right side. Resident #8 was sitting in her wheelchair sleeping. The room smelled of urine. At 10:30 a.m. Resident #326 was lying in bed with her eyes open leaning to the right side. Resident #8 was sitting in her wheelchair next to her bed. The room continued to smell of urine. At 11:01 a.m. Resident #8 was in her room. An unidentified staff member asked Resident #8 if she wanted to put pants on. Resident #8 declined. The unidentified staff member did not reposition or provide care to Resident #8. At 11:24 a.m. Resident #326 was lying in bed leaning to the right side. Resident #8 was sitting in her wheelchair in her room. At 11:48 a.m. certified nurse aide (CNA) #2 and CNA #3 provided incontinence care to Resident #326. The CNAs changed the resident's brief. The resident's brief was saturated with urine. There was a blue line on the outside of the brief that indicated the brief was wet. At 12:39 p.m. Resident #326 was lying in bed with her eyes closed leaning to the left side. Resident #8 was sitting in a wheelchair sleeping. -Resident #326 was not provided incontinence care or repositioning for over three hours, from 8:38 a.m. until 11:48 a.m (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #8 was not repositioned for four hours, from 8:38 a.m. until 12:39 p.m. II. Resident #326 A. Resident status Resident #326, age 87, was admitted on [DATE] and passed away on 4/2/25 at the facility. According to the April 2025 computerized physician orders (CPO), diagnoses include muscle weakness, limitation of activities due to disabilities and urinary tract infection. The 3/3/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required substantial/ maximal assistance of two people with toileting hygiene and personal hygiene. B. Record review The ADL care plan, revised 10/19/20, revealed Resident #326 had an ADL self care performance deficit initiated on 10/1/19 . Pertinent interventions indicated the resident required staff assistance for toileting. -However, observations revealed staff failed to offer or provide assistance with toileting (see observations above). The oxygen care plan, revised 10/22/22, revealed Resident #326 had oxygen therapy related to ineffective gas exchange initiated on 10/3/19. Pertinent interventions included changing the residents position every two hours to facilitate lung secretion movement and drainage. -However, observations revealed the staff failed to offer or provide assistance with repositioning (see observations above). III. Resident #8 A. Resident status Resident #8 age 85, was admitted on [DATE]. According to the April 2025 CPO diagnoses included dementia, lack of coordination and difficulty walking. The 2/28/25 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. She required maximum assistance from two staff members for transfers, toileting and showering. B. Record review The ADL care plan, initiated on 11/9/19 and revised on 11/12/19, revealed Resident #8 had a self-care performance deficit. Pertinent interventions included the resident required staff assistance for repositioning (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, observations revealed staff failed to offer or provide Resident #8 with repositioning for four hours (see observations above). IV. Staff interviews CNA #3 was interviewed on 4/1/25 at 11:35 a.m. CNA #3 said Resident #326 and Resident #8 needed help to go to the bathroom. CNA #3 said Resident #326 and Resident #8 needed to be checked every two hours for repositioning and incontinence care. Registered nurse (RN) #1 was interviewed on 4/1/25 at 1:08 p.m. RN #1 said Resident #326 and Resident #8 needed to be repositioned every two hours to check if they need to be cleaned to prevent skin breakdown and for comfort. Licenced practical nurse (LPN) #2 was interviewed on 4/2/25 at 1:40 p.m. LPN #2 said if any of the residents needed staff assistance then they should be checked at least every two hours. LPN #2 said checking for incontinence every two hours was important to prevent skin breakdown and to ensure the residents were clean and dry. The DON and the regional clinical resource (RCR) were interviewed together on 4/3/25 at 5:58 p.m. The DON said any resident that was dependent on staff for toileting should be checked every two hours. The DON said that was the standard of care that should be done. The DON said the nurses and the CNAs were trained to check Resident #326 and Resident #8 every two hours. The RCR said Resident #326 had an air mattress as an intervention for skin breakdown but the CNAs and the nurses needed to provide repositioning and offer incontinent care at least every two hours. The RCR said any resident whose care plan indicated they needed assistance with repositioning should be offered repositioning every two hours to prevent skin breakdown. The DON said it was important to provide timely repositioning and incontinence care to maintain skin integrity by offloading any bony areas and to maintain the residents comfort.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52309 Based on record review and interviews, the facility failed to document resuscitation choices accurately in the medical record one (#376) of five residents reviewed for advance directives out of 49 sample residents. Specifically, the facility failed to ensure: -Resident #376 had a physician's order for their cardiopulmonary resuscitation (CPR) wishes in the resident's electronic medical record (EMR); and, -Resident #376's care plan included the resident's CPR wishes. Findings include: I. Facility policy and procedure The Advanced Directive policy, reviewed February 2025, was provided by the nursing home administrator (NHA) on [DATE] at 10:20 a.m. It read in pertinent part, Documentation shall be maintained in each resident's record. The facility will have a system for staff to identify the code status of each resident. II. Resident #376 A. Resident status Resident #376, age 73, was admitted on [DATE]. According to the [DATE] computerized physician's orders (CPO), diagnoses included esophageal obstruction, lobar pneumonia (a type of pneumonia that affects one or more lobes of the lung) and asthma. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 13 out of 15. B. Record review Review of the [DATE] CPO did not reveal a physician's order indicating the resident's CPR wishes. -On [DATE] (during the survey), a physician's order was entered into Resident #376's EMR for the resident's CPR wishes. Review of the resident's comprehensive care plan did not reveal documentation indicating the resident's CPR wishes. A review of the resident's EMR did not reveal documentation indicating the resident's medical orders for scope of treatment (MOST) form was scanned into the EMR and was not available for review. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #3 could not locate Resident's #376's MOST form in the Advanced Directive binder, which was kept at the nurse's station.t have a copy of Resident #376's MOST form for review. On [DATE] at 5:25 the resident's MOST form was provided by social worker (SW) #2. The MOST form was signed on [DATE] (during the survey) by the resident's physician. The MOST form was scanned into the resident's EMR on [DATE] (during the survey). III. Staff interviews SW #2 and RN #3 were interviewed together on [DATE] at 5:15 p.m. RN #3 and SW #2 said on admission, the admitting nurse filled out the MOST form and confirmed the order in the EMR. They said a copy of the MOST form was put into the Advanced Directive binder and the original MOST form was placed in a folder for the provider to sign. They said once the original was signed this replaced the copy in the binder and the form was scanned into the EMR. SW #2 said she located Resident #376's MOST form in the folder that was waiting to be signed by the physician. SW #2 said the MOST form was signed by Resident #376 on [DATE]. SW #2 said Resident #376's MOST form had not been signed by the physician.

