STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065110	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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** 50314 Based on observations, record review and interviews, 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 (#3 and #44) residents of 32 sample residents. Specifically, the facility failed to: -Have staff members identify themselves when entering Resident #3's room, who was blind; and, -Assist Resident #44 to use the restroom in a dignified manner. Findings include: I. Failure of staff to identify themselves appropriately to Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included low vision of the right and left eye, macular degeneration and generalized anxiety disorder. The 12/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15 . Resident #44 required set-up or clean-up assistance with eating and oral hygiene and was dependent on staff for all other cares. B. Resident interview Resident #3 was interviewed on 1/13/25 at 3:18 p.m. Resident #3 said that she had very low vision but was essentially blind. Resident #3 said she felt afraid when staff members entered her room without announcing who they were. Resident #3 explained that her experience when staff did not announce who they were was limited to hearing the door open and then hearing footsteps approaching her. Resident #3 said sometimes she guarded her body when she heard footsteps approaching her because she did not know if someone was coming into the room to touch her body, or not. (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	C. Observations During a continuous observation of the 300 hall on 1/15/25, beginning at 1:09 p.m. and ending at 2:53 p.m., the following was observed: At 1:27 p.m., an unidentified laundry aide was knocked on Resident #3's door. The laundry aide entered the resident's room without announcing his name or title. At 1:42 p.m., Resident #3 illuminated her call button, indicating that she requested assistance. Certified nursing aide (CNA) #5 knocked on Resident #3's door and said the resident's name and walked inside without announcing her name or title. D. Record Review The psychosocial and behavioral plan of care, initiated on 11/24/24 and revised on 11/27/24, documented that Resident #3 was exhibiting or at risk for behavioral symptoms, poor coping mechanisms, or willingness to use inappropriate behaviors in response to her anxiety. The documented goals included Resident #3 would accept supportive strategies and demonstrate adequate control of emotions which would not result in injury to self or others, that Resident #3 would respond to early interventions influencing the alterability of her behaviors, and that Resident #3 would be compliant with nursing care. Interventions included to establish a rapport with Resident #3, to announce your name and title when entering her room, and to announce what you are providing her in her room. The plan of care documented Resident #3 had a deep past history of mistrust with caregivers, family and loved ones. II. Failure to provide Resident #44 restroom assistance in a dignified manner A. Resident status Resident #44, age less than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included pelvic and perineal pain, dementia, cognitive communication deficit and wheelchair dependence. The 10/21/24 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of eight out of 15. The MDS assessment indicated Resident #44 had no rejections of care. Resident #44 required moderate assistance with eating, and substantial or maximum assistance with all other activities of daily living (ADL). B. Observation and resident interview During a continuous observation on the 100 hall on 1/14/25, beginning at 3:01 p.m. and ending at 4:43 p.m., The following was observed: At 4:07 p.m., the light outside of room [ROOM NUMBER] illuminated, indicating a request for assistance. A voice was heard coming from room [ROOM NUMBER] which loudly proclaimed I need to urinate really badly. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 4:11 p.m., Resident #44 self-propelled herself in her wheelchair to exit her room. Resident #44 then proceeded to self-propell herself to the nurses station, where she observed her nurse on the phone taking a medical report. Resident #44 then self-propelled herself into the rehabilitation room. At 4:12 p.m., a loud voice was heard in the rehabilitation room which said I need to urinate really badly. A second voice was heard in response, Okay, just go back to your room, turn your call light on and your CNA (certified nurse aide) will help you. Resident #44 was interviewed on 1/14/25 at 4:14 p.m. Resident #44 said that she had been instructed to return to her room, turn on her call light, and wait for assistance. Resident #44 also said that she needed to urinate very badly. Resident #44 had a furrowed brow. At 4:17 p.m., Resident #44 was offered and assisted to use the restroom by a staff member. C. Record review The functional mobility plan of care, initiated on 10/16/24 and revised on 10/31/24, documented that Resident #44 was dependent on one staff member to assist with toileting needs, and that Resident #44 required moderate assistance with the stand-pivot transfer with assist rails. III. Staff interviews Registered nurse (RN) #1 was interviewed on 1/16/25 at 10:07 a.m. RN #1 said that it was not okay to turn away a resident who was asking you for help. RN #1 said that she would help the resident right away. RN #1 said it was not helpful for staff or residents to send the resident back to their room. RN #1 said residents should be assisted when they asked for help. RN #1 said that staff knew to say who they were when entering Resident #3's room. RN #1 said residents should have their preferences honored. Licensed practical nurse (LPN) #3 was interviewed on 1/16/25 at 11:25 a.m. LPN #3 said that if a resident requested assistance, it would not be okay to send the resident back to their room. LPN #3 said he would assist the resident right away because he personally empathized with how uncomfortable that feeling was and residents need help right away when they have the need to void. LPN #3 said it was not respectful to send a resident back to their room. LPN #3 said when he worked on the 300 hall he knew to always introduce himself when entering Resident #3's room. LPN #3 said Resident #3 was known to get scared and upset, so it was extra important to be calm and respectful with her. The director of nursing (DON) was interviewed on 1/16/25 at 2:05 p.m. The DON said it was not acceptable for staff members to tell a resident to return to their room and wait when they request assistance. The DON said the staff member should have either assisted the resident or found someone else who could assist the resident. The DON said it was not acceptable to enter Resident #3's room without announcing who you were, and that was written on her plan of care. The DON said Resident #3's plan of care should be followed.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to offer choices to residents for three (#8, #11, and #23) of five residents reviewed for activities of daily living (ADL) out of 32 sample residents. Specifically, the facility failed to ensure Resident #8, Resident #1 and Resident #23 received showers consistently according to their choice of frequency. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, page 1794, retrieved on 1/21/25, Frequent bathing and skin care help promote overall health and wellness. Older adults may find it necessary to bathe only every two or three days, use less soap, and increase the use of skin moisturizers. II. Resident #8 A. Resident status Resident #8, over the age of 65, was admitted on [DATE] and readmitted [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included dementia, congestive heart failure (CHF), and rheumatoid arthritis. According to the 11/6/24 minimum data set (MDS) assessment Resident #8 was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 9 out of 15. The assessment documented the resident required substantial or maximum assistance with bathing cares. B. Resident interview Resident #8 was interviewed on 1/13/25 at 2:18 p.m. Resident #8 said he wanted two baths every week but usually received one bath per week. Resident #8 said he felt ignored when staff did not assist him to bathe twice weekly. Resident #8 said he was often asked to have a bath in the afternoon which he did not prefer. C. Record review Bathing preference documentation, dated 8/23/23, documented that Resident #8 preferred to receive two baths per week on Monday and Thursday. The facility documented Resident #8 preferred to receive his bath in the morning. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Point of care bathing task documentation was reviewed for 30 days between 12/18/24 and 1/15/25. The facility documented Resident #8 was offered six baths in the review period. The facility documented Resident #8 refused one bath on 12/18/24 at 3:21 p.m. because it was too late in the day for him to receive a bath. All six occasions bathing was offered to Resident #8 in the last 30 days of the review period was documented to occur between 1:22 p.m. and 5:59 p.m. -The facility failed to offer morning bathing twice weekly in accordance with Resident #8's bathing preferences. D. Staff interviews Registered nurse (RN) #1 was interviewed on 1/16/25 at 10:07 a.m. RN #1 said residents were bathed according to their preferences. RN #1 said that was typically two or three times per week for each resident. RN #1 said that if a resident refused a bath, then it should be reoffered the same day or the following morning. Licensed practical nurse (LPN) #3 was interviewed on 1/16/25 at 11:25 a.m. LPN #3 said residents were bathed according to their preferences. LPN #3 said most of the residents preferred two baths each week. LPN #3 said if a resident refused their bath, he would reoffer it a few hours later or later on the same day. LPN #3 said it was important that residents were bathed to keep their skin clean. Certified nursing aide (CNA) #3 was interviewed on 1/16/25 at 11:37 a.m. CNA #3 said residents were usually bathed twice each week or according to their wishes. CNA #3 said if a resident refused a bath it would be reoffered the next day. The director of nursing (DON) was interviewed on 1/16/25 at 2:05 p.m. The DON said residents should be bathed in accordance with their preferences, but the facility tried to offer bathing twice a week to the residents. The DON said bathing preferences of each resident was obtained on admission and any time the resident wished to change their bathing preference. The DON said if a resident refused a bath, it should be reoffered the next day. The DON reviewed Resident #8's bathing preferences and bathing documentation in the electronic medical record (EMR). The DON said Resident #8 should have been offered more baths. The DON said staff should have reoffered a bath to Resident #8 after he refused it on 12/18/24. The DON said facility staff documented not applicable on two occasions which meant those were not his day to receive a bath. 48412 III. Resident #11 A. Resident status Resident #11, age greater than 65, was admitted on [DATE]. According to the January 2025 CPO diagnoses included generalized muscle weakness, need for assistance with personal care, age-related physical debility, dependence on a wheelchair, Parkinson's (neurological disorder) disease without dyskinesia (involuntary movements) and dementia. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/16/24 MDS assessment revealed Resident #11 had mild cognitive impairments with a BIMS of nine out of 15. Resident #11 had an impairment to one side of his body affecting one upper extremity and one lower extremity. B. Resident interview Resident #11 was interviewed on 1/14/25 at 9:12 a.m. Resident #11 said he usually got two showers a week but requested three showers a week on Mondays, Wednesdays and Fridays. He said showers were important to him because he sweated a lot. C. Record review Resident #11's functional mobility and ADLs care plan, revised 8/21/23 revealed the resident preferred three showers a week. Resident #11's bathing chart was provided by the corporate consultant (CC) on 1/16/25 at 3:49 p.m. The bathing chart revealed the resident received showers on the following days: 12/18/24, 12/20/24, 12/23/24, 12/27/24, 12/30/24, 1/3/25, 1/8/25, 1/13/25 and 1/15/25. -However, out of 11 opportunities, Resident #11 received nine showers. -Resident #11 preferred to shower three times per week as identified on his comprehensive care plan. CNA #2 was interviewed on 1/16/25 at 2:34 p.m. She said she was unsure what time or day Resident #11 preferred his showers. The DON was interviewed on 1/16/25 at 10:15 a.m. She said all residents had their preferences for bathing completed and the staff needed to follow the preferences. She said Resident #47 preferred three showers a week and was care planned for it and should be given three showers a week. IV. Resident #47 A. Resident status Resident #47, age greater than 65, was admitted on [DATE]. According to the January 2025 CPO diagnoses included need for assistance with personal care, dementia and Alzheimer's disease with late onset. The 1/12/25 MDS assessment revealed Resident #47 had mild cognitive impairments with a BIMS of 11 out of 15. Resident #47 needed set-up assistance or supervision with bed mobility, eating, toileting and personal hygiene. B. Resident interview Resident #47 was interviewed on 1/13/25 at 10:12 a.m. Resident #47 said she often received showers in the evening and wanted to shower in the morning. Resident #47 said she wanted showers in the morning so she could relax in the evenings. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review Resident #47's bathing chart was provided by the CC on 1/16/25 at 3:49 p.m. The bathing chart revealed the resident received the following showers: -On 12/19/24 at 3:29 p.m.; -On 1/7/25 at 10:53 a.m.; -On 1/11/25 at 5:59 p.m.; -On 1/11/25 at 9:22 p.m.; and -On 1/13/25 at 5:04 p.m. -However, out of five showers Resident #47 only received one shower in the morning. D. Staff interviews CNA #2 was interviewed on 1/16/25 at 2:34 p.m. CNA #2 said she believed Resident #47 preferred her showers in the morning. The DON was interviewed on 1/16/25 at 10:15 a.m. The DON said she was unaware that Resident #47 was receiving showers in the afternoon and evenings. She said if the resident preferred morning showers then she needed to be showered in the morning.

