STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065146	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hampden Hills Post Acute	14699 E Hampden Ave Aurora, CO 80014

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 46849 Based on observations and interviews, the facility failed to ensure reasonable accommodation of needs for residents on one of two floors. Specifically, the facility failed to ensure residents on the second floor received functional utensils for meals to achieve their highest practicable level of well-being. Findings include: I. Observations During a continuous observation of the second floor dining room on 1/14/25, beginning at 4:20 p.m. and ending at 5:45 p.m, the following was observed:. At 4:20 p.m. residents waited in the dining room for dinner service. At 5:00 p.m. the food was brought up to the dining room kitchenette from the first floor kitchen At 5:06 p.m. staff began to serve food onto paper plates for the residents. Residents were provided plastic utensils and styrofoam cups. The meal was chicken fried steak, brown gravy, mashed potatoes, baby carrots and tapioca pudding. Four residents at the first table in the dining room were served dinner. One resident at the table tried to use her plastic knife and fork to cut the chicken fried steak but she was unable to. The resident gave up and instead ate her pudding. A staff member came over to the table and attempted to assist another resident at the table cut up her chicken fried steak with a plastic knife but was unable to. The staff member had to get a regular knife from the kitchenette in order to cut the meat. The staff member had to use the regular knife to cut three other resident's chicken fried steak. Several other staff members attempted to cut the chicken fried steak for three additional residents but were unable to complete the task with the plastic knives. The staff members requested the regular knife that had been used earlier but none of the staff members were able to locate the regular knife and had to use the plastic utensils. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 5:10 p.m. two residents sitting in the corner of the dining room were served their meals, however, no staff members went to the table to offer assistance to the residents with cutting up their chicken fried steak. At 5:33 p.m. a staff member approached the two residents and offered assistance with cutting up their chicken fried steak. The residents told the staff member the chicken fried steak had been too difficult to cut and declined assistance. The residents told the staff member the food was now cold from waiting and both residents declined alternative options. II. Resident interviews Resident #24 was interviewed on 1/15/25 at 1:53 p.m. Resident #24 said she ate her meals in her room and said she was able to cut the chicken fried steak in the center but it was very difficult to cut the meat from the previous night's dinner with the plastic utensils. Resident #22 was interviewed on 1/15/25 at 2:14 p.m. Resident #22 said the chicken fried steak was too hard to cut with the plastic utensils the night before (1/14/25) and by the time the staff came to help her cut up the meat, she was no longer hungry. The resident said the residents on the second floor had been having this problem with the plastic utensils for a while. III. Staff interviews The dietary consultant (DC) was interviewed on 1/13/25 at 11:37 a.m. She said the facility was using disposable silverware on the second floor due to the elevator being temporarily out of service. The DC said it would be unsafe to have the staff carry all the dishes up and down the stairs. The DC was interviewed again on 1/16/25 at 3:09 p.m. The DC said when the facility was aware the elevator was going to be out of service, the management team discussed different concepts of how to bring the food up to the second floor. The DC did not know if the facility discussed with the resident council members the plan to use disposable silverware and dishes. The DC said the facility management team discussed all the areas in which the use of disposable dishes could be problematic, such as temperature and slowing down the delivery of food to the residents. She said the management team did not discuss if the residents would have difficulty using disposable utensils to eat with.

