STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065121	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Villa Pueblo, The	855 Hunter Dr Pueblo, CO 81001

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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 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** 51710 Based on observations, record review and interviews, the facility failed to ensure one (#1) of four residents reviewed for abuse out of seven sample residents were kept free from abuse. Specifically, the facility failed to protect Resident #1 from sexual abuse by Resident #6. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation Prevention policy and procedure, revised October 2022, was provided by the nursing home administrator (NHA) on 5/12/25 at 10:30 a.m. It read it pertinent part, Our facility prohibits the abuse, mistreatment, neglect, and/or exploitation of residents. We believe that all residents have the right to be free from such actions by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving our community, family members or legal guardians, friends, or any other individuals. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Retaliation by staff is abuse. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish. Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. When another resident is the alleged perpetrator of the abuse, both residents will be assessed for any injuries. Residents will immediately be separated, families and physicians notified of the event, and both residents will be monitored for further behaviors for the next eight (8) hours. The facility will consult with the resident's primary care physician (if necessary) and/or responsible party for possible interventions and adjustments to residents' care plan. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Incident of sexual abuse of Resident #1 by Resident #6 on 3/27/25 A. Facility investigation The facility's investigation report, initiated on 3/28/25 at 11:00 a.m., was provided by the NHA on 5/13/25 at 12:18 p.m. The investigation documented that on 3/27/25 at 4:00 p.m., certified nurse aide (CNA) #4 observed Resident #6 fondling Resident #1's front private areas while they were sitting next to each other in a resident common area. -The investigation failed to document what specific areas Resident #6 was touching on Resident #1, or whether it was over or underneath Resident #1's clothing. The investigation documented Resident #1 and Resident #6 had a history of being in a long-standing relationship and were often seen sitting together, holding hands and comforting one another. It documented it was the first time facility staff were aware of increased intimacy occurring between Resident #1 and Resident #6. However, the investigation additionally documented that when Resident #1 and Resident #6 were able to consent to sexual activity, it was welcomed by both parties and continued as a normal part of their relationship. Resident #1 was interviewed by the social services director (SSD) on 3/28/25, time not documented. The SSD documented Resident #1 voiced no concerns, she could not recall the incident that occurred with Resident #6 and Resident #1 was her baseline, normal self. Resident #6 was interviewed by the SSD, date and time not documented. The SSD documented Resident #6 stated he was sorry, he would not do it any longer and that he was agreeable to keeping his distance from Resident #1. The investigation documented Resident #1 and Resident #6 were separated and monitored with frequent checks. It documented both residents' care plans were updated regarding sexual activity and their relationship. -However, no documentation was found in the investigation, or Resident #1 and Resident #6's electronic medical records (EMR), addressing both residents' behavior monitoring or that the frequent resident checks were completed. -Additionally, no updated interventions to prevent further incidents of abuse were added to Resident #1 or Resident #6's care plans after the incident of sexual abuse on 3/27/25 (see record review below). The investigation concluded the incident of sexual abuse was unsubstantiated due to the history of a relationship between Resident #1 and Resident #6. It documented the relationship had been ongoing for the last several years, and that Resident #1's family was aware and consenting to the relationship. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, an interview with Resident #1's representative revealed he was not aware of a relationship between Resident #1 and Resident #6 or that an incident occurred between Resident #1 and Resident #6 on 3/27/25 (see Resident #1's representative interview below). -Additionally, an interview with the facility's NHA and regional clinical consultant (RCC) #1 revealed the NHA and RCC #1 were unaware of Resident #1's relationship with a former resident with the same first name as Resident #6 (see interviews below). -The investigation failed to document whether the facility investigated or confirmed with Resident #1 and/or her representative's that the previous consent for a long-term sexual relationship was with Resident #6 and/or the former resident who passed away. -The investigation failed to include a signed witness statement from CNA #4 regarding the alleged sexual abuse on 3/27/25. -Additionally, it did not include signed statements from the facility staff interviewed about the incident. The interviews were paraphrased and signed by the NHA and/or the SSD. B. Resident #1 (victim) 1. Resident status Resident #1, age 83, was admitted on [DATE] and readmitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis (autoimmune disorder affecting the central nervous system), generalized muscle weakness, need for assistance with personal care and unspecified dementia without behavioral/psychotic/mood disturbance (cognitive decline). The 4/2/25 minimum data set (MDS) assessment revealed the resident had short-term and long-term memory problems and she never/rarely made decisions about tasks of daily life. She needed substantial assistance with oral hygiene and transfers. She was dependent on staff for personal/toileting hygiene, showering, dressing, and bed mobility. She was always incontinent of bladder and bowel. 