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F 0689 Level of Harm - Minimal harm or potential for 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 provide adequate supervision to keep residents free from accidents/hazards for one (#276) of one resident out of 49 sample residents. Specifically, the facility failed to prevent an elopement from the secured unit building for Resident #276. Findings include: I. Facility policy and procedure The Elopement/Unsafe Wandering policy and procedure, revised June 2024, was provided by the nursing home administrator (NHA) on 4/6/25 at 1:12 p.m. It read in pertinent part, To provide a safe environment for all residents through appropriate assessment and interventions to prevent accidents related to unsafe wandering or elopement. Wandering is defined as random or repetitive locomotion and can be either goal directed or nongoal directed/aimless. Elopement is when a resident leaves the facility premises or a safe area without authorization and or any necessary supervision to do so. Residents with capabilities of ambulation and/or mobility in wheelchairs will have an elopement/wandering evaluation completed to determine the risks for elopement and unsafe wandering on admission. Residents with high risk factors identified on the elopement/wandering evaluation are considered at risk and will have an individualized care plan developed that includes measurable objectives and timeframes. The care plan interventions will consider the particular elements of the evaluation that put the resident at risk and the observations of wandering behavior. These interventions will address the individualized level of supervision needed to prevent elopement/unsafe wandering. If a resident is missing, it is a facility-wide emergency. Missing resident procedures will be initiated. Determine if the resident is out on an authorized leave or pass. If the resident was not authorized to leave, institute a search of the premises. If the resident is unaccounted for after a thorough search of the building and grounds, immediately notify the administrator, the director of nursing (DON), the resident's legal representative, the attending physician and law enforcement officials. When the resident returns to the facility, an assessment of the resident will be completed to determine if medical attention is required, provide interventions as indicated, notify search teams that the resident has been located, attending physician and resident representative will be notified of the resident's return, document relevant information in the resident's medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An elopement evaluation will be completed post-elopement with follow up documentation for a minimum of 72 hours following the incident. A review of the elopement incident by the interdisciplinary team (IDT) will include an investigation to determine the safety of the environment and probable causal factors leading to the elopement. The care plan will be updated and include interventions to address the possible need for increased level of supervision, staff will be educated on proper identification, assessment, and treatment of residents with elopement risks. Education will be provided on orientation and annually thereafter. II. Facility investigation of Resident #276's elopement on 3/31/25 The facility's investigation timeline of Resident #276's elopement was provided by the NHA on 4/2/25 at 12:19 p.m. The investigation revealed that at approximately 1:44 a.m. on 1/31/25 Resident #276 was seen on his unit. At 2:00 a.m. the unit nurse was on another unit with a different resident and the certified nurse aide (CNA) assigned to Resident #276's unit was on break. When the unit nurse returned to Resident #276's unit, the unit nurse noted that Resident #276 was not on the unit. The unit nurse and a CNA conducted a search and were able to find Resident #276 outside close to the entry of the facility's property. The staff were able to escort Resident #276 back into the facility. At 2:50 a.m. the registered nurse (RN) assessed Resident #276 for injuries. At 6:00 a.m. the unit nurse was verbally educated on ensuring that staff breaks were spaced appropriately so the unit was not unattended and ensuring that doors were properly latched when people entered and exited. At 7:00 a.m. Resident #276 was placed on frequent checks. At 8:45 a.m. the maintenance director (MTD) completed an environmental check to ensure that the doors were functioning and ensure that the doors latched properly. The MTD confirmed that everything was functioning and latching properly. At 6:18 p.m. the nurse practitioner documented a medication review for Resident #276. At 9:21 p.m. the psychiatric nurse practitioner documented completion of an evaluation of Resident #276. The investigation further documented that through facility determination, Resident #276 went over two desks at the nurse's station and activated the delayed egress door. The investigation included a timeline of the events of 3/31/25, root cause analysis and education to staff on the secure unit. The education included coordinating break times to ensure one staff member was always present on the unit. -However, the care plan did not address Resident #276's wandering behavior until during the survey process, even though the elopement/wandering assessment documented he was high risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Additionally, the care plan was not updated for elopement/wandering by social services until 4/3/25 (during the survey). III. Resident #276 A. Resident status Resident #276, age 83, was admitted on [DATE]. According to the April 2025 computerized physician order (CPO), diagnoses included dementia, type 2 diabetes and insomnia. The 3/24/25 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not conducted because Resident #276 was rarely or never understood. The staff assessment for mental status revealed that Resident #276 had short-term and long-term memory problems and his daily decision-making skills were severely impaired. The assessment indicated that Resident #276 required partial to moderate assistance with the majority of his activities of daily living (ADL). The assessment indicated that Resident #276 wandered. B. Resident representative interview Resident #276's representative was interviewed on 4/1/25 at 11:45 a.m. The representative said Resident #276 was recently diagnosed with dementia. She said a month ago he was able to drive himself to his appointments. She said he was adjusting to a new environment and it was all a new experience to him and to their family. The representative said she was aware of Resident #276's elopement on 3/31/25, she said the facility staff notified her, but she did not understand how a resident could elope from the secure unit. She said Resident #276's wishes were for safety and comfort and this was supposed to be the focus of his care. C. Observations On 4/2/25 at 1:50 p.m. an unidentified maintenance staff member was observed testing the doors to the middle secure unit to make sure that the doors locked properly. On 4/2/25 at 2:00 p.m. the door to the middle secure unit was observed to be slightly open. The door was able to be pushed fully open and allow a person to walk through the door and enter the middle secure unit without using a key card to unlock the door. On 4/2/25 at 2:31 p.m. the door to the middle secure unit was again able to be opened, without using a key card, in order to exit the middle secure unit. The light on the key pad where staff swiped their key cards was blinking from red to green, indicating that the door was not locked. D. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #276's mood/behavior care plan, initiated 3/27/25 and revised 4/2/25 (during the survey), revealed Resident #276 had mood/behavior problems due to his diagnosis of dementia with behaviors. The care plan documented that Resident #276 had had some agitation/aggression since admission and he liked to move furniture around and was at times difficult to redirect. The care plan documented Resident #276 would urinate in trash cans and on the floor. The care plan further revealed Resident #276 had a history of wandering without intent. Interventions included offering coffee, snacks, walks outside, going on outings, redirecting the resident to do a craft, offering a fidget lock box or pretend tool set, offering listening to Korean music and watching Korean television (TV). Review of Resident #276's secure unit placement care plan, initiated 4/3/25 (during the survey) revealed Resident #276 was a wanderer and elopement risk. Interventions included distracting the resident from wandering by offering a fidget lock box, fishing games, Korean music and TV, offering snacks and coffee and documenting the resident's wandering behaviors and attempted diversional interventions. The 3/20/25 elopement/wandering evaluation documented that Resident #276 was at high risk for wandering and elopement. The 3/20/25 medication administration note documented that Resident #276 was having behaviors of wandering, pacing the unit, touching other resident's hands, picking up the trashcan and moving it and then trying to sit on it and trying to sit on furniture that was already occupied. The note further documented that Resident #276 was pushing on the doors and causing the alarms to go off. The note documented that staff continued to redirect the resident but it was unsuccessful most of the time. The 3/21/25 behavior note documented that Resident #276 was pacing, restless and hitting the alarmed doors multiple times. The note documented that a drink and snack were given to Resident #276 and Resident #276 was able to make his needs known by asking or showing staff what he wanted. The 3/21/25 social services note documented that Resident #276's wandering behaviors continued. The 3/23/25 medication administration note documented that Resident #276 continued to wander and needed constant supervision. The 3/24/25 behavior note documented that Resident #276 continued to try to open doors and he was observed trying to open the back doors with a fork. The note further documented Resident #276 continued to wander into other residents' rooms. The 3/25/25 medication administration note documented Resident #276 continued to wander and exit seek. The 3/27/25 behavior note documented Resident #276 was restless and exit seeking by hitting the doors multiple times and causing the alarms to go off. The note documented that staff was able to redirect him by offering snacks and TV and staff would anticipate Resident #276's needs. The 3/28/25 behavior note documented Resident #276 was restless, pacing nonstop, wandering into other residents' rooms and causing the alarms to go off by hitting the doors. The note documented that staff redirected him by offering snacks, coloring and light activities, but Resident #276 continued to be restless. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An incident note, dated 3/31/25, documented that Resident #276 had an unwitnessed fall around 2:50 a.m. As the RN was coming to the unit to do a fall assessment, Resident #276 was observed sitting in a wheelchair in the common area. The unit nurse had notified RN that Resident #276 jumped over the nurse's station wall and was able to leave the unit through the doors of the neighboring unit and out of the building. The note documented that the unit nurse told the RN that she was on a different unit and the CNA was on her break during the time that Resident #276 left the building. The unit nurse and a CNA drove around the building and were able to locate Resident #276 outside of the building but still on the facility campus. Resident #276 was observed to have a quarter-sized laceration on his right front forehead and a laceration on his left foot on the tarsal area of the big toe, and a minor laceration on the right knee from the fall outside of the facility. The unit nurse was to complete the fall and elopement interventions. The 3/31/25 nursing note documented that the nurse returned to the unit from the other two units to find that Resident #276 was missing. After searching each room, the nurse and CNA went outside to find Resident #276 near the entrance of the facility grounds, which was close to a very busy street. The note documented that Resident #276 was trying to go home and the unit nurse notified the RN of the incident and to come and perform an assessment on the resident. The same injuries were listed as in the incident note above. IV. Staff interviews The assistant nursing home administrator (ANHA) was interviewed on 4/2/25 at 10:03 a.m. The ANHA said Resident #276 eloped from the secured unit by jumping over the nurse's station to the other unit and pushed on the door by the hallway furthest from the nurse's station, which was a fire door that opened after a delayed period. She said the resident did not exit the building but he did leave the unit. The NHA was interviewed on 4/2/25 at approximately 11:15 a.m. The NHA said he did not recall all the details, but said he would ask the director of nursing (DON) to provide a timeline and walk through the events of 3/31/25. The DON was interviewed on 4/2/25 at 1:20 p.m. The DON said Resident #276 walked from his bedroom to the nurse's station around 2:00 a.m. and crawled over the nurse's station and went over the nurse's station through the neighboring unit. She said he was able to exit through that unit because the door was not fully latched closed. She said Resident #276 then found his way to the main exit. She said the doors were locked from the outside from 8:00 p.m. until 6:00 a.m. She said you could push the main doors of the secure unit open and it would not alarm but if someone left, they could not get back in. The DON said Resident #276 was found outside in the parking lot close to the entrance of the facility property. Social worker (SW) #3 was interviewed on 4/2/25 at 1:42 p.m. SW #3 said that social services did not have a specific schedule that they used when going on breaks but that the nursing staff did because there had to be someone on the floor at all times. CNA #1 was interviewed on 4/2/25 at 1:58 p.m. CNA #1 said when CNAs went on their breaks, they told each other they were going on break and they could only go one at a time so that way everyone could shift units and ensure there was always someone covering the floor. She said there was supposed to be someone on the floor at all times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #5 was interviewed on 4/2/25 at 2:34 p.m. CNA #5 said that staff rotated when they went on their breaks to ensure the floor was always covered. She said if the light on the door was blinking then that meant the door was locked. CNA #6 was interviewed on 4/2/25 at 2:43 p.m. CNA #6 said that nurses would help cover the floor when the CNAs went on break. He said that if staff saw that a door was open then they should go and look to see why the door was open. He said that if there were any residents that were on elopement precautions then he would check the