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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 - Few	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** 52045 Based on observations, record review and interviews, the facility failed to provide the resident the right to make choices about aspects of his life in the facility that are significant to the resident related to left leg prosthetics for one (#55) of one resident out of 59 sample residents. Specifically, the facility failed to honor Resident #55's requests to be fitted and provided with a left leg prosthetic which he had prior to being admitted to the facility. Findings include: I. Resident #55 A. Resident status Resident #55, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included bipolar disorder (mental illness that causes shifts in a person's behaviors), current episode of depression and acquired absence of left leg above the knee. The 11/19/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required set up assistance with chair to chair transfer and toileting. B. Observations On 1/13/25 at 2:30 p.m. Resident #55 was observed in his room sitting in his wheelchair and had a left above the knee amputation (AKA) and did not have a prosthetic leg to fit his AKA. C. Resident interview Resident #55 was interviewed on 1/13/25 at 2:33 p.m Resident #55 said that he had asked for a new left leg prosthetic since he arrived at the facility and had not yet received assistance to get the prosthetic. Resident #55 said he was not allowed to bring his prosthetic to the facility due to having bed bugs at his previous home. He believed his prosthetic was thrown away. Resident #55 said he was not given many options and choices regarding his health care and not having the prosthetic leg made him feel bad because he had to depend on other people for things he could do on his own. Resident #55 said he spoke with therapy and the director of nursing (DON) in October 2024 about getting a new prosthetic leg and was still waiting for an answer. D. Record review (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the physician's progress note dated 7/5/24 revealed that the resident was able to ambulate (walk) when using a prosthetic leg. The interdisciplinary team (IDT) progress note dated 10/22/24 revealed the resident requested to be fitted with a new prosthetic leg and a physician's order was written to follow up with a prosthetics provider. -However, review of Resident #55's electronic medical record (EMR) did not reveal any documentation regarding follow up on the referral. E. Staff interviews The social services director (SSD) was interviewed on 1/16/25 at 12:12 p.m. The SSD said Resident #55's medical provider was responsible for following up on getting the resident his prosthetic device. The SSD said there should have been documentation in the resident's chart on the status of the prosthetic. She said she was not aware of the status of the referral. The nursing home administrator (NHA) was interviewed on 1/16/25 at 2:00 p.m. The NHA said the therapy department was responsible for assessing Resident #55 for a prosthetic leg and making a referral for the device if needed. The NHA said the resident did not have a referral for a prosthetic fitting but he recently made a referral and the resident had an appointment coming up on 2/5/25, through his physician's office. The director of rehabilitation (DOR) and the physical therapy assistant (PTA) were interviewed on 1/16/25 at 2:19 p.m. The PTA said the facility's process, once a resident was referred for therapy services, was to evaluate the resident's level of functioning and determine their assistive needs. The PTA said Resident #55 was assessed and the therapist did not recommend a new prosthetic leg because the resident did not express a desire to transfer or walk. The PTA said that the only reason that the therapy department would provide a resident with a prosthetic leg was if the resident wanted it for walking or transferring. The PTA said per the physical therapy (PT) initial evaluation note dated 6/23/24, the resident declined to work with PT with a front wheel walker and said that he preferred to use a wheelchair to get around. The PTA said on evaluation, Resident #55 was independent with bed mobility and supervision with transfers from bed to wheelchair. The PTA said Resident #55 was also able to propel himself 150 feet independently.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 51711 Based on record review, observations and interviews, the facility failed to ensure prompt action was taken upon the filing of a grievance of a group. Specifically, the facility failed to ensure resident complaints expressed during the resident council meetings were documented on a grievance and resolved to the residents satisfaction. Findings include: I. Facility policy and procedure The Residents Rights, Subject: Grievances policy and procedure, revised January 2025, was provided by the nursing home administrator (NHA) on 1/16/25 at 9:28 p.m. It revealed in pertinent part, The facility will establish a grievance process to address resident concerns without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their facility stay; and the facility will make prompt efforts to resolve grievances the residents may have. The facility's grievance official is responsible for overseeing the grievance process, receiving and tracking the grievances; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident, if requested; and coordinating with state and federal agencies as necessary. Resident and/or resident representatives have the right to file grievances orally or in writing, the right to file grievances anonymously, and obtain a written decision regarding his or her grievance as requested. Copies of the Grievance Resolution Forms are available from the Grievance Official and at each nursing station. The Grievance Official evaluates and investigates the concern and takes immediate action to resolve the concern and prevent further potential violations of any resident's right while the alleged violation is being investigated. Upon receipt of a grievance and/or complaint, the grievance officer will respond to the individual expressing the concern within (three) working days of the initial concern to acknowledge receipt and describe