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 48412 Based on record review and interviews, the facility failed to ensure money from personal funds accounts was managed accurately for one (#39) of five residents reviewed for personal funds accounts out of 32 sample residents. Specifically, the facility failed to notify Resident #39, who was Medicaid funded, or their legal representative, when the resident's personal funds account reached $200.00 less than the eligibility resource limit for one person. Findings include: I. Facility policy and procedure The Accounting and Records of Resident Funds, revised 2001, was provided by the nursing home administrator (NHA) on 1/16/25 at 12:57 p.m. It read in pertinent part, A representative of the business office informs the resident if the balance in his or her personal funds account reaches $200 (two-hundred dollars) less than the resident's resource limit and that if the amount in the account reaches the resource limit for one person, the resident may lose eligibility for Medicaid. II. Record review A. Resident #39 A review of the facility's current trust account balance revealed that Resident #39 had $1,960.86 in his account as of 1/15/25, which was $39.14 away from exceeding the allotted limit for Medicaid-funded residents. -There was no documentation indicating the facility notified Resident #39 or his legal representative when his personal funds account reached $200 less than the eligibility resource limit until 1/15/25 (during the survey). III. Staff interviews The NHA and business office manager (BOM) were interviewed together on 1/15/25 at 2:33 p.m. The BOM said she notified Resident #39 his account was close to the allotted limit for Medicaid. The BOM said she did not have documentation indicating the resident was notified his account was close to the allotted limit for Medicaid prior to 1/15/25. The NHA said the facility would work with the BOM to implement a performance improvement plan (PIP) to prevent this from happening again. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The BOM said Resident #39, or any other resident, with funds over the limit was at risk of losing their Medicaid. IV. Facility follow-up The NHA provided a PIP for Medicaid allowable limit on 1/15/25 at 3:16 p.m. which read in pertinent part, It was identified during the annual survey on 1/15/25 that there was no documentation of notification to resident or resident guardian or power of attorney (POA) of Medicaid allowable limit almost being reached for two residents. We have created a binder to ensure that going forward there will be proof that the notification was sent out. When the notification is sent out, the date and document will be put into the binder with resident's name. This will be audited weekly to ensure compliance. The binder will be updated weekly, updated yearly with the correct personal needs account amount on the authorization sheet and added to the binder. There will be a monitoring lof updated weekly, and brought to quality assurance and performance improvement (QAPI) monthly for three months to ensure compliance.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48412 Based on observations, record review and interviews,, the facility failed to ensure residents, family members and legal representatives had full access to review the results of the facility's most recent survey findings including the survey results, certifications, complaint investigations and plans of correction in effect for the preceding three years. Specifically, the facility failed to: -Ensure the residents knew where the state survey results were located; and, -Ensure the binder was accessible for review by residents and visitors. Findings include: I. Facility policy and procedure The Availability of Survey Results policy, undated, was provided by the nursing home administrator (NHA) on 1/16/25 at 12:57 p.m. It read in pertinent part, The survey binder is located in the main lobby and is available for review by interested persons who wish to review information relative to our company's compliance with federal and state rules, regulations and guidelines governing our company's operations. A representative of management is assigned the responsibility of making weekly inspections of the survey binder to ensure that the binder contains current information, is located in its designated area(s) and is readily accessible without one having to ask staff members for the information. II. Group interview The group interview was conducted on 1/15/25 at 10:30 a.m., with eight residents (#11, #51, #47, #35, #5, #62, #24 and #23), who were identified as alert and oriented by facility and assessment. The residents said they were unaware they could view the federal and state survey results. The residents said they were not aware the results of the surveys had been posted for them to be able to access and read. The residents said they were unaware there was a binder accessible for residents and family members to read past survey results. The residents said they would be interested in reading the results of previous surveys. III. Observations On 1/14/25 at 12:00 p.m., the binder containing the past survey results was unable to be located and there was not a sign posted in the facility indicating where the binder was located. (continued on next page)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	On 1/15/25 at 2:47 p.m., the binder containing the past survey results was unable to be located and there was not a sign posted in the facility indicating where the binder was located On 1/16/25 at 12:20 p.m., the binder containing the past survey results was located on the lowest shelf underneath another binder in the front area near the receptionist's desk. The binder was unlabeled. -The binder was not easily accessible by residents or visitors and there was not a sign that indicated where the binder could be located. IV. Staff interviews The NHA was interviewed on 1/16/25 at 12:25 p.m. The NHA walked to the main lobby and pulled the state survey binder from the bottom shelf and removed it from underneath another binder. He said the residents would not know where the binder was located without asking a staff member. The NHA said he was going to label the binder and ensure it was not on the bottom shelf or underneath other binders.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on interviews and record review, the facility failed to ensure one (#34) of three residents reviewed were free from abuse out of 32 sample residents. Specifically, the facility failed to ensure Resident #34 was free from physical abuse by Resident #53. Findings include: I. Facility policy and procedure The Abuse policy, dated September 2022, was provided by the nursing home administrator (NHA) on 1/16/25 at 12:57 p.m. The policy identified in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. All findings of all investigations are documented and reported. II. Incident of physical abuse of Resident #34 by Resident #53 A. Incident on 12/28/24 The 12/31/24 investigation report for abuse was provided by the NHA on 1/15/25 at 3:15 p.m. p.m. The investigation report documented pushing was the nature of the suspected physical abuse. The report identified Resident #34 informed the staff that his roommate (Resident #53) made contact with his chest on 12/28/24 when Resident #34 forgot to close the bedroom door. The report indicated both residents were assessed without injury on 12/31/24 and offered emotional support. The facility issued a room move to separate Resident #34 and Resident #53. The facility interviewed both residents on 1/2/25. According to the documented interviews, Resident #53 said he was upset with Resident #34 because he let Resident #53's dog out of the room when he did not shut the door. Resident #34 said he returned to his room after smoking. He was walking to his side of the shared room when Resident #53 put his hands on Resident #34's chest. Resident #34 said he was startled, was backed up to the wall and put his hand out in front of him to get Resident #53 away from him. Resident #34 said he did not tell anyone because he was trying to make efforts to get along. Resident #34 said he decided to report the incident because he felt Resident #53 would otherwise get away with the bad treatment towards Resident #34. The investigation report indicated five other residents and five staff members were interviewed on 1/3/25 without concerns of abuse. The investigation for abuse determined physical abuse was substantiated because of the intentionality of the incident. B. Resident #34 - victim (continued on next page)

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Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Resident status Resident #34, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included chronic ischemic heart disease, epilepsy (seizure disorder), history of falling, weakness, depression and encounter for palliative care. The 10/17/24 minimum data set (MDS) assessment identified Resident #34 was cognitively intact with a brief interview for mental status (BIMS) score of 13 out 15. He did not exhibit behaviors or disorganized thinking or inattention. Resident #34 did not have physical and verbal behaviors other behavioral symptoms directed to others. The resident was independent in most of his activities of daily living (ADL) cares and used both a walker and wheelchair for mobility. 2. Resident interview Resident #34 was interviewed on 1/14/25 at 4:09 p.m. He said Resident #53 was a new roommate and would yell at Resident #34 because his remote control for his television would unintentionally change the channels on Resident #53's television. He said he told the maintenance director (MTD) of the remote control malfunction and the MTD said he had a plan and would come back later to try to fix it. Resident #34 said one day he used the remote control, forgetting it was a problem, and changed the channel on his television which inadvertently changed the channel on his roommate's television. Resident #34 said Resident #53 started to yell, scream and curse at him. Resident #34 said he tried to explain to Resident #53 that he did not change the channel on purpose and maintenance was going to try to fix the problem but his roommate continued to yell at him. Resident #34 said the yelling happened a couple of times, both in the evening hours between 6:00 p.m. and 8:00 p.m. Resident #34 said he was surprised no one heard him or came to the room. Resident #34 said he told MTD that Resident #53 would get crazy, curse at him and go ballistic when he yelled at him because he was mad about the television remote control situation. Resident #34 said a few days later, on Saturday (12/28/24) morning between 7:30 a.m. and 8:00 a.m., he went outside to smoke. He said when he came back to his room his roommate came up from behind him and shoved him with so much force that Resident #34 almost fell down. He said Resident #53 started yelling at him to close the door. He said he turned around and Resident #53 started to come at him again so he grabbed Resident #53's throat to protect himself. Resident #34 said his roommate then backed away and left the room. He said a couple days later he told the marketing director (MKD) what happened. He said the following day Resident #53 was moved out of his room. He said he later realized that Resident #53 wanted the door shut because his dog spent time with him and he did not want the dog to get out. Resident #34 said the altercations with Resident #53 made him feel bad. Tearfully, he said he had always been a sensitive person and had a hard time forgetting when bad things happened to him. He said it was always something he had difficulty with. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34 said he felt that when he was shoved he was not going to say anything but the more he thought about it, he felt it was abusive and wrong to attack another resident so he decided to report Resident #53. He said he currently felt safe in the facility but at the time of the incident, he did feel a little fearful. He said he could not hear well and did not hear when the resident came from behind him. He said he was startled and then felt fear when he turned around and Resident #53 was coming at him so he put his hands out to stop him. Resident #34 said he had seen Resident #53 outside when he went to smoke but there had not been any more concerns and the television remote control was now fixed. 