2. Resident representative interview Resident #1's representative was interviewed on 5/13/25 at 2:04 p.m. The representative said Resident #1 had been diagnosed with dementia and Alzheimer's disease (a progressive brain disorder), and would not know what was going on if someone attempted to touch her intimately. The representative said he was aware of a relationship Resident #1 had with a former resident in the facility, however, he said that resident (who had the same first name as Resident #6) passed away five to six years ago. The representative said he was unaware of a relationship between Resident #1 and Resident #6 and he denied being informed of the incident that occurred on 3/27/25. 3. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The potential for decline in mood and behavior care plan, initiated 8/27/14 and revised 2/20/18, revealed Resident #1 had the potential for decline in mood and behavior related to her diagnosis of dementia. It documented Resident #1 would often talk nonsensically and on unrelated topics, that she exhibited short-term memory deficits and needed reminding and cues to complete her daily tasks, and that she needed redirection and orientation daily. Interventions, initiated 8/27/14, included offering redirection and orientation as needed to complete daily tasks, providing comfort and support, allowing time to calm and reapproaching if she was agitated and resistive and reporting any changes in mood and behavior to nursing and the SSD. The actual mood and behavior care plan, initiated 1/19/21 and revised 3/28/25, revealed Resident #1 had behaviors of being combative during care, and she would strike out at and/or kick at staff during incontinence care. It documented Resident #1 had a consenting relationship with a male resident, that both parties welcomed the relationship without any negative consequences, and it was an ongoing relationship for both parties. -However, the care plan did not specify whether or not the consenting relationship was with Resident #6 or the other male resident who passed away. Interventions, initiated 1/19/21, included explaining care and processes while performing each step, interacting with an empathetic and supportive manner and offering one-to-one interaction as needed. -There were no updated interventions were added to Resident #1's care plan after the sexual abuse incident with Resident #6 on 3/27/25. -A review of Resident #1's progress notes did not reveal documentation addressing the incident of sexual abuse with Resident #6 on 3/27/25, what monitoring/behavior tracking was completed or what interventions were put into place after the alleged incident occurred. -A review of Resident #1's May 2025 CPO did not reveal any physician's orders for behavior monitoring for an intimate relationship or consent. -A review of Resident #1's EMR revealed there were no documented sexual consent assessments for a relationship between Resident #1 and Resident #6. C. Resident #6 (assailant) 1. Resident status Resident #6, age 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included unspecified cerebral palsy (brain disorder that affects movement and coordination), unspecified disorder of psychological development, generalized muscle weakness, other seizures and moderate intellectual disabilities. The 2/12/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of six out of 15. He required setup assistance with eating. He was dependent on staff for oral/personal/toileting hygiene, dressing, bed mobility, and transfers. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review The mood/behavior care plan, initiated 4/7/22 and revised 5/13/25 (during the survey), revealed Resident #6 had the potential for decline in mood and behaviors related to his diagnoses of depression and intellectual and developmental disabilities (IDD). It documented Resident #6 would often hold hands and pet other peoples' arms or legs while sitting next to consenting females/males. It documented Resident #6 had a consenting relationship with a female resident and both parties welcomed the relationship without negative effects. Interventions, initiated 4/7/22, included monitoring and documenting each behavioral event, offering psychosocial support or one-to-one interaction as needed and interacting in an empathetic and supportive manner. -The care plan did not include documentation addressing an intimate or sexually active relationship between Resident #1 and Resident #6. -Additionally, no updated interventions were added to Resident #6's care plan after the sexual abuse incident with Resident #1 on 3/27/25. The cognition care plan, initiated 4/7/22 and revised 8/29/22, revealed Resident #6 had impaired thought processes and required assistance with complex decision making due to IDD diagnosis with impaired mental development. Interventions, initiated 4/7/22, included communicating with resident/family/caregivers regarding residents' capabilities and needs, cueing/reorienting/supervising as needed and monitoring/documenting/reporting any changes in cognitive function as needed. -A review of Resident #6's progress notes did not reveal documentation addressing the incident of sexual abuse with Resident #1 on 3/27/25, what monitoring/behavior tracking was completed or what interventions were put into place after the