steps taken toward resolution. The grievance official or designee completes the Grievance Resolution Form, takes appropriate corrective action in accordance with State Law if the alleged violation of resident's rights is confirmed by facility or an outside entity having jurisdiction, such as State Survey Agency, Quality Improvement Organization, or local law enforcement agency within its area of responsibility. The Grievance Official or designee will contact all parties of the outcome. II. Resident interviews (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Thirteen residents (#5, #23, #25, #29, #39, #55, #69, #98, #118, #158, #163, #174 and #698) were interviewed during the survey process. All 13 residents were determined to be alert, oriented and cognitively intact based on facility assessments. All residents said the food at the facility did not taste good. Resident #39 was interviewed on 1/14/25 at 1:49 p.m. Resident #39 said she had ordered items to be delivered from two different retailers. She said she had proof of the delivery to the front desk at the facility, however, she did not receive the packages and were reported as missing to the management at the facility. Resident #39 said she was reimbursed for the missing packages, but had not received a resolution to her concern of her packages being delivered to the facility but not receiving them. Resident #118 was interviewed on 1/13/25 at 1:38 p.m. Resident #118 said she did not like the food, the taste was bad and the coffee was always cold. Resident #55 was interviewed on 1/14/25 at 10:05 a.m. Resident #55 said the food at the facility was not appetizing. Resident #163 was interviewed on 1/13/25 at 2:28 p.m. Resident #163 said the food was not flavorful and had no taste. Resident #5 was interviewed on 1/13/25 at 4:39 p.m. Resident #5 said she hated the food. She said the food did not have enough flavor, the meat was tough and the food was often not hot enough. Resident #23 was interviewed on 1/14/25 at 10:04 a.m. Resident #23 said the food was terrible and was either too salty or did not have any salt in it. She said a spoonful of gravy was so salty that it pulled all the moisture out of her mouth. Resident #69 was interviewed on 1/14/25 at 9:00 a.m. Resident #69 said food at the facility was not good and was always cold. Resident #158 was interviewed on 1/13/25 at 10:31 a.m. Resident #158 said the food was not always hot enough. Resident #25 was interviewed on 1/13/25 at 3:52 p.m. Resident #25 said the food did not taste good, was not hot enough and did not have enough flavor. Resident #29 was interviewed on 1/13/25 at 1:49 p.m. Resident #29 said the food was not warm when it was served. Resident #98 was interviewed on 1/13/25 at 2:28 p.m. Resident #98 said the portions of food at the facility were too small. Resident #174 was interviewed on 1/15/25 at 9:47 a.m. Resident #174 said he requested condiments and a slice of cheese with his breakfast. He said he was tired of being served the same meal of eggs every morning and wanted to make himself a sandwich. He said he was not served the condiments and the cheese as he requested. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #698 was interviewed on 1/13/25 at 1:49 p.m. Resident #698 said there was a lack of food choices at the facility. He said he preferred sausage links but was brought sausage patties. He said the facility often did not serve what he wanted, but only what was on the menu. B. Record review The 10/22/24 food committee meeting notes documented the following food complaints. -The fruit served in fruit bowls was hard, residents did not receive what they ordered, bacon was too hard, soups had too much pepper, the dining rooms needed more staff for the weekend service and snacks would run out before some residents could get them. -No grievance forms were completed to resolve the resident's concerns. The 11/18/24 food committee meeting notes documented the following food complaints. -The bacon was too hard, the food service assistance in the dining rooms on the weekends had not improved, the residents did not like the tortellini, snacks were not being provided in enough quantity, omelets, waffles and rice were served too often. -No grievance forms were completed to resolve the resident's concerns. The 12/16/24 food committee meeting notes documented the following food complaints. -Condiments were not being offered or delivered on room trays as requested. The tortellini would remain on the menu and residents were instructed to order from the always available menu when it was on the menu. -No grievance forms were completed to resolve the resident's concerns. V. Staff interviews Social services assistant (SSA) #2, the social services director (SSD) and the social services consultant (SSC) were interviewed on 1/16/25 at 2:59 p.m. SSA #2 said grievance forms were posted throughout the facility and were able to be filled out by a resident, resident representative or a staff member. She said the grievance form was placed in a box located in the front lobby of the facility. She said the grievances were retrieved every morning, read in the morning staff meeting and then handed over to the appropriate department head. She said grievances should be resolved and the resident provided a resolution within three days of receiving the form. SSA #2 said she was the grievance official and also ran the resident council meetings and took the minutes. The SSD said the facility staff were educated on the facility grievance process during the regularly scheduled monthly all staff meeting. SSA #2 said she did not always fill out a grievance form when a resident expressed a concern. She said she did not have a way to track those concerns she did not document nor their resolve. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SSA #2 said she was aware Resident #39's concern of not receiving her packages, which were also documented in the resident council meeting on 1/15/25. She said multiple residents had brought up the concern during the resident council meetings. She said another resident was taking the packages and placing them in her room. She said the other resident had since been discharged from the facility. SSA #2 said she did not complete a formal grievance for Resident #39's concern. SSA #2 and the SSD said they were unaware of any food related grievances filed by the residents at the facility. -However, the resident council minutes documented multiple resident complaints regarding the food at the facility. SSA #2 said she would begin to run resident council meetings differently by asking residents more probing questions and completing grievances for their concerns. She confirmed she did not complete grievances for resident concerns from the resident council meeting. The registered dietitian (RD) and the dietary consultant (DC) were interviewed on 1/16/25 at 3:09 p.m. The RD said she was aware of resident complaints regarding not having enough snacks, but had not been informed of resident complaints regarding not receiving condiments until today (1/16/25). The DC said the dietary department will be implementing a condiment tray for the aides to have when delivering meal trays to the residents. The RD said the dietary manager (DM) received all complaints from residents. -The DM was unavailable for an interview during the entire survey process. The NHA interviewed on 1/16/25 at 5:46 p.m. The NHA said he was unaware of the missing packages delivered to the facility from the front desk area. The NHA said he reimbursed a lot of residents for a variety of things and did not always keep track. He said last week the facility approved the purchase of two electronic devices for residents, but he did not record the occurrence. The NHA said he implemented a new process two to three weeks ago for packages delivered to the facility for residents. He said previously, the packages were left at the front desk, which was not always manned by a staff member, but the new process required the packages be locked up and verified by a staff member before handing them over to a resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on interviews and record reviews the facility failed to maintain a clean and sanitary homelike environment for residents. Specifically, the facility failed to ensure residents were provided clean washcloths and hand towels. Findings include: I. Facility policy and procedure The Safe and Homelike Environment policy, revised November 2024, was provided by the nursing home administrator (NHA) on 1/16/25 at 9:22 p.m. It read in pertinent part, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the residents to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The characteristics of the homelike environment are a clean, sanitary, orderly environment. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. A homelike environment is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of homelike should include the resident's opinion of the living environment. II. Observations On 1/13/25 at 1:41 p.m. room [ROOM NUMBER] had no hand towels or washcloths.Both of the towel holder bars were broken. On 1/13/25 at 3:35 p.m. room [ROOM NUMBER] had no hand towels or washcloths. On 1/13/25 at 4:38 p.m. room [ROOM NUMBER] had no hand towels or washcloths. On 1/13/25 at 4:02 p.m. room [ROOM NUMBER] had no hand towels or washcloths. On 1/14/25 at 10:02 a.m. room [ROOM NUMBER] had no hand towels or washcloths. On 1/15/25 beginning at 2:06 p.m., the following observations were made: -room [ROOM NUMBER] had no hand towels or washcloths; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -Room # 1001 had no hand towels or washcloths; -room [ROOM NUMBER] had one wash cloth and no hand towels; -room [ROOM NUMBER] had no hand or washcloths and the towel holder bar was broken; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washclothes. The towel holder bar for the resident on side B of the room was broken; -Room # 2007 had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had one dirty washcloth for the resident on side A of the room and no hand towels or wash cloth for the resident on side B; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had no hand towels or washcloths; -room [ROOM NUMBER] had one dirty wash cloth for the resident on side A of the room and no hand towels or wash cloth for the resident on side B; -room [ROOM NUMBER] had no hand towels or washcloths; and, -room [ROOM NUMBER] had no hand towels or washcloths. On 1/16/25 at 9:30 a.m. a tour with the director of nursing (DON) and the assistant director of nursing (ADON) was completed. The Golden Gate unit had a linen closet which had 18 towels for approximately 65 residents residing on the unit. The second floor laundry room had no hand towels in any of the three blue linen carts. III. Resident group interview (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Six alert and oriented residents (#128, #44, #124, #70, #60, and #167), selected by the facility and deemed to be interviewable through facility assessment, were interviewed on 1/15/25 at 10:00 a.m. The residents said the facility did not have enough towels or wash cloths and they frequently could not get a clean hand towel on the days they requested one. The residents said shower days were the most problematic and the facility often ran out of clean towels, especially on days when 10 or more residents on their units took showers. IV. Additional resident interviews Resident #5 was interviewed on 1/13/25 at 4:38 p.m. Resident #5 said he did not have linen hand towels in his room. He said he had to use paper towels to dry his hands. Resident #23 was interviewed on 1/14/25 at 10:05 a.m. Resident #23 said she had no hand towels in her room. She said she had to beg the staff for towels. She said she had been told the facility was short on towels. She said she had used paper towels on her face many times. Resident #24 was interviewed on 1/13/25 at 1:41 p.m. Resident #24 said she did not get linen hand towels in her room. She said she preferred using linen hand towels versus paper towels. V. Staff interviews The DON was interviewed on 1/16/25 at 9:30 a.m. The DON said the nursing staff were responsible for passing out hand towels and wash cloths to the residents. She said hand towels and wash cloths should be passed out on each shift and replaced as needed. She said she was not aware the hand towels were not being passed out. She said she would correct the issue immediately. The housekeeping supervisor (HKS) was interviewed on 1/16/25 at approximately 11:00 a.m. The HKS said the hand towels were in the laundry room, and the