Kardex. He said that staff got elopement and dementia training during all-staff meetings. Licensed practical nurse (LPN) #5 was interviewed on 4/2/25 at 2:57 p.m. LPN #5 said CNAs were rotated for their breaks and nurses went when they found the time to go on their breaks. She said there was always someone on the floor. She said the doors that went to the outside of the unit had a light that blinked by the lock, which indicated they were locked. SW #3 was interviewed again on 4/2/25 at 2:01 p.m. She said new interventions that were put in place for him were the fidget lock box, fake tools and art supplies. SW #3 was interviewed a third time on 4/3/25 at 5:36 p.m. SW #3 said the facility staff believe Resident #276 was able to elope due to the lock not properly locking in the other unit's door. The MTD was interviewed on 4/3/25 at 5:45 p.m. The MTD said he identified a problem with the double door on the secure unit that was not latching appropriately. He said since it was noted, the door was guarded by staff members to ensure no residents left the unit. He said the door was fixed and functioning appropriately as of this afternoon 4/3/25. The MTD said he checked all the doors on the secure unit monthly to ensure they were functioning properly, however, he said this problem was not noted until recently.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards of practice for one (#116) of two residents reviewed for dialysis out of 49 sample residents. Specifically, the facility failed to: -Consistently and thoroughly complete the dialysis communication forms between the facility and the dialysis center; and, -Ensure thorough documentation was completed for Resident #116 dialysis treatments. I. Facility policy and procedure The Renal Dialysis, Care of Resident, Hemodialysis Access Site policy and procedure, revised December 2020, was provided by the nursing home administrator (NHA) on 4/6/25 at 1:12 p.m. It read in pertinent part, It is the policy of the facility to provide standards in the care of the residents on renal dialysis and the care of the vascular access site for hemodialysis. The facility licensed nurse will complete the baseline information, pre- and post-dialysis section of the nurse dialysis communication record. The dialysis center licensed nurse will complete the dialysis center section of the nurse dialysis communication record. II. Resident #116 A. Resident status Resident #116, age 80, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included end-stage renal disease, acquired absence of the kidney, malignant neoplasm of the right kidney, dementia, Melkersson's syndrome (a neurological disorder that caused facial swelling or paralysis) and the need for renal dialysis. The 1/26/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status score (BIMS) of eight out of 15. She required substantial assistance with toileting, showering, and dressing. She required supervision with personal hygiene and set up for oral hygiene and eating. The MDS assessment indicated the resident received dialysis treatments. B. Resident interview and observations Resident #116 was interviewed on 3/31/25 at 2:57 p.m. Resident #116 said she did not know what day of the week she went to dialysis. She said there was a sign above her bed that indicated she attended dialysis on Tuesday, Thursday and Saturday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review Review of Resident #116's dialysis care plan, initiated 1/24/25, revealed the resident received dialysis on Tuesdays, Thursdays and Saturdays at 7:10 a.m. Interventions included checking arteriovenous fistula (a surgical connection between a vein and artery used for dialysis) as ordered, not drawing blood or taking blood pressing in arm with graft, encouraging the resident to go to scheduled dialysis appointments, monitoring labs and reporting to the doctor as needed, monitoring, documenting and reporting to doctor as needed any signs and symptoms of infection to access site and nutritionist to consult. -However, the care plan did not indicate to monitor vital signs and weights pre- and post-dialysis treatment. Review of Resident #116's April 2025 CPO revealed the following physician's order related to dialysis: Dialysis on Tuesday, Thursday and Saturday, ordered 1/28/25. Check vital signs upon return from dialysis, ordered 1/26/25. Monitor port site for signs and symptoms of infection every shift, ordered 1/23/25. Prostat AWC (a liquid protein supplement), 30 milliliters (ml) twice a day for dialysis and to optimize nutrition, may mix with juice, ordered 2/13/25. Nepro (oral nutritional supplement), provide three times a day for malnourishment and to optimize nutrition, ordered 1/24/25. Review of the February 2025 (2/1/25 to 2/28/25) medication administration record (MAR) revealed the following: -Dialysis was left blank on 2/1/25, 2/6/25, 2/8/25 and 2/22/25. -Review of the resident's electronic medical record (EMR) did not indicate why the MAR was left blank on 2/1/25, 2/6/25, 2/8/25 and 2/22/25. Review of the March 2025 MAR revealed the following: -Dialysis was left blank on 3/20/25 and 3/27/25. -Review of the resident's EMR did not indicate why the MAR was left blank on 3/20/25 and 3/27/25. Resident #116's dialysis binder was provided by licensed practical nurse (LPN) #4 on 4/3/25 at 1:43 p.m. Each log had three sections on one sheet of paper, which revealed the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The first section was to be filled in by the facility before dialysis with the date and the resident's vital signs, which included temperature, pulse, respirations, blood pressure, weight and oxygen saturation levels. The section indicated to document the resident's weight, the resident's prescribed diet and if the resident's access site was intact. The section also prompted the nurses to document if the resident was COVID-19 positive, if the facility had a resident who was COVID-19 positive and if the resident was exposed to COVID in the past 14 days. The second section was the post-dialysis section was to be filled out by the facility with the resident's vital signs and if the access site was intact. A nurse's signature was required to validate that the information was completed. The third section of the communication form was to be filled out by the dialysis center staff. The documentation included the resident's vital signs, the resident's weight pre- and post-dialysis, the diet, if the access to the site was intact, and any recommendations or comments. A provider's signature and a date were required to validate that the information was completed. -However, Resident #116's dialysis binder included two communication forms. Resident #116's dialysis communication logs from 2/13/25 to 3/29/25 were provided by the NHA on 4/3/25. -The facility was unable to provide dialysis communication forms for 1/25/25, 1/28/25, 1/30/25, 2/1/25, 2/4/25, 2/6/25, 2/8/25 and 2/11/25. -Review of the resident's EMR did not indicate if the resident missed dialysis on 1/25/25, 1/28/25, 1/30/25, 2/1/25, 2/4/25, 2/6/25, 2/8/25 and 2/11/25. Review of the communication forms that the facility provided documented the following: The pre-dialysis section had the diet section left blank on the following dates: 2/20/25, 2/27/25, 3/20/25, 3/25/25 and 3/27/25 The pre-dialysis section had the weight left blank on 2/13/25, 3/11/25 and 3/29/25 The pre-dialysis section had the access site intact section blank on 3/22/25. The dialysis center section was left blank on the following dates: 2/18/25, 3/8/25, 3/15/25, 3/20/25, and 3/27/25 III. Staff interviews LPN #4 was interviewed on 4/3/25 at 6:10 p.m. He said when a resident went to dialysis, the facility nurse was responsible for obtaining the resident's pre-dialysis vital signs, weight and making sure the dialysis access site was intact. He said he documented the information on the dialysis communication sheet. He said the dialysis communication sheet went with the resident to dialysis in a binder. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #4 said the dialysis staff completed the dialysis center information on the communication sheet. LPN #4 said when the resident returned from the dialysis center, the resident's vital signs were obtained. He said the facility nurse entered the post-dialysis vital signs either on the dialysis communication sheet or on the MAR. He said he was not sure why some of the communication sheets were not completed in their entirety for Resident #116. Assistant director of nursing (ADON) #1 and the director of nursing (DON) were interviewed on 4/3/25 at 4:22 p.m. ADON #1 said when a resident was admitted to the facility and was receiving dialysis, the facility would make sure they knew the days, time, and location when the resident went to dialysis. ADON #1 said the nurse monitored the port or fistula site for signs and symptoms of infection each shift. ADON #1 said if the resident had a fistula, the nurse would remove the dressing as indicated per the dialysis center, which generally was the day after dialysis. ADON #1 said the days the resident had dialysis, the nurse completed vital signs and obtained the resident's weight. ADON #1 said the nurse documented the vital signs and the resident's weight on the communication form. ADON #1 said the communication form was placed in a binder that also had the resident's face sheet, the resident's preferences for life sustaining measures and a list of the resident's medication. ADON #1 and the DON said they did not know information was missing from the dialysis communication form for Resident #116. They said they did not know Resident #116's MAR was missing information.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to ensure residents who were diagnosed with dementia received the appropriate treatment and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one (#276) of one resident out of 49 sample residents. Specifically, the facility failed to effectively identify person-centered approaches for dementia care for Resident #276. Findings include: I. Facility policy and procedure The Specialized Dementia and Behavioral Care Program policy and procedure, undated, was provided by the nursing home administrator (NHA) on 4/6/25 at 1:12 p.m. It read in pertinent part, The Specialized Dementia and Behavioral Care Program includes a secured unit (SU) designed to meet the needs and ensure the safety of individuals with Alzheimer's, dementia/delirium, psychiatric/behavioral diagnoses, and other diagnoses deemed appropriate for the secured unit by the admissions assessment. To respond to the needs of both family and resident, the therapeutic milieu includes such services as individualized assessments and plan of care based on the needs of the resident. These services are designed to provide an understanding of the resident's specific requirements and skilled approach in the management of health, safety, and an emotional support of residents and family. The primary objective of the SU is to provide therapeutic setting that will maximize the resident's functioning for as long as possible and help ease the burden for families. The SU will maintain resident safety by being locked and/ or alarmed at all entry and exit doors. Through resident care planning, each resident will be cared for by an interdisciplinary team (IDT) of professionals working cooperatively and collaboratively to provide individualized care. II. Resident #276 A. Resident status Resident #276, age 83, was admitted on [DATE]. According to the April 2025 computerized physician order (CPO), diagnoses included dementia, type 2 diabetes and insomnia. The 3/24/25 minimum data set (MDS) assessment revealed a brief interview for mental status (BIMS) assessment was not conducted because Resident #276 was rarely or never understood. The staff assessment for mental status revealed that Resident #276 had short-term and long-term memory problems and his daily decision-making skills were severely impaired. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated that Resident #276 required partial to moderate assistance with the majority of his activities of daily living (ADL). The assessment indicated Resident #276 found listening to music he enjoyed, group activities, participating in his favorite activities, going outside and participating in his religious activities were very important to him. The assessment indicated that Resident #276 wandered but did not exhibit any other behaviors. B. Observations During a continuous observation on 3/31/25, beginning at 11:40 a.m. and ending at 12:55 p.m., the following was observed: At approximately 12:00 p.m. Resident #276 was eating in the dining area, he was standing then sitting, then standing staff was assisting him and trying to redirect him to sit while eating. At 12:04 p.m. staff brought Resident #276 more food, he ate some but did not finish. At approximately 12:10 p.m. Resident #276 was grabbing books from the community book shelf and carried them around the unit. -Staff on the unit did not attempt to redirect the resident by offering a different meaningful activity to the resident At 12:13 p.m. an unknown male resident told Resident #276 to put the books back, however, Resident #276 did not put the books back. The unknown male resident then hit the back of the books that Resident #276 was holding. Staff did not observe the interaction or intervene. At 12:38 p.m. Resident #276 unplugged the computer from the wall and staff redirected him by telling him that the church group was coming up. -However, staff did not attempt to take the resident to the middle secure unit where the church group would be held. At 12:40 p.m. Resident #276 wandered into another resident's room. Staff did not see Resident #276 in the other residents' room until he came out of the room. Staff again told Resident #276 about the church group. -However, staff again did not attempt to take the resident to where the church group would be held. At 12:55 p.m. staff was taking other residents over to the middle unit for the church group activity. -However, staff did not take Resident #276 to the church group, despite having told the resident two times that the church group activity was coming up. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continuous observation on 3/31/25, beginning at 3:36 p.m. and ending at 4:09 p.m., the following was observed: At 3:46 p.m. Resident #276 was in the common area sleeping in a rocking chair At 3:53 p.m Resident #276 woke up and began to push the entertainment center that was underneath the TV towards an unknown female resident. Resident #276 stopped right before he pushed it into the unknown female resident's foot. -However, staff did not intervene and attempt to offer the resident any meaningful activities to distract him from moving the furniture. Resident #276 walked into another resident's room and began to take his pants down to urinate in the other resident's bathroom. Staff was heard telling him not to use that bathroom and to use his own bathroom. -However, staff did not attempt to take the resident to his room to see if he needed to use the bathroom. At 3:57 p.m. staff moved the entertainment center back to where it had come from. At 4:09 p.m. Resident #276 was trying to remove an unknown female resident from the recliner she was sitting in. Staff continued to intervene by telling him no and that someone was already sitting in the chair. -However, staff did not attempt to offer the resident any meaningful activities to redirect the resident. C. Record review The impaired cognitive function care plan, revised 3/21/25, revealed Resident #276 had dementia with behaviors. Interventions included administering medications as ordered, communicating with family and care givers regarding capabilities and needs and keeping the resident's routine consistent. The trauma care plan, revised 3/27/25 revealed Resident #276 was at risk for re-traumatization due to his history of wartime trauma and experiences with racism. Interventions included anticipating and meeting the resident's needs, approaching the resident in a calm manner, ensuring the resident had opportunities to connect with religious/spiritual groups, ensuring the resident had opportunities to go outside and providing sensory activities to ground the resident when he was anxious. Review of Resident #276's mood/behavior care plan, initiated 3/27/25 and revised 4/2/25 (during the survey) revealed Resident #276 had mood/behavior problems due to his diagnosis of dementia with behaviors. The care plan documented that Resident #276 had had some agitation/aggression since admission and he liked to move furniture around and was at times difficult to redirect. The care plan documented Resident #276 would urinate in trash cans and on the floor. The care plan further revealed Resident #276 had a history of wandering without intent. Interventions listed included offering coffee, snacks, walks outside, going on outings, redirecting the resident to do a craft, offering a fidget lock box or pretend tool set and offering listening to Korean music and Korean television. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/20/25 medication administration note documented that Resident #276 was having behaviors of wandering, pacing the unit, touching other resident's hands, picking up the trashcan and moving it and then trying to sit on it and trying to sit on furniture that was already occupied. The note further documented Resident #276 became aggressive with staff when staff offered assistance. The note documented that staff continued to redirect the resident, but it was unsuccessful most of the time. -However, the note failed to document what interventions, if any, staff attempted to use to redirect the resident. The 3/21/25 behavior note documented that Resident #276 was easily upset when putting chairs on the table while other residents were still eating. Resident #276 got upset when he was told no and he did not like it when he was approached with medication and he slapped the nurse on the wrist and said No. He did eventually take his medication. The 3/23/25 at 12:35 a.m.behavior note documented Resident #276 was having behaviors of hitting, kicking and attempting to bite staff while staff was trying to provide care. -However, the note failed to document if staff attempted to use interventions to distract the resident from his behaviors. The 3/23/25 at 5:33 a.m. behavior note documented Resident #276 continued trying to bite staff and kick and hit staff anytime care was attempted. Resident #276 was talking in Korean only and getting easily agitated. Resident #276 was cleaned and changed only to be seen shortly after with his pants on his head, tearing up his brief and randomly urinating around the unit. An unsteady gait was noted. Resident #276 was assisted to his room, only to find he had torn up his bed and the bedding and mattress were on the floor, as well as other belongings scattered around the room. Staff cleaned the room, and the resident was encouraged to lay down, but he refused. Resident #276 was reminded that he could not be nude in the common area, but Resident #276 was ignoring staff and attempting to urinate on the floor again. Staff would continue to monitor. -However, the note failed to document that staff attempted to offer the resident meaningful activities to redirect his behaviors. The 3/24/25 nursing note documented that Resident #276's representative said he preferred to sleep on the floor and on the carpet at home while he was watching TV. The note documented this was a behavior he had done for years. -However, the facility failed to document the resident's preferred behavior of sleeping on the floor as a potential intervention for the behavior observed in the 3/23/25 nursing note (see note and care plan above). The 3/25/25 behavior note documented Resident #276 was very restless. He was pacing, hitting alarm doors and flipping tables and chairs multiple times. Staff was to redirect as needed. -However, the note failed to document what interventions, if any, staff attempted to use to redirect the resident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/27/25 behavior notes documented Resident #276 was urinating in inappropriate places and had hit a CNA really hard on the ear. -However, the note failed to document what interventions, if any, staff attempted to use to redirect the resident. The 3/28/25 behavior note documented that Resident #276 had been awake for most of the night shift pacing, restless, wandering the unit and rearranging furniture. The resident refused to stay in bed. Resident #276 became agitated when staff redirected him from entering other resident's rooms. The resident attempted to unplug the TV and cords from the wall. Staff tried to redirect him with watching TV and coloring. The redirection only lasted a few minutes before Resident #276 continued with his behaviors. -However, the note failed to document if staff attempted to use to redirect the resident with other care planned interventions, such as offering the resident coffee or snacks (see care plan above). III. Staff interviews Social worker (SW) #3 was interviewed on 4/2/25 at 1:42 p.m. SW #3 said staff did dementia training through an online training program and the facility was trying to get a specialized training set up again to have staff trained yearly. SW #3 was interviewed a second time on 4/2/25 at 2:01 p.m. SW #3 said new interventions that were put into place recently for Resident #276 were a fidget lock box, fake tools and art supplies. SW #3 was interviewed a third time on 4/3/25 at 5:36 p.m. SW #3 said the facility recently found out about Resident #276's trauma history of wartime Korea and experiences with racism from his family. She said the family member informed the facility that Resident #276 was very busy and was always moving and doing something. SW #3 said the family member said he liked to fix things, so the facility got him some fake tools and he liked to fish so the facility tried some fishing games with him. SW #3 said none of those interventions seemed to help. -However, observations during the survey did not reveal that staff had offered those interventions to the resident to redirect him (see observations above). SW #3 said the facility was collaborating with Resident #276's family on determining effective interventions for him. She said the resident's dementia decline had been rapid, according to the family. SW #3 said facility staff reviewed all the new residents' charts before they were admitted to the unit. She said the facility staff had noticed that Resident #276 had not been sleeping which staff thought could be a contributing factor to his behaviors. SW #3 said facility staff had the resident on standard monitoring at night. She said he was exhibiting behaviors as soon as he was admitted to the facility. SW #3 said, as soon as facility staff knew about an effective intervention that worked with a resident, the resident's care plan was updated. She said the resident had recently started on Haldol (an antipsychotic medication) and the staff thought the medication was helping with the resident's behavior stabilization.