alleged incident occurred. -A review of Resident #6's May 2025 CPO did not reveal any physician's orders regarding behavior monitoring for an intimate relationship or consent. -A review of Resident #6's EMR revealed there were no documented sexual consent assessments for a relationship between Resident #1 and Resident #6. III. Staff interviews CNA #2 was interviewed on 5/13/25 at 4:01 p.m. CNA #2 said she had never observed Resident #6 inappropriately touching another resident. However, she said she had been previously told to separate Resident #6 from another resident if he was observed inappropriately touching them. CNA #2 said Resident #6 was being monitored for inappropriate touching behaviors. CNA #2 said she was unsure where behaviors were tracked, however, she said she thought the behavior monitoring could be found in the resident's EMR. CNA #2 said she could determine consent because she knew her residents and she knew who could consent and who could not. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #3 was interviewed on 5/13/25 at 2:43 p.m. CNA #3 said Resident #6 has previously gotten a little touchy with other residents, especially female residents. CNA #3 said facility staff tried to keep Resident #6 separated from Resident #1, however, she said Resident #6 kept going back to Resident #1. CNA #3 said Resident #6 had backed off of Resident #1 due to him taking a liking to another resident. Licensed practical nurse (LPN) #2 was interviewed on 5/13/25 at 3:18 p.m. LPN #2 said a resident's medication administration record (MAR) was where facility staff could go to determine whether a resident was on behavior monitoring and what behaviors were being monitored. LPN #2 said Resident #6 was previously being monitored for his close interactions with other residents. LPN #2 was unsure when the resident's monitoring started or stopped. Registered nurse (RN) #1 was interviewed on 5/13/25 at 3:37 p.m. RN #1 said she had never observed Resident #1 and Resident #6 together or inappropriate touching between them, but she said she had heard about it. RN #1 said she was not familiar with Resident #6, however, she said she was made aware to separate and document if she observed him touching another resident inappropriately. -However, a review of Resident #1 and Resident #6's EMRs did not reveal physician's orders, care plan interventions, or progress notes that addressed monitoring for inappropriate touching or consent (see record review above). The NHA and RCC #1 were interviewed together on 5/14/25 at 1:20 p.m. The NHA said the facility did not have a formal assessment it used to determine a resident's capacity to consent to a sexual relationship with another resident. The NHA said Resident #1 and Resident #6 could both give consent and would vocally express whether they consented to something or not. The NHA said interventions the facility put into place after the alleged incident between Resident #1 and Resident #6 on 3/27/25 included staff re-education on residents' rights to sexual expression and consent and monitoring Resident #1 and Resident #6's behaviors for signs of distress/non-consent. The NHA said any interventions should be documented in the resident's care plan. The NHA confirmed updated interventions were not documented in Resident #1 or Resident #6's care plans. RCC #1 said Resident #1's representative was aware of the resident's relationship with Resident #6 and he consented to Resident #1 having relations with other residents. RCC #1 said Resident #1 and Resident #6 used to live in the same room together a few years ago. -However, the resident's representative said Resident #1 was in a relationship previously with a resident who had passed away and the representative was not aware of a relationship between Resident #1 and Resident #6 (see Resident #1's representative interview above). The NHA and RCC #1 said they were not aware that Resident #1's representative was not aware of a relationship between Resident #1 and Resident #6 and they were unable to confirm whether or not Resident #6 was the same resident that Resident #1 had a previous consensual relationship with. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA, RCC #1, and the SSD were interviewed together on 5/14/25 at 2:10 p.m. The SSD said Resident #1 had had relationships with two different male residents with the same first name. The SSD said Resident #1 had a relationship with a former resident and they lived in the same room together until he passed away several years ago. The SSD said after that, Resident #1 began a relationship with Resident #6. The SSD said it had been a while since she was able to make contact with Resident #1's representative. She said she had tried contacting him multiple times, but he would not answer or return her calls or his voicemail box was full. The SSD said she did not document her attempts to contact Resident #1's representative. The facility's medical director (MD) was interviewed on 5/14/25 at 4:12 p.m. The MD said, for residents with dementia, facility staff should contact the resident's representative to determine what the resident's wishes would be if they had the capacity to consent to a sexual relationship. He said a signed agreement by both parties consenting to the relationship should be obtained. The MD said he was notified of a relationship between Resident #6 and a different resident a while ago, but he said he was not aware of a relationship between Resident #1 and Resident #6. -However, a review of Resident #1 and Resident #6's EMRs did not reveal signed consent forms for an intimate relationship for either resident (see record review above). -Additionally, Resident #1's representative denied knowledge of a relationship between Resident #1 and Resident #6 (see interview above).