3. Record review The psychosocial emotional trauma care plan, revised 7/29/24, indicated the resident was at risk for decreased psychosocial wellbeing; adjustment issues; emotional distress; ineffective coping skills; poor impulse control; and, adverse effects on function, mental, physical, social, or spiritual wellbeing related to the history of stressful events or experience. Interventions, dated 4/21/24, directed staff to encourage Resident #34 to express emotions and help him identify triggers that prompted symptoms. The psychosocial well-being care plan, initiated on 1/13/25 (during the survey), indicated Resident #34 was at risk for psychosocial well-being concerns related to diagnosis of depression and his overall health status. Interventions, dated 1/13/25, directed staff to allow Resident #34 to voice feelings and frustrations as needed; assist Resident #34 to communicate with his family and friends through phone calls, video calls, and email; assist Resident #34 with conflict resolution as needed; encourage Resident #34's friends and family to visit; listen to Resident #34 attentively and observe Resident #34 for tearfulness, increased agitation, and decreased participation in care. -Review of Resident #34's progress notes between 12/1/24 and 1/14/25, did not identify altercations, behavior monitoring or concerns between Resident #34 and Resident #53. The progress notes did not identify visits offered to the resident offering emotional support or follow up after the 12/28/24 incident. The January 2025 CPO revealed a physician's order for targeted behavior for sad statements. It directed staff to monitor how often the sad behavior occurred and how he responded to redirection for every day and night shift, ordered on 11/28/24 and discontinued on 12/10/24. -The December 2024 treatment administration record (TAR) did not identify Resident #34's behaviors were monitored between 12/11/24 and 12/31/24. The January 2025 TAR did not identify Resident #34's behaviors were monitored between 1/1/25 and 1/14/25. C. Resident #53 - assailant 1. Resident status (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 CPO, diagnoses included chronic obstructive pulmonary disease, alcohol dependence with alcohol-induced persisting dementia, major depressive disorder, single episode, severe without psychotic features and insomnia. The 12/13/24 MDS assessment identified Resident #53 had moderate cognitive impairments with a BIMS score of 10 out of 15. The MDS assessment indicated Resident #53 did not have physical or verbal behavioral symptoms other behaviors directed by others. Resident #53 did not have limitations with upper and lower range of motion. The resident's functional ability identified the resident was independent or needed some supervision with his ADLs. According to the MDS, he did not use a mobility device for ambulation. 2. Resident interview Resident #53 was interviewed on 1/13/25 at 2:45 p.m. Resident #53 said he had a lot of problems with his former roommate (Resident #34) and referred to him as a derogatory name. He said they had a lot of verbal fights, cursing at each other, but he did not hit him (Resident #34) because he did not want to get discharged from the facility. He said he was now in a new room and had not had any problems with his new roommate. 3. Record review The behavior care plan, revised 12/23/24, identified Resident #53 exhibited or was at risk for behavioral symptoms, including striking out, grabbing others, combative, verbally, or physically abusive, inappropriate disrobing, smearing/throwing food/feces/objects) due to: anxiety, dementia, depression, history of alcohol abuse, history of substance abuse, insomnia and major depression. Interventions, dated 11/17/24, directed staff to anticipate Resident #53's needs and meet the needs promptly; encourage the resident to verbalize his feelings; maintain a calm, slow, and understandable approach; manage environmental factors to optimize comfort; observe and document changes in behavior, including frequency of occurrence and potential triggers with outward frustration or verbal aggression toward other residents or roommates; observe the resident's mood and response to medication; observe whether the behavior endangers the resident and/or others and intervene if necessary, removing others from the surrounding area; and, reduce stimulation such as noise, crowding, other physically aggressive residents to the extent possible. The psychosocial unsettled relationships care plan, initiated 1/13/25 (during survey), indicated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #53 had an unsettled relationship with friends, other residents, and roommates. He could become irritated and exhibit verbal or physical behaviors with increased confusion and frustration without processing the situation. Interventions, dated 1/13/25, directed staff to assess Resident #53 for mood and/or behavioral problems; assist the resident with psychosocial needs, to include preferences with placement of roommates who had similar likes/interests; assist the resident in identifying the origin of the complaint or concern; monitor Resident #53's behavior and determine appropriate interventions for each situation; encourage the resident to verbalize feelings of anger, anxiety, or sadness in an acceptable manner; provide understanding and validation of his preference of routine; establish a therapeutic relationship; redirect and offer solutions with the resident when he was frustrated; encourage Resident #53 to share how staff could assist or correct a situation; praise efforts in the use of effective coping strategies and provide reassurance and active empathetic listening. A maintenance work order sheet was provided by the NHA on 1/15/25 at 4:56 p.m. The work order sheet revealed a work order was created on 12/21/24 for the shared room of Resident #34 and Resident #53 and set to be completed on 12/24/24. According to the work order notes, the televisions were placed back to back so (the remotes) did not change each other's (television). The December 2024 TAR directed staff to monitor Resident #53's targeted behaviors of aggression. According to the December 2024 TAR, the resident exhibited easily altered aggression on 12/29/24, 12/30/24, and 12/31/24. -The TAR did not identify behaviors on 12/21/24 and 12/24/24 (see interview below) or behaviors on 12/28/24 when the physical altercation occurred. -Review of progress notes did not identify what the behavior was that was documented on 12/30/24 and 12/31/24 as a targeted aggressive behavior on the December 2024 TAR. The 12/29/24 medication administration note identified Resident #53's roommate exited the bedroom without shutting the bedroom door behind him. Resident #53 was alone in his room and got up out of bed and said loud enough for the nurse to hear in the hallway that he was going to initiate a physically aggressive act towards his roommate because the roommate did not shut the bedroom door. The note documented a manager on call was notified of Resident #53's behavior. According to the note, staff would make sure the door was closed at all times to prevent an altercation. -However, according to the investigation report, a physical altercation had already occurred on 12/28/24. -The 12/29/24 medication administration note did not identify the resident's roommate (Resident #34) was asked if he had been threatened by Resident #53 or if there had been any physical or verbal altercations with Resident #53. The review of the December 2024 progress notes for Resident #53 revealed the 12/29/24 medication administration note was the only note in December 2024 that identified concerns or behaviors related to Resident #53's roommate. III. Staff interviews (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MTD was interviewed on 1/15/25 at 10:35 p.m. The MTD said a work order was created to look at Resident #34's television. He said he was told that Resident #34's remote control was changing Resident #53's television channels. The MTD said when he was looking at the televisions, he fixed the remote control situation (on 12/24/24). The MTD said Resident #34 told him there was tension between him and his roommate. He said Resident #34 said his roommate cursed and yelled at him. The MTD said he was not sure he mentioned Resident #34's concerns to someone else. The MTD said he thought Resident #34's concerns were something that may have already been reported. The MTD said he probably should have made sure someone else knew about the report of cursing and tension towards Resident #34 from Resident #53. The NHA was interviewed on 1/15/25 at 3:18 p.m. The NHA said any reports of pushing, the use of threatening words and cursing at another resident would warrant immediate follow up with the residents to determine what was going on. The NHA said he was not aware of any verbal altercations between Resident #53 and Resident #34. He said he would want to know if there were reports of a verbal altercation before the situation escalated to a physical altercation. He said cursing at a resident and/or talk of threatening a resident would need to be investigated and reported. The NHA said allegations should be reported to him, as the abuse coordinator, and he needed to know what was going on so actions could be taken. He said he should have been made aware of the verbal altercation reported to the MTD by Resident #34. The NHA said threatening behavior and/or cursing at another resident could cause the resident harm. The NHA said he was notified of the reported 12/28/24 physical altercation between Resident #34 and Resident #53 by the social service director (SSD) on the evening of 12/30/24. He said he reported the allegation and started the investigation on 12/31/24. He said he substantiated the allegation of physical abuse based on intent. He said Resident #53 intentionally pushed Resident #34. He said the residents were separated and Resident #53 was provided a different room on 12/31/24. He said if he would have been made aware of situation sooner, than he would have started an investigation and looked into moving Resident #53 prior to the physical altercation. The NHA said knowing about the concerns between Resident #34 and #53 before 12/30/24 could have potentially decreased Resident #34's discomfort. The NHA said Resident #53 had a history of altercations with another roommate. He said Resident #53 was moved to Resident #34's room after the altercation with his former roommate in November 2024. He said there was an argument between the two roommates and Resident #53 threatened his roommate at the time. The NHA said he was not aware of the threatening words made by Resident #53 as documented on 12/29/24. He said the interdisciplinary team tried to review progress notes to identify potential concerns, but the note was not identified as a concern. The NHA said behavior tracking was documented in TARs and a note documented a behavior would usually just be completed when there was a significant change from a resident's baseline behavior. The NHA said the nurse supervisor should have informed the DON and the NHA when Resident #53's threatening remarks were reported to her so an investigation could have been started. He said the facility's abuse training was ongoing and he would look at additional education needs. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON and the NHA were interviewed together on 1/15/25 at 4:54 p.m. The DON said the nurse who documented the threatening words spoken on 12/29/24 by Resident #53 notified licensed practical nurse (LPN #1), who was identified as the supervisor on 12/29/24 that the nurse reported her concern to. The DON said LPN #1 did not notify her of the threatening statement. She said the nurses were not trained to report remarks by a resident made to themselves in the privacy of their room. The DON said the threatening statement was made loud enough for the nurse in the hallway to hear him but Resident #34 was not in the room at the time. She said no one followed up with Resident #34 or initiated an investigation to identify if he was being threatened by Resident #53 or if there were concerns between the two roommates. The DON said Resident #53 was already on behavior tracking so his behaviors should have been monitored. The DON said she would report the 12/29/24 incident on the evening of 1/15/25. The DON was interviewed again on 1/16/25 at 1:20 p.m. She said she was in the process of reeducating the staff on abuse and reported Resident #53's 12/29/24 threats of physical aggression. The NHA was interviewed on 1/16/25 at 1:32 p.m. The NHA said there were two opportunities missed to identify and address the situation between Resident #34 and #53 before the physical altercation. He said even a check-in with the residents could have potentially prevented the physical altercation. IV. Facility follow-up A 1/16/25 abuse reporting and investigation training participation sheet was provided by the NHA on 1/16/25 at 12:57 p.m. The participation sheet identified 31 facility staff members received abuse training on 1/16/25.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412 Based on observations, record review and interviews, the facility failed to ensure services provided to one (#10) of seven residents met professional standards of quality out of 32 sample residents. Specifically, the facility failed to ensure Resident #10's enteric-coated omeprazole was not crushed prior to administration. Findings include: I. Professional reference According to the MayoClinic, Omeprazole oral route (2024) was retrieved on 1/21/25 from https://www.mayoclinic.org/drugs-supplements/omeprazole-oral-route/description/drg-20066836 It read in pertinent part, Do not crush or chew the tablet. Do no crush or open the capsule. Swallow whole. II. Resident #10 A. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO) diagnoses included gastro-esophageal reflux disease, chronic obstructive pulmonary disease (COPD) and need for assistance with personal care. The 11/25/24 minimum data set (MDS) assessment revealed Resident #10 was unable to participate due to rarely being understood. The staff assessment revealed Resident #10 had short-term and long-term memory problems and her cognitive skills for daily decision-making were severely impaired. B. Observations and interview On 1/15/25 at 9:55 a.m., licensed practical nurse (LPN) #4 was crushing Resident #10's morning medications, which included an Omeprazole Capsule Delayed-Release 20 mg capsule. LPN #4 said the resident's medications needed to be crushed and ready for when the resident woke up. LPN #4 said any medication that was enteric coated, an extended-release or a delayed-release could not be crushed. She said if there was a medication that needed to be crushed but was unable to be crushed she would call the doctor asking for an alternative option. C. Record review On 6/23/21 a physician's order was entered for Resident #10 for Omeprazole Capsule Delayed-Release 20 milligrams (mg) to be administered every morning. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Staff interviews LPN #5 was interviewed on 1/15/25 at 9:40 a.m. LPN #5 said any medication that was enteric coated, an extended-release or a delayed-release could not be crushed. She said if there was a medication that needed to be crushed, but was unable to be crushed she would call the doctor asking for an alternative option. Registered nurse (RN) #3 was interviewed on 1/15/25 at 9:45 a.m. RN #3 said any medication that was enteric coated, an extended-release or a delayed-release could not be crushed. She said if there was a medication that needed to be crushed, but was unable to be crushed she would call the doctor asking for an alternative option. The director of nursing (DON) and the corporate consultant (CC) were interviewed together on 1/15/25 at 10:30 a.m. The DON said any medication that was enteric coated, an extended-release or a delayed-release could not be crushed. She said if there was a medication that needed to be crushed, but was unable to be crushed she would call the doctor asking for an alternative option. The DON said she was preparing education for the nursing staff regarding crushing medications. IV. Facility follow-up The CC provided education that was provided to the nursing staff on 1/15/25 at 11:00 a.m. (during the survey). The education explained that any medication that was enteric coated, an extended-release or a delayed-release could not be crushed. The facility posted a list of medications from the pharmacy describing which medications were crushable and which medications were not crushable.

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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** 50314 Based on record review and interviews, the facility failed to ensure an environment free from risk of accident hazards for one (#8) of five residents out of 32 sample residents. Specifically, the facility failed to: -Implement and update fall care plans in a timely manner for Resident #8; and, -Ensure neurological checks were completed appropriately for Resident #8 following an unwitnessed fall. Findings include: I. Facility policy and procedure The Falls and Fall Risk, Managing policy, revised March 2018, was provided by the corporate consultant (CC) on 12/18/24 at 3:12 p.m. It documented in pertinent part, According to the minimum data set (MDS), a fall is defined as unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g. a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. In conjunction with the attending physician, staff will identify and implement relevant interventions (hip padding or treatment of osteoporosis, as applicable) to try and minimize serious consequences of falling. The Neurological Record Documentation procedure, not dated, was provided by the director of nursing (DON) on 1/16/25 at 4:57 p.m. It documented in pertinent part, that after a fall, resident vital signs must be obtained and neurological assessments must be performed every 15 minutes for one hour following the fall event, then every 30 minutes for two hours after the first hour assessments, then assessments are performed every hour for the following two hours, then assessments were performed every shift thereafter until 72 total hours had passed since the fall even occurred. II. Resident #8 A. Resident status (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8, age greater than65, was admitted on [DATE] and readmitted [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included dementia, congestive heart failure (CHF) and rheumatoid arthritis. The 11/6/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. He was independent when eating, required set-up or clean-up assistance with oral hygiene, required moderate assistance with personal hygiene, and required substantial or maximum assistance with showering, toileting hygiene, lower body dressing, and footwear. The assessment documented the resident required substantial or maximum assistance with all acts of mobility. B. Record review The fall plan of care, initiated 8/3/23 and revised 10/29/24, documented Resident #8 had experienced a fall on 10/26/24. The plan of care documented Resident #8's goal was to have no falls with injury through the review date of 2/16/25. Interventions included keeping Resident #8's bed in a low position, ensuring non-slip grips were placed next to the resident's bed and bathroom and assisting the resident to organize belongings for a clutter-free environment. An intervention for the resident to be evaluated and treated by therapy as indicated was documented to have been added to the fall plan of care on 10/29/24. Nursing fall risk assessment, dated 10/26/24, documented Resident #8 was a moderate risk for falling. Interdisciplinary (IDT) -fall progress note, dated 10/29/24, documented Resident #8 experienced an unwitnessed fall on 10/26/24 at 3:00 p.m. when he was attempting to self-transfer to his bed from his wheelchair and slid to the ground. The progress note documented that physical therapy and occupational therapy would evaluate and provide treatment forResident #8 because he fell . The neurological record documentation, dated 10/26/24 to 10/29/24, documented the vital signs obtained and neurological assessments performed by nursing staff after Resident #8 fell on [DATE]. -The flow sheet failed to document neurological assessments performed or vital signs obtained during the day shift on 10/27/24 and 10/28/24. -The facility failed to perform neurological assessments per the facility's protocol (see interview below). A review of Resident #8's January 2025 CPO revealed a physician's order for physical therapy to evaluate and provide treatment to the resident, ordered on 10/29/24. Physical therapy note, dated 10/29/24, documented Resident #8 was evaluated by physical therapy on 10/29/24. -The facility failed to implement the newly identified fall prevention intervention in a timely fashion (see record review above and interviews below). (continued on next page)

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	065110	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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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 - Minimal harm or potential for actual harm Residents Affected - Few	D. Staff interviews The physical therapist (PT) was interviewed on 1/15/25 at 2:19 p.m. The PT said if a resident was referred to PT following a fall, the resident could be seen the same day if the therapy department was notified. The PT said she was not aware of a time the PT could not see a resident the day it was ordered, unless it was ordered near the end of the day. Registered nurse (RN) #1 was interviewed on 1/16/25 at 10:07 a.m. RN #1 said if a resident experienced an unwitnessed fall she would immediately assess the resident for any injuries and start obtaining neurological assessments per the facility schedule printed on the documentation sheet. RN #1 said it was not okay to skip or miss neurological assessments for any reason unless the resident refused. RN #1 said it was important to complete neurological assessments to watch for delayed head injuries. Licensed practical nurse (LPN) #3 was interviewed on 1/16/25 at 11:25 a.m. LPN #3 said if a resident had an unwitnessed fall, he would make sure the resident was okay and then get a RN to assess the resident. LPN #3 said neurological assessments were then completed by the protocol printed on the documentation form. LPN #3 said it was never acceptable to miss a neurological assessment because nurses had to make sure the resident did not develop a head injury. The DON was interviewed on 1/16/25 at 2:05 p.m. The DON said she considered a fall to be an unplanned descent to the floor. The DON said when a resident experienced an unwitnessed fall, she expected a RN to perform an assessment, ensure the resident did not have injuries and begin neurological assessments. The DON said neurological assessments should be performed according to the printed schedule on the neurological record documentation sheet. The DON said neurological assessments should not be skipped or missed unless the resident was not in the building. The DON said it was important to perform all the neurological assessments according to the printed schedule to ensure residents did not injure their brain. The DON said she reviewed the neurological record documentation for Resident #8. The DON said the facility did not document a neurological assessment or vital signs on day shift of 10/27/24 or 10/28/24 for Resident #8. The DON said after a resident experienced a fall, the facility would review and update the plan of care with new interventions. The DON said the new intervention should closely match the reason for the fall. The DON said that physical therapy could see residents the same day if needed. The DON said it should not have taken three days for Resident #8 to be evaluated by physical therapy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314 Based on record review and interviews, the facility failed to ensure catheter care in accordance with professional standards of care for two (#50 and #58) of three residents reviewed for appropriate catheter use and care out of 32 sample residents. Specifically, the facility failed to: -Provide suprapubic catheter care to Resident #50; -Conduct a thorough assessment after Resident #58 completed antibiotics for a urinary tract infection (UTI) to ensure the resident did not display further signs or symptoms of an UTI. Findings include: I. Professional reference According to the National Institutes of Health Library of Medicine: Prevention of Dependent Loops in Urine Drainage Systems in hospitalized Patients, retrieved on 1/22/25 from https://pmc.ncbi.nlm.nih.gov/articles/PMC4423413/#F1. It revealed in pertinent part, A dependent loop is formed by excess drainage tubing in a urine drainage system where urine or liquid can accumulate. Dependent loops trap drained urine and are suspected of impeding bladder drainage and increasing the residual volume of retained urine in the bladder. II. Facility policy and procedures The Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing policy, revised June 2014, was provided by the corporate consultant (CC) on 1/15/25 at 11:55 a.m. It documented in pertinent part, Be able to identify and report the clinical signs and symptoms of a urinary tract infection (with or without catheter), including: acute dysuria, fever, pain, swelling or tenderness of testes, suprapubic tenderness, costovertebral angle tenderness, leukocytosis, hematuria, incontinence, increased urgency or frequency, hypotension, confusion and/or functional decline, and/or purulent discharge around the catheter. Perform daily meatal hygiene with soap and water for residents with indwelling catheters. The Catheter Care, Urinary policy, revised August 2022, was provided by the facility on 1/15/25 at 11:55 a.m. The policy directed staff to make sure the catheter tubing and drainage bag were kept off the floor, observe and report complaints of burning, tenderness or pain in the urethral area. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Infections, Clinical Protocol policy, revised March 2018, was provided by the CC on 1/15/25 at 11:55 a.m. The policy documented the nursing staff and the physician would monitor the progress of a resident with an infection until it was resolved with no further significant clinical signs of symptoms. III. Resident #50 A. Resident status Resident #50, age greater than 65, was admitted on [DATE] and readmitted [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included bladder disorder unspecified, other retention of urine and obstructive and reflux uropathy (abnormal urine flow in the urinary system). The 10/24/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. He was dependent on staff for assistance with bathing and toileting hygiene. He required substantial or maximal assistance with dressing, footwear and personal hygiene. B. Resident interviews and observations Resident #50 was observed and interviewed on 1/14/25 at 10:18 a.m. Resident #50 said he was experiencing discomfort at his suprapubic catheter insertion site. Resident #50 said his suprapubic catheter was not being cleaned daily. Resident #50 said he did not think his suprapubic catheter had been changed since October 2024. Resident #50 said he was concerned about his suprapubic catheter. Resident #50 revealed his suprapubic catheter site. The suprapubic catheter site skin appeared to be dark and inflamed, with inflammation extending approximately one centimeter (cm) lateral to the insertion site. A small amount of white drainage was seen where the suprapubic catheter entered the body. Black and brown matter was adhered to approximately one cm of length of the yellow catheter tube. No dressing was observed on the suprapubic catheter at the insertion site. Resident #50's suprapubic catheter site was observed again on 1/15/25 at 11:12 a.m. The suprapubic catheter tubing had black and brown matter adhered to approximately one cm of length of the yellow catheter tube. No dressing was on the suprapubic catheter at the insertion site. Resident #50 was interviewed again on 1/15/25 at 11:14 a.m. Resident #50 said facility staff had not assessed or cleaned his suprapubic catheter yesterday or today. Resident #50 said he had experienced several UTIs in the facility before and he was concerned that these symptoms indicated another UTI was developing. C. Record Review (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The suprapubic catheter plan of care, initiated 2/7/24 and revised 8/13/24, documented Resident #50 had a suprapubic catheter placed on 1/2/24 by a urologist as a result of multiple traumatic urinary diagnoses. The resident's goal was to be free from catheter-related trauma and complications through the review date. Interventions included performing catheter care every shift and as needed, cleansing the suprapubic catheter daily with normal saline, patting dry and covering with a dry dressing every day and as needed if soiled or dislodged, checking the suprapubic catheter tubing for kinks each shift, monitoring and documenting intake and output each shift, monitoring and document pain or discomfort due to the catheter, and to monitor, record and report signs and symptoms of urinary tract infection such as: pain, burning, blood tinged urine, cloudiness, no urinary output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behaviors, or changes in eating patterns. Point of care documentation of catheter care offered and provided was reviewed for 30 days (12/17/24 and 1/16/25). In 30 days of opportunities, the facility documented catheter care was performed daily on 29 of those 30 days. The facility documented catheter care was performed on 1/14/25 and 1/15/25. -However, black and brown matter was observed to be adhered to the catheter tubing on 1/14/25 and 1/15/25, indicating catheter care had not been performed. -Licensed practical nurse (LPN) #6 and the CC said Resident #50's catheter needed to be cleaned on 1/15/25 (see interviews below). Urinary catheter staff education was provided by the CC on 1/15/25 at 4:48 p.m. The education documented that five staff members received education on 1/15/25 on how to properly clean urinary catheters. The education consisted of a printed facility urinary catheter care policy that was individually signed by the staff members. The education included documentation that perineal hygiene included using a clean washcloth with warm water and soap (or bathing wipe) to cleanse and rinse the catheter from insertion site to approximately four inches outward. D. Staff interviews LPN #6 was interviewed on 1/15/25 at 11:35 a.m. LPN #6 said she had not observed Resident #50's catheter or performed catheter care for Resident #50 today. (1/15/25) LPN #6 said catheter care should be performed daily and as needed if the tubing was dirty. LPN #6 said she was not aware of any concerns with Resident #50's suprapubic catheter. LPN #6 then entered and observed Resident #50's suprapubic catheter with the resident's permission. LPN #6 said there was black and brown matter on the suprapubic catheter tubing and the tubing needed to be cleaned. LPN #6 said that urine was flowing freely into the drainage bag and the urine color itself had not changed. LPN #6 said she was not concerned with how Resident #50's suprapubic catheter appeared on observation at that time. LPN #6 said she would perform catheter care to remove the black and brown matter that adhered to the tubing. The CC was interviewed on 1/15/25 at 12:08 p.m. The CC said she had an opportunity to look at Resident #50's catheter. The CC said the catheter needed to be cleaned. The CC said that there was no current concern to change the catheter tubing or involve a physician at this time. The CC said education would be provided to all nursing staff on how to clean a urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 1/16/25 at 10:07 a.m. RN #1 said suprapubic catheters should be cleaned every day. RN #1 said if there was visible matter on the suprapubic catheter, it should be scrubbed off because it was an infection risk for the resident. Licensed practical nurse (LPN) #3 was interviewed on 1/16/25 at 11:25 a.m. LPN #3 said all catheters should be cleaned daily and as needed when the tubing was unclean. LPN #3 said if any matter was visible on the catheter tubing, it must be scrubbed off to prevent infection. The DON was interviewed on 1/16/25 at 2:05 p.m. The DON said that indwelling catheters should be cleansed daily and as needed. The DON said that if a resident had a catheter with white drainage, or if a resident was experiencing pain or discomfort at their catheter site it should be reported to the physician. The DON said she did not have a chance to see Resident #50's catheter on 1/15/25. The DON said black or brown matter adhered to the urinary catheter should be cleansed off of the catheter tube because the adhered matter can contribute to the development of a urinary tract infection. 40467 IV. Resident #58 A. Resident status Resident #58, age greater than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included neuromuscular dysfunction of the bladder, unspecified urinary incontinence, other urethral stricture, male, unspecified site, benign prostatic hyperplasia with lower urinary tract symptoms and obstructive and reflux uropathy. The 12/17/24 MDS assessment documented Resident #58 was cognitively intact with a BIMS score of 14 out of 15. He did not have inattention, disorganized thinking or rejection of care behaviors. The resident required partial to moderate assistance with most of his activity of daily living (ADL) care needs. Resident #58 used a wheelchair for mobility. According to the MDS assessment, the resident used an indwelling catheter B. Resident interview and observation Resident #58 was observed in his room on 1/13/25 at 3:20 p.m. Resident #58 sat in his wheelchair. His indwelling catheter bag laid flat on the floor in front of him. The long catheter tubing was outstretched by more than six inches from his feet. He said he placed the catheter bag on the floor earlier when he was urinating and had not picked it up off the floor. He said he placed the catheter bag on the floor so when he urinated the urine would go straight to the bag and not back up the catheter tube. He said he routinely would lay the catheter bag on the floor when he was sitting in his wheelchair and urinated. Resident #58 said he was prone to urinary track infections and in the past he went to the hospital for sepsis. Resident #58 picked up the catheter bag from the floor and clipped the bag to the wheelchair. A loop was created in the catheter tubing when he clipped the bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58 was interviewed on 1/15/25 at 2:01 p.m. He said his catheter was leaking during the night of 1/14/25 and today (1/15/25) he had a burning feeling when he urinated. He said he told the staff and they told him they would keep an eye on it for now. Resident #58 was observed a second time on 1/15/25 at 5:02 p.m. His catheter bag was hooked to the bottom rail of his wheelchair. A section of catheter tubing hung below the catheter bag and about one inch off the floor, creating a dependent loop. Resident #58 was interviewed on 1/16/25 at 1:02 p.m. He said he still had a burning sensation when he urinated and told his nurse. C. Record review The indwelling foley catheter care plan, revised 10/15/24, identified Resident #58 was at risk for complications with urinary system related to his indwelling catheter for wound healing history of obstruction and reflux uropathy bladder with retention. The care plan included the following interventions, dated 9/13/23, providing the resident catheter care and empty his catheter every shift and as needed; notifying the nurse of foul-smelling urine, blood, or discharge; keeping the catheter anchored for security and to prevent trauma; and, notifying the physician of signs and symptoms of a UTI such as mental status changes, foul smelling urine, color change in urine, hematuria, sedimentation, burning with urination and an increased body temperature. The 11/12/24 physician's order directed staff to monitor placement of Resident #58's foley catheter. According to the CPO, staff should make sure the catheter had no kinking or compression that could obstruct urine flow to the gravity bag during catheter care on every day and night shift. -However, observations revealed the resident's catheter tubing had a loop, which could prevent the flow of urine (see observations above). The 1/3/25 nurse progress note documented Resident #58's nurse clamped