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48112 Based on observations, record review, and interviews, the facility failed to ensure all drugs and biologics were properly stored and labeled for one (#101) of two residents reviewed out of 49 sample residents. Specifically, the facility failed to ensure medications that were not administered were not left unsecured at Resident #101's bedside. Findings include: I. Facility policy and procedure The Medication Access and Storage policy and procedure, revised August 2019, was provided by the nursing home administrator (NHA) on 4/6/25 at 1:12 p.m. It read in pertinent part, The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. II. Resident #101 A. Observation and resident interview On 3/31/25 at 3:20 p.m., during an interview with Resident #101, a white rectangular box labeled lidocaine hydrochloride (hcl) 3% cream (topical pain medication) was on the resident's bedside table. Inside the box was a used tube labeled lidocaine hcl 3% cream. Resident #101 said the staff applied the cream when providing personal care. On 4/2/25 at 11:24 a.m. registered nurse (RN) #2 was interviewed in Resident #101's room. RN #2 said the lidocaine HCl 3% cream and diclofenac 3% gel (topical pain medication) were on the resident's bedside table. RN #2 said the resident went to a program of all-inclusive care for the elderly daily and they could have sent her back with a prescription. RN #2 went to the medication cart. He said he was unable to locate either medication in his cart. RN #2 said he reviewed the resident's computerized physician orders (CPO) in the resident's electronic medical record (EMR) and he did not see an order for the lidocaine HCl 3% cream or for the diclofenac 3% gel. B. Record review A review of Resident #101's EMR did not reveal documentation that the resident was able to self-administer medications. A review of Resident #101's EMR revealed the resident did not have a physician's order for the lidocaine HCl 3% cream or for the diclofenac 3% gel. C. Staff interviews (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 was interviewed on 4/2/25 at 11:24 a.m. RN #2 said medications should never be left at a resident's bedside. RN #2 said the only time a medication could be left with a resident was if the resident had an assessment indicating the resident was able to self-administer medication. RN #2 said he only worked the unit Resident #101 resided on and there was only one resident who could self-administer medications. RN #2 said Resident #101 could not self-administer because a self-administered assessment was not completed for her. RN #2 said he never administered either medication and he would ask the resident when she returned from PACE to see who administered the medications. RN #2 was interviewed again on 4/2/25 at 5:35 p.m. He said he talked to Resident #101. He said Resident #101 said the staff applied both medications and she did not specify which staff member used the medication. RN #2 said he told the director of nursing (DON). The DON was interviewed on 4/2/25 at 5:51 p.m. The DON said medications could not be left with residents. She said the only time medications could be left with a resident was if the resident had an assessment indicating the resident was able to self-administer medications. The DON said Resident #101 could not self-administer medications because an assessment was not completed. The DON said it was important not to leave medications at the bedside because other residents could have found the medication and an accident could have occurred. III. Facility follow-up The NHA provided the following information on 4/4/25 at 11:30 a.m. An action plan titled the Over-the-Counter (OTC) Medications Process Improvement Plan revealed that OTC medications were found at the bedside. The facility conducted an audit to identify other residents who have medication at their bedside. No additional residents were identified with medications at the bedside. Education was initiated for nursing staff that treatments could not be left at the bedside.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48112 Based on observations and interviews, the facility failed to consistently serve food that was palatable in taste. Specifically, the facility failed to ensure resident food was palatable in taste and texture. Findings include: I. Facility policy and procedure The Palatable Food policy and procedure, revised October 2021, was provided by the food and nutrition resource (FNR) on 4/4/25 at 1:45 p.m. It read in pertinent part, The facility will prepare and serve food that were palatable, attractive and at a safe and appetizing temperature. The facility will prepare food by methods that conserve nutritive value, flavor, and appearance. The facility will utilize pre-written menus. II. Observations On 4/3/25 at 11:31 a.m., the daily lunch menu was observed on the wall next to the entrance of the Longs Peak dining room. It revealed the menu was vegetable soup, house salad with dressing, orange-glazed chicken, Hawaiian rice, sugar snap peas, bread or roll with butter, chocolate cake and a choice of beverage. A test tray for a regular diet was evaluated by five surveyors immediately after the last resident had been served their meal for lunch on 4/3/25 at 12:47 p.m. The test tray consisted of an orange glazed chicken, green peas, Hawaiian rice, roll, pureed vegetable soup, and chocolate cake. - The chicken was dry and flavorless; and, - The Hawaiian rice tasted like plain rice and did not contain pineapple (see record review below). -The posted menu indicated snap peas were to be served, the test tray consisted of green peas. III. Resident interviews Resident #100 was interviewed on 3/31/25 at 4:39 p.m. He said he did not like the food because he thought it was the same items all the time. Resident #111 was interviewed on 3/31/25 at 1:48 p.m. She said she wanted more variety in the meals. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #105 was interviewed on 3/31/25 at 12:21 p.m. She said the food was either too salty or tasteless. Resident #76 was interviewed on 4/1/25 at 9:47 a.m. He said the food was not as good as it used to be, and the food was too spicy. Resident #58 was interviewed on 3/31/25 at 1:42 p.m. She said she did not like the food. She said the dietary manager (DM) did not understand the residents wanted better quality, more variety and more options. Resident #53 was interviewed on 3/31/25 at 3:53 p.m. She said the food was cold and the food did not look appetizing. IV. Record review The recipe for the Hawaiian rice and the orange-glazed chicken breast was provided by the DM on 4/3/25 at 6:23 p.m. The Hawaiian rice recipe indicated the ingredients included: white rice, water, green bell peppers, margarine and pineapple tidbits. The orange glazed chicken breast recipe indicated the ingredients included: chicken breasts, margarine, brown sugar, ground allspice, dry mustard, salt, all purpose flour and orange juice. The November 2024 resident council meeting minutes revealed Resident #29 said her food was still served cold. Resident #73 said she wanted more vegetables. The December 2024 resident council meeting minutes revealed the residents wanted more variety in ice cream. V. Staff interviews Cook (CK) #1 was interviewed on 4/3/25 at 11:32 a.m. She said the Hawaiian rice consisted of rice, butter, bell peppers and onions. -However, according to the recipe, CK #1 should have put pineapple tidbits in the rice (see record review above). CK #2 was interviewed on 4/3/25 at 12:36 p.m. He said he cooked additional chicken because they ran out of chicken. He said he used the chicken breasts that were used for items on the always available menu. He said the orange-glazed chicken that was prepared before lunch service was cooked with chicken thighs. CK #1 was interviewed again on 4/3/25 at 12:39 p.m. She said the sauce she used for the additional chicken breast cooked during meal service consisted of brown sugar, honey and an orange. -However, according to the recipe CK #1 should have included ground allspice, dry mustard, salt and flour (see record review above). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM, the FNR and the nursing home administrator (NHA) were interviewed on 4/3/25 at 5:35 p.m. The DM and the NHA said they tasted the food daily. The DM said she tasted the chicken at lunch today and the NHA had breakfast. The FNR said she tasted the lunch meal before lunch meal service started. The FNR said the lunch meal tasted good. The DM said the chicken tasted drier than it should have tasted. The DM said they ran out of chicken thighs midway through meal service, so they used chicken breasts. The DM said chicken thighs would have tasted better with the orange glaze than chicken breasts. The FNR said she tasted the chicken thighs and the DM said she tasted the chicken breasts. The DM said she did not serve sugar snap peas because they had an issue with their distributor. The DM said they could have modified their posted menu. The DM said the pureed soup could be salty once it was modified. The DM said the Hawaiian rice was not the same as what would be served at a restaurant based on the residents' dietary restrictions. She said that usually, Hawaiian rice was saucy. The DM said the Hawaiian rice should have had peppers, onions, and pineapple. The DM said she was not aware that there was no pineapple in the Hawaiian rice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 52045 Based on observations and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of seven units. Specifically, the facility failed to ensure staff wore the appropriate personal protective equipment (PPE) when providing care for Resident #326 and #95, who were both on enhanced barrier precautions (EBP) for pressure wounds. Findings include: I. Failed to ensure staff wore the appropriate PPE for Resident #326 and #95, who were both on EBP for pressure wounds A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), retrieved on 4/3/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent parts, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. II. Facility policy and procedure The Infection Prevention and Control Program policy, revised October 2022, was received from the director of nursing (DON) on 4/1/25 at 1:30 p.m. The policy read in pertinent part, The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The elements of the infection prevention and control program consist of coordination/oversight, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The program will be carried out by the facility infection preventionist. It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Goals: -Decrease the risk of infection to residents and personnel; -Recognize infection control practices while providing care; -Identify and correct problems relating to infection control; -Ensure compliance with state and federal regulations related to infection control; -Promote individual resident's rights and well-being while trying to prevent and control the spread of infection; and, -Monitor personnel health and safety. The infection prevention and control program is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. 'Personnel' covers staff, volunteers, visitors, and other individuals providing services under a contractual agreement. III. Resident #326 A. Observations On 4/1/25 at 11:32 a.m. a sign on Resident #26's door indicated the resident was on EBP. Resident #326 had pressure wounds on his thigh and coccyx. The sign on the resident's door indicated gloves and gowns must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. PPE was hanging on the back of Resident #326's door. On 4/1/25 at 11:48 a.m. certified nurse aide (CNA) #2 and CNA #3 were providing incontinence care to Resident #326. The CNAs changed the resident's brief. Both CNAs wore gloves while the incontinence care was provided. -However, CNA #2 and CNA #3 failed to put on protective gowns prior to providing incontinence care to Resident #326. IV. Resident #95 A. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 1:34 p.m. a sign on Resident #95's door indicated the resident was on EBP. Resident #95 had pressure wounds on both of his heels. The sign indicated gloves and gowns must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. PPE was hanging on the back of Resident #95 door. On 4/3/25 at 11:15 a.m. CNA #1 was observed providing incontinence care to Resident #95. CNA #1 took Resident #95 to the bathroom, assisted the resident to a standing position, removed the resident's soiled pants and brief and assisted the resident onto the toilet. CNA #1 put on gloves prior to providing incontinence care to the resident. -However, CNA #1 failed to put on a protective gown prior to providing incontinence care to Resident #95. V. Staff interviews CNA #3 was interviewed on 4/1/25 at 11:35 a.m. CNA #3 said if a resident was on EBP, the room would have PPE available. She said EBP meant staff were to wear a gown when providing residents' care. CNA #3 said she was unsure if Resident #326 was on EBP she was and not sure why there was a sign on the resident's door. Registered nurse (RN) #1 was interviewed on 4/1/25 at 1:08 p.m. RN #1 said she would check the medical record dashboard to see if a resident was on EBP and also get a verbal report from the nurse going off shift. In addition, RN #1 said she would look for the signs on the doors which indicated a resident was on EBP. RN #1 said there should be PPE behind the doors in the residents' rooms if they were on EBP. RN #1 said the nurses and the CNAs should put on a gown and gloves for direct contact resident care, such as toileting, wound care, dressing and transferring to prevent a resident from getting an infection. RN #1 said she was unsure of how many residents she currently had on EBP in her unit. Licenced practical nurse (LPN) #2 was interviewed on 4/2/25 at 1:40 p.m. LPN #2 said when a resident was on EBP, the nurses and the CNAs were supposed to wear gloves and gowns when taking them to the bathroom, getting them dressed or changing the wound dressings to avoid spreading infections. CNA #1 was interviewed on 4/3/25 at 11:22 a.m. CNA #1 said if a resident was on EBP, she needed to put on gloves and a gown when providing resident care, such as toileting and dressing. She said she forgot to put on a gown when she took Resident #95 to the bathroom. CNA #1 said it was important to maintain EBP to prevent the residents from getting any infections or spreading infections. The DON, the regional clinical resource (RCR) and the infection preventionist (IP) were interviewed together on 4/3/25 at 1:46 p.m. The DON and the IP said CNAs and nurses were to wear gloves and a gown when providing foley care, incontinence care, wound care, dressing and transfers if a resident was on EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065108	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villas at Sunny Acres, The	2501 E 104th Ave Thornton, CO 80233

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP said it was important to wear the appropriate PPE for the safety of the residents and staff and to prevent the potential spread of infections.