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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** 51710 Based on observations, record review, and interviews, the facility failed to ensure two (#2 and #4) of seven residents out of seven sample residents received services provided or arranged by the facility that met professional standards of quality. Specifically, the facility failed to ensure weekly skin assessments were consistently completed, per physican's orders, for Resident #2 and Resident #4. Findings include: I. Facility policy and procedure The Professional Standards policy, revised December 2024, was provided by the nursing home administrator (NHA) on 5/15/25 at 8:43 a.m. It read in pertinent part, The facility is committed to providing the highest quality of care to our residents. We believe that everyone deserves to live with dignity, respect, and the opportunity to thrive. Our goal is to foster a safe, nurturing, and supportive environment through continuous improvement in care practices. Communication and coordination of care: effective communication among all members of the care team, residents, and families will be prioritized to ensure coordinated and comprehensive care. The facility will have protocols in place for timely updates on residents' health status and any changes in care. The Skin Assessment for Breakdown policy, revised February 2025, was provided by the NHA on 5/14/25 at 11:20 a.m. It read in pertinent part, The licensed nurse will complete a weekly skin assessment to monitor for skin breakdown and pressure ulcers. Physicians will be notified of new skin breakdown, with treatment order when applicable. II. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included amyotrophic lateral sclerosis (neurological disorder affecting nerve cells in the brain and spinal cord causing loss of upper and lower motor neurons), subdural hemorrhage without loss of consciousness (collection of blood between the inner layer of skull and the surface of the brain), protein-calorie malnutrition (nutrition deficit) and dysphagia (difficulty swallowing). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/16/25 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. She was dependent on staff for toileting, dressing, bed mobility and transfers. The MDS assessment indicated Resident #2 was at risk for developing pressure ulcers/injuries. B. Resident interview Resident #2 was interviewed on 5/12/25 at 12:52 p.m. Resident #2 answered questions by writing answers on paper (due to her loss of motor speech abilities). Resident #2 wrote that she was not sure when her skin was looked at by nursing staff. C. Record review The skin care plan, initiated 2/13/25, revealed Resident #2 had an increased risk of skin breakdown related to impaired mobility, episodes of bladder incontinence and scleroderma. Interventions included completing weekly skin observations. Review of Resident #2's May 2025 CPO revealed the following physician's order: Document the weekly skin assessment findings on skin observation tool form every Sunday evening, ordered 4/11/25. Review of Resident #2's electronic medical record (EMR) revealed the resident had a hospital stay from 2/18/25 to 2/24/25 and again from 4/3/25 to 4/11/25. Review of Resident #2's EMR, from 2/11/25 to 5/13/25, revealed weekly skin observation tool assessments were completed and documented on the following days: 2/12/25, 3/10/25, 3/31/25, 4/13/25, 4/27/25 and 5/11/25. -Weekly skin observation tool assessments were not documented per physician's orders (see physician's order above) for the following days (excluding the two weeks the resident was in the hospital during that time frame - see above): 3/5/25, 3/17/25, 3/24/25, 4/20/25 and 5/4/25. III. Resident #4 A. Resident status Resident #4, age 82, was admitted on [DATE] and readmitted on [DATE]. According to the May 2025 CPO, diagnoses included atherosclerotic heart disease of native coronary artery without angina pectoris (a condition that restricts blood flow in the heart, without chest pain), chronic systolic (congestive) heart failure, fibromyalgia (widespread muscle pain and fatigue), generalized muscle weakness and unspecified dementia (cognitive disorder) with agitation. The 4/9/25 MDS assessment revealed the resident was moderately cognitively impaired with with a BIMS score of seven out of 15. She required substantial assistance with bed mobility and transfers. She was dependent on staff for showering and personal/toileting hygiene. She used a manual wheelchair for locomotion. She was always incontinent of bowel and bladder. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment indicated the resident was at risk for developing pressure ulcers. B. Record review The skin care plan, initiated 8/22/22 and revised 11/29/22, documented Resident #4 was at risk for skin breakdown related to impaired mobility, obesity, wearing oxygen via nasal cannula, a pacemaker (an implanted device that monitors heart rate and rhythm), major depressive disorder, unsteady gait with poor balance, weakness, hypertension (high blood pressure), angina (chest pain), coronary artery disease (a condition affecting arteries of the heart) and incontinence. Interventions, initiated 8/22/22, included completing weekly skin observations, providing incontinence care after each incontinent episode and as needed, keeping skin clean and dry and notifying the provider and promptly implementing treatment if skin breakdown occurred. Review of Resident #4's May 2025 CPO revealed the following physician's order: Weekly skin observation every Tuesday evening shift for skin monitoring. Document findings on skin observation tool, ordered 9/5/23. Review of Resident #4's EMR, from 2/11/25 to 5/13/25, revealed weekly skin observation tool assessments were completed and documented on the following days: 2/11/25, 3/4/25, 3/11/12, 4/1/25, 4/8/25, 4/15/5, 4/22/25, 4/29/25 and 5/6/25. -Weekly skin observation tool assessments were not documented per physician's orders (see physician's order above) for the following days: 2/18/25, 2/25/25, 3/18/25, 3/25/25 and 4/8/25. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 5/14/25 at 9:18 a.m. LPN #1 said residents' skin assessments were to be completed once weekly. She said an average of one to two residents per shift were scheduled for skin assessments each day. LPN #1 said skin assessments were to be documented in the residents' EMRs under the skin observation tool form. LPN #1 said it was important for skin assessments to be completed weekly to identify any issues with residents' skin timely. Regional clinical consultant (RCC) #1 was interviewed on 5/14/25 at 11:30 a.m. RCC #1 said skin assessments were to be completed weekly by the nurse and the nurses were to report any abnormal findings to the provider. RCC #1 said skin assessments were to be documented in the residents' EMRs under the skin observation tool. RCC #1 reviewed Resident #2 and Resident #4's EMRs and said both residents were missing skin observations (see record review above). RCC #1 said it was best practice to attach a schedule to flag the nurse in the EMR to ensure skin observations were not missed. RCC #1 said it appeared nurses were referring to a paper schedule for skin assessments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #2 was interviewed on 5/14/25 at 12:28 p.m. RN #2 said resident skin assessments should be completed twice weekly. RN #2 said the assessments were documented in the residents' EMRs. RN #2 said there was a printed schedule at the nurse's station that detailed when residents were due for skin assessments. RN #2 said an alert in the residents' treatment administration records (TAR) additionally let nurses know when residents were scheduled for skin assessments. 47064

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	065121	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Villa Pueblo, The	855 Hunter Dr Pueblo, CO 81001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for one (#2) of three residents reviewed for ADLs out of seven sample residents. Specifically, the facility failed to ensure Resident #2, who was dependent on staff for care, received showers per her preference. Findings include: I. Facility policy and procedure The Bath Shower/Tub policy and procedure, revised January 2025, was received from the nursing home administrator (NHA) on 5/14/25 at 11:08 a.m. It revealed in pertinent part, The purpose of this procedure is to promote cleanliness, provide comfort to the resident and observe the condition of the resident's skin. Document the date and time the shower/tub bath was performed, and the name and title of the individual who is assigning the resident with the shower/tub bath, all assessment data (any reddened areas, sores on the residents skin) obtained during the shower/tub bath, how the resident tolerated the shower/tub bath, if the resident refused the shower/tub bath, the reason(s) why and the intervention taken and the signature and title of the person recording the data. Notify the supervisor if the resident refuses the shower/tub bath. Notify the physician of any skin areas that may need to be treated. Report other information in accordance with facility policy and professional standards of practice. II. Resident #2 A. Resident status Resident #2, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included amyotrophic lateral sclerosis (neurological disorder affecting nerve cells in the brain and spinal cord causing loss of upper and lower motor neurons), subdural hemorrhage without loss of