the catheter drainage tubing for 40 to 45 minutes at two separate times before attempting to collect urine from the catheter after disconnecting drainage tubing. According to the note, the nurse was unable to collect urine at that time and would pass the concern on to the day nurse. The 1/5/25 laboratory note documented a urine culture was collected from the foley port of Resident #58 and sent to the hospital lab for analysis. The 1/8/25 CPO identified the resident had a physician's order for Cephalexin (Keflex) oral tablet antibiotics. The CPO directed staff to give the resident 500 milligrams (mg) twice a day for five days for a UTI with a start date 1/8/25 and competed on 1/13/25. The 1/9/25 72-hour charting note documented Resident #58 started Keflex for a UTI. According to note, the resident denied pain or discomfort and had no adverse reactions during this shift The 1/10/25 72-hour charting note documented Resident #58 continued on Keflex for a UTI. According to note, the resident denied pain or discomfort and had no adverse reactions during this shift (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/11/25 72-hour charting note documented Resident #58 continued on Keflex for a UTI. According to note, the resident denied pain or discomfort and had no adverse reactions during this shift The 1/12/25 72-hour charting note documented Resident #58 continued on Keflex for a UTI. According to note, the resident denied pain or discomfort and had no adverse reactions during this shift The January 2025 medication administration record (MAR) documented Resident #58 took his last dose of antibiotics for his UTI on the morning of 1/13/25. Review of Resident #58's electronic medical record (EMR) did not identify the resident was placed on 72 hour charting after he completed his prescribed antibiotics on 1/13/25 (see interviews below). The EMR did not identify the resident was assessed for UTI symptoms after he completed the antibiotics on the morning of 1/13/25. D. Staff interview The DON and the CC were interviewed together on 1/16/25 at 1:04 p.m. The DON said Resident #58 has a history of concerns with UTI's and was followed by a urologist. The CC said he was last seen by the urologist on 11/19/24. The DON said Resident #58 recently was treated with antibiotics for a UTI. She said the nurses would complete 72 hour charting to monitor the response to the antibiotics. She said the nurses should complete 72 hour charting after the resident completed the antibiotics for a UTI to make sure the UTI was gone and he no longer had signs and symptoms of an infection. The DON said she reviewed Resident #58 progress notes. She said there were no 72 hour progress notes that identified the nurses were assessing the resident for signs and symptoms of the UTI after he completed the course of antibiotics. She said the nurses were probably asking how he was feeling but did not chart his response or if there were concerns. The DON said she would reeducate the nursing staff to complete 72 charting the completion of antibiotics. The DON said a catheter bag should never be placed on the floor because of the risk of cross-contamination and infection. She said she was not aware that Resident #58 placed the catheter bag on the floor to help with drainage to the catheter bag. The RCR said a loop in the catheter tubing could cause back flow of the urine. The DON said she would review the resident's catheter and look at solutions to these concerns to decrease the risk of infection.

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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** 40467 Based on observations, record review and interviews, the facility failed to ensure a resident diagnosed with dementia, received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one (#53) of four residents reviewed for mood and behavior out of 32 sample residents. Specifically, the facility failed to effectively implement person-centered approaches for dementia care to prevent resident-to-resident altercations. Cross-reference: F600 failure to prevent resident abuse. Findings include: I. Facility policy and procedure The Dementia Clinical Protocol policy and procedure, revised November 2018 was provided by the nursing home administrator (NHA) on 1/16/25 at 3:29 p.m. The policy read in part, For the individual with confirmed dementia, the IDT (interdisciplinary team) will identify a resident-centered care plan to maximize remaining function and quality of life. The IDT will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. Resident needs will be communicated to direct care staff through care plan conferences, during change of shift communications and through written documentation (nurses' notes and documentation tools). Progressive or persistent worsening of symptoms and increased need of staff support will be reported to the IDT. The staff will monitor the individual with dementia for changes in condition and decline in function and will report these findings to the physician. The IDT will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors. II. Resident status Resident #53, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician's orders (CPO), diagnoses included chronic obstructive pulmonary disease, alcohol dependence with alcohol-induced persisting dementia, major depressive disorder, single episode, severe without psychotic features, and insomnia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/13/24 minimum data assessment (MDS) assessment identified Resident #23 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. The MDS assessment indicated Resident #53 did not have physical or verbal behavioral symptoms other behaviors directed by others. The resident's functional ability on admission identified the resident was independent or needed some supervision with his ADLs. According to the MDS assessment, he did not use a mobility device for ambulation. III. Incident of physical abuse of Resident #34 by Resident #53 The 12/31/24 investigation report for abuse was provided by the NHA on 1/15/25 at 3:15 p.m. p.m. The investigation report identified Resident #53 pushed Resident #34 on 12/28/24 because he did not shut the shared bedroom door and Resident #53 did not want his dog to get out of the room. The facility was not aware of the incident until Resident #34 reported the incident to a staff member on 12/30/24. The investigation for abuse determined physical abuse was substantiated because of the intentionality of the incident. IV. Resident interviews Resident #53 was interviewed on 1/13/25 at 2:45 p.m. Resident #53 said he had a lot of problems with his former roommate (Resident #34) and referred to him as a derogatory name. According to the resident, he and his roommate had a lot of verbal fights, cursing at each other. Resident #34 was interviewed on 1/14/25 at 4:09 p.m. Resident #34 said his roommate yelled and cursed at him on two different occasions prior to the 12/28/24 incident of physical abuse. He said he reported yelling and cursing to the maintenance director when he worked on his television remote (12/24/24). -The facility failed to document and observe potential triggers, outward frustration or verbal aggression toward other residents or roommates and intervene as necessary as identified by Resident #53's behavior care plan (see below). V. Record review The behavior care plan, revised 12/23/24, identified Resident #53 exhibited or was at risk for behavioral symptoms (for example) striking out, grabbing others, combative, verbally, or physically abusive, inappropriate disrobing, smears/throws food/feces/objects) due to: anxiety, dementia, depression, history of alcohol abuse, history of substance abuse, insomnia and major depression. Interventions, dated 11/17/24, read in pertinent part, directed staff to anticipate Resident #53's needs and meet the needs promptly; encourage the resident to verbalize his feelings; maintain a calm, slow, and understandable approach; manage environmental factors to optimize comfort; observe and document changes in behavior, including frequency of occurrence and potential triggers with outward frustration or verbal aggression toward other residents or roommates; observe the resident's mood and response to medication; observe whether the behavior endangers the resident and/or others and intervene if necessary, removing others from the surrounding area; and, reduce stimulation such as noise, crowding, other physically aggressive residents to the extent possible. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The psychosocial unsettled relationships care plan, initiated 1/13/25 (during survey), indicated Resident #53 had an unsettled relationship with friends, other residents, and roommates. He could become irritated and exhibited verbal or physical behaviors with increased confusion and frustration without processing the situation. Interventions, dated 1/13/25, directed staff to assess Resident #53 for mood and/or behavioral problems; assist the resident with psychosocial needs, to include preferences with placement of roommates who had similar likes/interests; assist the resident in identifying the origin of the complaint or concern; monitor Resident #53's behavior and determine appropriate interventions for each situation; encourage the resident to verbalize feelings of anger, anxiety, or sadness in an acceptable manner; provide understanding and validation of his preference of routine; establish a therapeutic relationship; redirect and offer solutions with the resident when he was frustrated; encourage Resident #53 to share how staff could assist or correct a situation; praise efforts in the use of effective coping strategies and provide reassurance and active empathetic listening. -The facility did not implement new interventions to address Resident #53's mood and behavior until 1/13/25, two weeks after physical abuse was reported and substantiated and provided a new roommate. The December 2024 treatment administration record (TAR) directed staff to monitor Resident #53's targeted behaviors of aggression. According to the December 2024 TAR, the resident exhibited easily altered aggression on 12/29/24, 12/30/24, and 12/31/24. The TAR did not identify behaviors on the 12/21/24 and 12/24/24 (see interview below) or behaviors on 12/28/24 when the physical altercation occurred. Review of progress notes did not identify what the behavior was on 12/30/24 and 12/31/24 as a targeted aggressive behavior on the December 2024 TAR as directed by Resident #53's behavior care plan. The 12/29/24 medication administration note identified Resident #53's roommate exited the bedroom without shutting the bedroom door behind him. Resident #53 was alone in his room and got up out of bed and said loud enough for the nurse to hear in the hallway that he was going to initiate a physically aggressive act towards his roommate because the roommate did not shut the bedroom door. The note documented a manager on call was notified of the Resident #53's behavior. According to the note, staff would make sure the door was closed at all times to prevent an altercation. -The facility failed to address the physically aggressive threat other than to document they would make sure the door was shut. -The staff did not approach the Resident #43 to understand Resident #53 feelings and concerns as identified in his behavior care plan. -Resident #53 was not provided another room to separate him from the situation that was triggering his aggression as identified in his behavior care plan. The review of the December 2024 progress notes for Resident #53 revealed the 12/29/24 medication administration note was the only note in December 2024 that identify concerns or behaviors related to Resident #53's roommate. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	VI. Staff interview The maintenance director (MTD) was interviewed on 1/15/25 at 10:35 p.m. The MTD said when he was looking at the televisions (12/24/24), Resident #34 told him there was tension between him and his roommate. He said Resident #34 said his roommate would curse and yell at him. The MTD said he was not sure he mentioned Resident #34's concerns to someone else. The MTD said he thought the Resident #34's concerns were something that may have already been reported. The MTD said he probably should have made sure someone else knew about the report of cursing and tension towards Resident #34 from Resident #53. The NHA was interviewed on 1/15/25 at 3:18 p.m. The NHA identified the resident had a pattern of altercations with a roommate. He said he was moved to Resident #34's room after an altercation with his former roommate in November 2024. He said there was argument between the two roommates and Resident #53 threatened his roommate at the time. The NHA said he was not aware of the threatening words made by Resident #53 as documented on 12/29/24. He said the interdisciplinary team tried to review progress notes to identify potential concerns but the note was not identified as a concern. The NHA said behavior tracking was documented in TARs and a note documented a behavior would usually just be completed when there was a significant change from a resident's baseline behavior. The director of nursing (DON) was interviewed on 1/15/25 at 4:54 p.m. The DON said the threatening remarks on 12/29/24 were loud enough for the nurse in the hallway to hear him but Resident #34 was not in the room at the time. The DON said Resident #53 was already on behavior tracking so his behaviors should have been monitored. The social service director (SSD) was interviewed on 1/16/25 at 3:07 p.m. The SSD said she helped the facility with dementia care training with the certified nurse aides (CNA). She said she helped the CNAs understand and familiarize themselves with person centered care planned interventions. The SSD said Resident #53 had vascular dementia which could contribute to aggressive behaviors. She said Resident #53 was reclusive. His personal space and visits with his dog was very important to him. The SSD said he could make his needs known and it was important for staff to meet him where he was at, meaning identifying his behavior needs. She said staff attempted to pair him with an appropriate roommate. She said his new roommate (after the 12/28/24 incident) spent most of his time on his side of the shared room in bed. She said moving Resident #53 to another room was the safest option after the 12/28/24 physical aggression. The SSD said to help prevent Resident #53's aggressive behaviors, staff should watch for restlessness and changes in his normal behavior. She said if they observe any concerns in his behavior, staff should ask him if there was something bothering him so the concern could be addressed. The SSD said arguing with his roommate would be an opportunity to use dementia care inventions. She said staff should have watched Resident #53's watch body language and interactions. She said it would have been important to keep an eye on the interactions between Resident #53 and Resident #34. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40467 Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in one of one kitchen and dining room. Specifically, the facility failed to: -Ensure hand hygiene was conducted appropriately after touching potential contaminated surfaces; and, -Ensure hand hygiene was conducted before and after glove use. Findings include: I. Professional reference The Center for Disease Control and Prevention (CDC) About Hand Hygiene For Patients in Healthcare Settings (2/27/24), was retrieved on 1/23/25 from https://www.cdc.gov/clean-hands/about/hand-hygiene-for-healthcare.html, read in pertinent part, Patients in healthcare settings are at risk of getting infections while receiving treatment for other conditions. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics, and protects healthcare personnel and patients. According to the CDC, hand washing should occur before preparing or eating food, before touching the eyes, nose or mouth, and after touching potential contaminated surfaces. II. Facility policy and procedure The Food Preparation and Service policy, undated, was provided on nursing home administrator (NHA) on 1/16/25 at 3:22 p.m. The policy read in pertinent part, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. Cross contamination can occur when harmful substances, (for example) chemical or disease-causing microorganisms are transferred to food by hands including gloved hands, food contact services, sponges, cloth towels, or utensils that are not adequately cleaned. The Preventing Foodborne Illness policy, revised November 2022, was provided on nursing home administrator (NHA) on 1/16/25 at 3:22 p.m. The policy read in pertinent part, Food and nutrition services employees follow appropriate hygiene and sanitary practices to prevent the spread of foodborne illnesses. All employees who handle, prepare or serve food are trained in the practices of safe food handling and preventing foodborne illnesses. Employees will demonstrate knowledge and competency in these practices prior to working with food or servicing food to residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the policy, employees must wash their hands during food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks and/or after engaging in activities that contaminate the hands. The policy identified that gloves are considered single-use items. The gloves must be discarded after completing the task. According to the policy, hands were to be washed after the gloves were removed and before the new gloves were replaced. B. Observations During a continuous observation of the lunch meal service in the dining room on 1/13/25, beginning at 11:45 a.m and ending at 12:52 p.m., the following was observed: At 12:03 p.m. dietary aide (DA) #4 began delivering meal trays to residents in the dining room. DA #4 did not perform hand hygiene before serving three meal trays to residents. At 12:06 p.m. DA #4 touched the outer surface of his face mask with his hand. He did not perform hand hygiene after touching his mask. He proceeded to serve two more meal trays to residents before performing hand hygiene. At 12:15 p.m DA #4 touched the outer surface of his face mask with his hand, delivered a meal tray to a resident in the dining room and placed five meal trays in a mobile food cart before he performed hand hygiene at 12:17 p.m. During a continuous observation of the lunch meal service in the kitchen on 1/15/25, beginning at 11:40 a.m and ending at 12:55 p.m., the following was observed: At 12:01 p.m. DA #1 touched the outer surface of her mask and proceeded to sort meal tickets. She did not change her gloves and wash her hands after she touched her mask. Between 12:07 p.m. and 12:15 p.m DA #1 placed the meal tickets, desert bowls and napkin rolled utensils on each resident meal tray without changing her gloves and performing hand hygiene after touching her mask. At 12:11 p.m. cook (CK) #1 removed her gloves and placed new gloves on her hands without performing hand hygiene. CK #1 separated a pot pie from the disposable cardboard shell with a cooking utensil but touched the rim of the pie crust with her gloved hand. At 12:16 p.m. DA #2 placed gloves on his hands without washing his hands. DA #2 proceeded to place meal tickets, napkins, utensil and dessert bowls on each of the resident meal trays. At 12:43 p.m. DA #2 touched the outer surface of his face mask with the back of his gloved hand, touched four resident meal bowls before removing his gloves and performing hand hygiene. C. Record review (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The online hand hygiene education certificates for the dietary staff were provided by the NHA on 1/16/25 at 3:22 p.m. The certificates identified DA #1, DA #2, DA #3, DA #4 and DA #5 last completed basic hand hygiene training and handling food safely training in November 2023. The DM completed basic hand hygiene training in November 2023 but evidence of handling food safety training was not provided by the facility. Review of the provided educations did not identify CK #1 received the online basic hand hygiene training or handling food safety training. D. Staff interviews DA #2 was interviewed on 1/16/25 at 2:05 p.m. He said hand hygiene should be completed anytime the hands touch something dirty and between glove changes. CK #1 was interviewed on 1/16/25 at 2:07 p.m. She said hand hygiene should be completed when gloves were changed and after touching any potential surfaces. DA #5 was interviewed on 1/16/25 at 2:07 p.m. He said hand hygiene was completed in between tasks, every time a task was changed and when serving trays. DA #3 was interviewed on 1/16/25 at 2:09 p.m. He said staff should wash their hands after using the restroom, every time they enter the kitchen and before touching resident dishes. He said he was trained to perform hand hygiene with alcohol base hand rub (ABHR) after every third delivery of a meal tray. The DM was interviewed on 1/16/25 at 2:11 p.m. She said her staff has had hand hygiene training but it had not been recent. She said the dietary staff also attended an all staff infection control training that demonstrated proper hand hygiene but the training was not food handling specific. The DM said staff should wash their hands anytime they touch something potentially contaminated and between glove changes. The DM said she trained her to use ABHR after every third tray delivered to the residents. Registered nurse (RN) #2 was interviewed on 1/16/25 at 2:54 p.m. RN #2 identified herself and the facility ' s infection control nurse. She said hand hygiene should be performed before placing gloves on and after removing the gloves, anytime the hands touch potentially contaminated surfaces, or touch a resident. She said staff delivering meal trays should use ABHR between each meal delivery to avoid potential cross-contamination. RN #2 said staff should wash their hands after three uses of ABHR. RN #2 said she had not completed hand hygiene training with the dietary staff. RN #2 was interviewed again on 1/16/25 at 3:45 p.m. RN #2 said she audited the hand hygiene practices in the kitchen with the dietary staff on 1/16/25. She said she identified concerns with hand hygiene and re-educated the dietary on proper hand hygiene procedures. D. Facility follow-up The Clinical Competency Validation for Hand Hygiene audit checklist was provided by the clincal consulant (CC) on 1/16/25 at 4:58 p.m. The review of the competency audit identified hand hygiene practices of five (DM and DA #2, #3, #5 and #6) dietary staff were observed by RN #2 on 1/16/25. According to the audit, there were hand hygiene concerns identified during the observation. RN #2 addressed the identified concerns and provided hand hygiene education to the present dietary staff.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to ensure residents or their representative were aware of the nature and implications of the facility's arbitration agreement to inform their decision on whether or not to enter into such agreements for four (#15, #36, #58 and #74) of six residents out of 32 sample residents. Specifically, the facility failed to: -Thoroughly explain the arbitration agreement in a form and in a manner the residents and/or resident representatives understood the agreement before signing the arbitration agreement; -Accurately inform residents the arbitration agreement was a binding agreement before the agreement was signed; -Accurately inform residents the agreement waived residents' right to a trial before a judge or jury for all disputes between the resident and the facility. -Accurately inform residents the agreement could be rescinded by written notice within 90 days of the signing of the agreement; and, -Ensure staff reviewing the arbitration agreement with residents understood the components of the agreement. Findings include: I. The arbitration agreement The Voluntary Agreement for Arbitration, undated, was provided by the nursing home administrator (NHA) on 1/16/25 at 1:27 p.m. The agreement read in part, Under Colorado law two or more parties may agree in writing for the settlement by binding arbitration of any dispute arising between them, including disputes relating to health care matters. By signing this agreement, you will give up your constitutional right to a jury or court trial as you are agreeing that any dispute between you and the facility will be subject to binding and final arbitration. You, as our resident, have the right to seek legal counsel concerning this agreement, and you have the absolute right to rescind this agreement by written notice within 90 days after the agreement has been signed and executed by both parties. The resident and or legal representative understands, agrees to, and has received a fully executed copy of the voluntary arbitration agreement, and acknowledges that terms have been explained to him/her, or his/her designee, in a manner that he/she understands by an agent of the facility and that he/she has had an opportunity to ask questions. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Each party agrees to waive the right to a trial, before a judge or jury, for all disputes, including those at law or equity, subject to arbitration under this voluntary arbitration agreement.In the event that any portion of this voluntary arbitration agreement is determined to be invalid or enforceable, the remainder of this voluntary arbitration agreement will be deemed to continue to be binding upon parties hereto in the same manner as if the valid or enforceable provision were not part of the agreement. The undersigned acknowledged that each of them has read this voluntary arbitration agreement and understands that by signing each has waived his/her right to a trial before a judge or jury and that each of them voluntarily consents to all of the terms of the voluntary agreement. By signing this agreement you are agreeing to have any issue of medical malpractice decided by neutral binding arbitration rather than by a jury or court trial. You have the right to legal counsel and you have the right to rescind this agreement within 90 days from the date of signature by both parties unless the agreement was signed in contemplation of hospitalization in which case you have 90 days after discharge or release from the hospital to rescind the agreement. II. Explanation of arbitration to the residents The admissions coordinator (AC) was interviewed on 1/14/25 at 4:39 p.m. The AC said she completed most of the admissions paperwork with the new admissions to the facility. She said when she was not available, the marketing director (MKD) was her back up and completed the admission paperwork process. The AC said most of the admissions paperwork, including the arbitration agreement, was signed by the resident's power of attorney (POA) but she has had several residents that signed their own paperwork. The AC said she always checked with the facility's clinical team to determine if the resident was capable of signing their own paperwork when a POA was not present or in place. The AC said she was trained to explain to the residents that if there were any challenges between the facility and the resident, the facility would try to settle the concern without involving lawyers. She said the arbitration agreement was optional and they did not have to sign it. She said the agreement was not binding and would assume it was a resident right to change their mind if they signed the agreement but still wanted to go to court. She said she was not aware of a timeline/deadline a resident had to rescind the agreement once it was signed. The AC said she would always offer the residents a copy of the arbitration agreement but usually the residents did not want a copy. III. Resident interview Resident #15 was interviewed on 1/15/25 at 1:11 p.m. Resident #15 said he signed all of his admission paperwork but no one told him about the details of the arbitration agreement. He said he had some forgetfulness but would remember something like that. He said he would want to address any legal concerns he had with the facility with the option to sue if warranted. He said if he signed the agreement, he would want to know the deadline to change his mind. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36 was interviewed on 1/15/25 at approximately 1:20 p.m. Resident #36 said she was not familiar with an arbitration agreement. She said was not aware of signing the agreement or anything regarding settling facility disputes with a third party. Resident #58 was interviewed on 1/15/25 at 1:49 p.m. Resident #58 said he signed all of his own paperwork. He said he was not told what an arbitration agreement was or that signing the agreement would waive his right to go to court. He said he had a lawyer and that would be something we would have wanted to review with his lawyer before signing. Resident #74 was interviewed on 1/16/25 at 9:12 a.m. Resident #74 said she did not know what arbitration was and was not aware that she signed an arbitration agreement. She said she would have wanted someone to explain the agreement to her before signing anything. Resident #54 was interviewed on 1/16/25 at 9:18 a.m. He said he knew what an arbitration agreement was and he had signed the agreement with the facility. He said he probably would not ever feel the need to rescind the agreement but he was not told of a timeline when he could change his mind if he wanted to. IV. Record review Arbitration agreements were reviewed for Resident #15, Resident #36, Resident #58, Resident #74 and Resident #54. Each resident signed their own arbitration agreement. The arbitration agreements were signed by either the AC or the marketing director (MKD) as the facility representatives. Resident #15 was admitted on [DATE]. The arbitration agreement was signed by AC on 11/27/24. The arbitration agreement was signed by Resident #15 on 11/27/24. Resident #36 was admitted on [DATE]. The arbitration agreement was signed by the AC on 10/28/24. The arbitration agreement was signed by Resident #36 on 10/28/24. Resident #58 was admitted on [DATE]. The arbitration agreement was signed by the MKD on 10/25/24. The arbitration agreement was signed by Resident #58 on 10/25/24. Resident #74 was admitted on [DATE]. The arbitration agreement was signed by the AC on 12/17/24. The arbitration agreement was signed by Resident #74 on 12/17/24. Resident #54 was admitted on [DATE]. The arbitration agreement was signed by the MKD on 12/27/24. The arbitration agreement was signed by Resident #54 on 12/27/24. IV. Staff interviews The MKD was interviewed on 1/16/25 at 9:23 a.m. The MKD said he would occasionally review the admissions paperwork including the arbitration agreement with the residents and or their POA's when the AC was not available. He said he would look at the arbitration agreement together with the resident and make sure they understand and were comfortable with signing before signing it was comfortable. He said the arbitration agreement was voluntary and not binding. He said he was not sure of a deadline to rescind the agreement, he would have to read it with them. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 1/16/25 at 9:38 a.m. The NHA said the intent of the agreement was to solve disputes but it did not limit the resident from going to court. He said if a resident signed the agreement, they had 30 days to rescind the agreement but if they did not rescind the agreement, they could still go to court. He said the facility wanted to make sure the residents knew that if they had any concerns, the facility wanted to help resolve the concern. He said the residents can request a copy of the agreement and have it read to them. V. Facility follow-up A plan of improvement, dated 1/16/25, was provided by the NHA on 1/16/25 at 12:12 p.m. According to the plan, arbitration agreement education was provided to the AC and the MKD on 1/16/25. The documented education identified the AC and the MKD were trained to ensure the signing party understood they had 30 days to take back their arbitration. According to the provided education, the residents signed away their right to go to court and will use an unbiased party as the arbitrator. The plan of improvement identified the facility would add documentation in the residents' charts that the resident/POA had the right to revise the agreement within 30 days of signing it. -However, the arbitration agreement the facility had in place, documented the residents had 90 days to rescind the agreement. According to the plan of improvement, an audit was conducted to ensure residents/POA who signed the arbitration agreement in the last 30 days understood the agreement. The plan identified the notification to six of the facility's residents or their representatives who signed the arbitration agreement. -The plan of improvement did not include Resident#15, Resident #36, Resident #58, and Resident #74

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065110	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Cliffs Post Acute	2901 N 12th St Grand Junction, CO 81506

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 - Many	Provide and implement an infection prevention and control program. 50314 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to implement an effective water management plan. Findings include: I. Professional reference According to Center for Disease Control (CDC), Controlling Legionella in Potable Water Systems, last reviewed 1/3/25, was retrieved on 1/21/25 from https://www.cdc.gov/control-legionella/php/toolkit/potable-water-systems-module.html It read in pertinent part, Operation, maintenance, and control limits guidance: Monitor temperature, disinfectant residuals, and pH frequently based on Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, increase the measurement frequency if there's a high degree of measurement variability. Hot water: Store hot water at temperatures above 140 F (degrees Fahrenheit) or 60 C (degrees Celsius). Ensure hot water in circulation does not fall below 120 F (49 C). Recirculate hot water continuously, if possible. Cold water: Store and circulate cold water at temperatures below the favorable range for Legionella (77-113 F, 25-45 C). Legionella may grow at temperatures as low as 68 F (20 C). Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. Ensure disinfectant residual is detectable throughout the potable water system. Clean and maintain water system components, such as thermostatic mixing valves, aerators, showerheads, hoses, filters, and storage tanks, regularly. Consider testing for Legionella in accordance with the routine testing module of this toolkit. B. Facility policy and procedure (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Legionella Water Management Program policy and procedure, dated July 2024, was provided by the nursing home administrator (NHA) on 1/13/25 at 2:17 p.m. The program did not include documentation of when dead legs and low-flow piping runs were appropriately flushed to prevent the growth and spread of legionella. -However, the CDC recommended that all dead legs and low flow piping runs should be flushed at least weekly to prevent the growth and spread of legionella (see professional reference above). III. Record review The water management maintenance logs were provided by the NHA on 1/13/25 at 2:17 p.m. The maintenance logs documented the facility had obtained water temperature readings in the building on a weekly basis. -There was no documentation available to verify that dead legs and low flow piping runs had been flushed in the last calendar year. On 1/14/25 at 12:52 p.m., the NHA documented that two resident rooms had been unoccupied for seven contiguous days or more in the last 60 days. -The water management plan failed to document when empty resident rooms had low flow piping runs and lead legs flushed. IV. Staff interviews The maintenance director (MTD) was interviewed on 1/15/25 at 10:23 a.m. The MTD said he had recently assumed the MTD role in the past few months. The MTD said the facility tested for legionella annually, which was negative in August 2024. The MTD said he did not know where all the water piping and dead legs in the building were. The MTD said he did not know how often dead legs and low flow piping runs such as sink and toilet p-traps (back drainage) should be flushed to prevent the growth and spread of waterborne bacteria such as legionella. The MTD said the facility did not have documentation to show when resident rooms or infrequently used water fixtures were flushed. The NHA was interviewed on 1/15/25 at 10:44 a.m. The NHA said he was not sure how often dead legs and low flow piping runs should be flushed to prevent the growth of legionella. The NHA said the facility did not have documentation to verify that flushing of dead legs and low-flow piping runs had occurred in the last calendar year.