consciousness (collection of blood between the inner layer of skull and the surface of the brain), protein-calorie malnutrition (nutrition deficit) and dysphagia (difficulty swallowing). The 4/16/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She was dependent on staff for toileting, dressing, bed mobility and transfers.She required set up assistance with eating. B. Observations (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/25 at 11:45 a.m. Resident #2 was in the dining room being assisted by a family member during lunch. Resident #2's hair was slicked back into a pony tail and looked greasy and shiny. On 5/13/25 at 8:29 am Resident #2 was in the dining room sitting at the eating assistance table with four other residents and two staff members. Resident #2's hair was pulled back and was greasy, shiny and slicked back. C. Resident #2 and family interview Resident #2 was interviewed on 5/12/25 at 12:52 p.m. A family member was present in the resident's room. Resident #2 used a pen and paper to communicate due to a medical condition. Resident #2 wrote down that she had not reviewed a shower in about 10 days. Resident #2 said she would like at least one shower, at a minimum, every seven days. D. Record review The ADL care plan revealed Resident #2 required assistance with ADLs due to impaired functional ability/mobility and activity intolerance due to scleroderma. Interventions included one-person assistance with bathing. -Review of the certified nurse aides (CNA) task documentation record where the CNAs documented showers and other cares revealed there was no documentation that Resident #2 had received a shower from 4/14/25 to 5/11/25, a period of 30 days. -Review of a second CNA task documentation record from 4/14/25 to 5/11/25, where CNAs were to document if the resident received a bath each day revealed there was one documentation which indicated Resident #2 had received one shower during the 30-day period, on 4/27/25, and the resident was dependent on staff to complete. -Review of Resident #2's progress notes failed to reveal any refusals of showers by the resident. On 5/14/25 at 12:48 p.m. regional clinical consultant (RCC) #1 provided paper documentation for Resident #2's showers. According to the P-hall shower schedule, last updated 11/5/24, Resident #2 was to receive showers on Tuesday and Fridays every week. -The P-hall shower schedule was last updated prior to the admission of Resident #2. There were two showers sheets provided by RCC #1 which documented two showers out of 10 shower opportunities from 4/14/25 to 5/13/25 were provided to Resident #2, one on 4/27/25 and the second on 5/6/25. -The facility failed to provide Resident #2 with two showers a week, per the shower schedule. -Review of Resident #2's electronic medical record (EMR) revealed no documentation to indicate why Resident #2 did not receive her showers as scheduled. III. Staff interviews (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 5/14/25 at 9:04 a.m. CNA #1 said there was a book at the nurses station with the resident shower schedule for each hall. CNA #1 said the facility had a shower aide to provide showers to residents but the shower aide was often pulled to the floor to work as a CNA instead of providing resident showers. CNA #1 said when the shower aide had to work the floor, all CNAs working were responsible to complete showers for the residents they were assigned to. CNA #1 said the CNAs were to chart the residents' showers in the CNA charting system when they were completed. CNA #1 said CNAs were to report any skin issues noted while showering residents to the nurse or let the nurse know if a resident was refusing the shower. CNA #1 said if the resident refuses a shower they would attempt at different times to accommodate the resident but then would also involve the nurse to see if there was anything that was preventing the resident from taking the shower. CNA #1 said if the resident still refused the shower, the CNA and the nurse would chart it in the resident's EMR. CNA #1 said to his knowledge, Resident #2 did not refuse showers. Licensed practical nurse (LPN) #1 was interviewed on 5/14/25 at 9:18 a.m. LPN #1 said CNAs were to offer showers to residents on their assigned days and if the resident refused, then the CNA was to notify the nurse. LPN #1 said she would assess the resident to see if there was a reason the resident did not want the shower. LPN #1 said she would try to accommodate changes for shower times to meet residents' needs. LPN #1 said if the resident refused, she would put in a progress note in the residents' EMR. LPN #1 said it was important residents received their showers to help promote skin integrity and prevent skin break down. RCC #1 was interviewed on 5/14/25 at 11:30 a.m. RCC #1 said staff would document resident showers on a paper shower schedule and then chart the shower in residents' EMR. RCC#1 said agency staff CNAs sometimes had issues accessing the EMR to chart, so they could be charting on paper. RCC#1 said shower documentation should be completed on paper and in the EMR. RCC #1 said the facility had a bath aide to complete scheduled showers who was scheduled to work 12 hours per day from 6:00 a.m. to 6:00 p.m. RCC #1 said she was unaware the bath aide was being pulled from giving residents showers to work on the floor as a CNA. RCC #1 said if the bath aide was pulled to work the floor, then it was the responsibility of the floor CNAs to complete the showers for their assigned residents. RCC #1 said the shower schedule would document the residents' preferences for showers and it was the responsibility of the shower aides to update the schedule with resident preferences. -However, the paper shower schedule had not been updated since 11/5/24 (see record review above). RCC #1 said it was important residents received showers to promote hygiene, skin cleanliness and prevent skin breakdown.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51710 Based on record review and interviews, the facility failed to ensure that the medical record was complete and accurate in keeping with accepted standards of practice for one (#1) of seven residents out of seven sample residents. Specifically, the facility failed to ensure physician's visit progress notes for Resident #1 were maintained in her electronic medical record (EMR). Findings include: I. Facility policy and procedure The Charting and Documentation policy, revised January 2025, was provided by the nursing home administrator (NHA) on 5/14/25 at 11:20 a.m. It read in pertinent part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT) regarding the resident's condition and response to care. The following information is to be documented in the resident medical record: -Objective observations; -Medications administered; -Treatments or services performed; -Changes in the resident's condition; -Events, incidents or accidents involving the resident; and -Progress toward or changes in the care plan goals and objectives. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. II. Resident #1 A. Resident status (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1, age 83, was admitted on [DATE] and readmitted [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included multiple sclerosis (an autoimmune disorder affecting the central nervous system), generalized muscle weakness, need for assistance with personal care and unspecified dementia without behavioral/psychotic/mood disturbance (cognitive decline). The 4/2/25 minimum data set (MDS) assessment revealed the resident had short-term and long-term memory problems.She needed substantial assistance with oral hygiene and transfers. She was dependent on staff for personal/toileting hygiene, showering, dressing, and bed mobility. She was always incontinent of bladder and bowel. B. Record review -A review of Resident #1's EMR revealed the last physician's visit progress note documented was in April 2024. Physician's visit progress notes for Resident #1 were provided by the NHA on 3/15/25 at 10:54 a.m. The physician's visit progress notes revealed Resident #1 was seen on the following dates: 11/24/24, 1/18/25 and 3/22/25. -However, the physician's notes were not readily accessible in the resident's EMR. III. Staff interviews The NHA and regional clinical consultant (RCC) #2 were interviewed together on 5/15/25 at 11:12 a.m. The NHA revealed the facility did away with its medical records department last fall, before she began working at the facility. The NHA said the previous NHA assigned the facility's receptionist the responsibility of scanning medical records into a resident's EMR. The NHA said medical records should be uploaded into the EMR within 24 hours of receipt. The NHA said Resident #1's physician's access to the facility's EMR was revoked in December 2024, when the physician self-terminated his role as the facility's medical director and primary physician. The NHA said the physician and Resident #1 both chose for the physician to remain Resident #1's primary provider and Resident #1 was the only resident the physician now saw at the facility. However, the physician's EMR access was not reinstated, so the physician's notes were no longer uploaded to Resident #1's EMR. The NHA said Resident #1's physician was re-granted access to the facility's EMR system on 5/15/25, during the survey. The NHA failed to mention why the physician's access was not reinstated before 5/15/25. The NHA said maintaining resident records was important because staff needed to have a full picture of what was going on with a resident.