certified nurse aides (CNA) were to bring the hand towels to the linen closets as needed. -However, observations revealed there were no hand towels in the second floor laundry room (see observation above). The maintenance director (MTD) was interviewed on 1/16/25 at 2:10 p.m. The MTD said he was not aware that resident rooms had broken and non-functional towel holder bars. He said he had a handwritten checklist of repairs to be made and showed that towel holder bar repairs were not on the list. The MTD said the nursing staff should have reported the broken towel holder bars so they could have been repaired and made functional to hold residents' towels and washcloths. VI. Facility follow up On 1/16/25 at 2:06 p.m. the DON provided an audit of all the residents' rooms which was conducted on 1/16/25, during the survey. The audit revealed 22 resident rooms had broken towel holder bars. She said all of the broken towel holder bars were getting replaced as soon as possible.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure the minimum data set (MDS) assessment accurately reflected residents' status based on the criteria outlined in the resident assessment instrument (RAI) for one (#99) of one resident out of 59 sample residents. Specifically, the facility failed to ensure the MDS assessments for Resident #99 accurately documented that the resident had a preadmission assessment screening and resident review (PASRR) Level II qualifying diagnosis. Findings include: I. Professional reference According to the American Association of Post-Acute Care Nursing (AAPACN) The Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Process (October 2024), retrieved on 1/29/25 from https://www.aapacn.org/resources/rai-manual/, The RAI helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life. The MDS assessment is a core set of screening, clinical, and functional status elements, including common definitions and coding categories, which formed the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. II. Facility policy and procedure The MDS Accuracy policy, revised February 2024, was provided by the nursing home administrator (NHA) on 1/16/25 at 9:26 p.m. It read in pertinent part: It is the policy of this facility to code accurately on the MDS assessment. III. Resident #99 A. Resident status Resident #99, age 84, was admitted on [DATE]. According to the January 2025 computerized physician's orders (CPO), diagnoses included bipolar disorder. The 9/27/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of The assessment documented that the resident was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. B. Record review (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Preadmission Screening and Resident Review (PASRR) Level II Notice of Determination (NOD) for Mental Illness (MI) dated 9/20/24 revealed that information gathered during the PASRR Level II evaluation determined that Resident #99 had a PASRR condition and was determined appropriate for nursing facility level of care. Specialized services required/recommended included: psychiatry case consultation and additional one-to-one engagement support. -However, the 9/27/24 MDS assessment failed to document the resident's PASRR Level II diagnosis. IV. Staff interviews The social services director (SSD) and social services assistant (SSA) #2 were interviewed together on 1/16/25 at 11:53 a.m. The SSD said it was the social services department's responsibility to review the PASRRs and provide Level II determination information to the MDS coordinators (MDSC) so that the residents' MDS would be coded correctly. MDSC #1 and MDSC #2 were interviewed together on 1/16/25 MDSC #1 and MDSC #2 said they reviewed the residents' records, including admission records, skilled nursing notes and social services assessments to complete the MDS assessment. They said PASRR information was provided to the MDSCs by social services. They said when the information was not up-to-date due to a missing PASRR screening the MDSCs relied on social services to provide updated information. MDSC #2 said she would correct the MDS assessment as soon as updates were provided. MDSC #2 said she was not aware that Resident #99 had received a PASRR Level II determination and would review the documentation and make updates to the MDS assessment as appropriate.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on interviews and record review, the facility failed to incorporate recommendations from the preadmission screening and resident review (PASRR) level II determination and evaluation from the State Mental Health Agency in the case of residents with serious mental illness or a related condition for one (#47) of two residents reviewed for PASRR out of 59 sample residents. Specifically, the facility failed to arrange and incorporate recommendations from the PASRR level II notice of determination for Resident #47. Findings include: I. Resident status Resident #47, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included Down's syndrome and major depressive disorder. The 12/24/24 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. The assessment revealed the resident had been identified as having a level II PASRR. II. Resident interview Resident #47 was interviewed on 1/15/25 at 1:27 p.m. Resident #47 said she had been interested in leaving the facility to go shopping, becoming involved in community activities and making friends with people her age in the community. However, she said the facility's social services department had not set up any community activities or services for her. III. Record review The PASRR level II, provided by the facility on 1/15/25, included an evaluation which revealed the resident had been evaluated for IDD (intellectual and developmental disability) due to a qualifying diagnosis of Down's syndrome. Specialized services were recommended to include supported community connections (community integration activities). Review of Resident #47's at-risk care plan, initiated 1/13/25 (during survey), revealed the resident had a level II PASRR due to Down's syndrome. The recommendations included case management, psychiatric case consultation, individual therapy, transportation to behavioral management and pastoral care. Interventions, dated 1/13/25 (during the survey), included anticipating and meeting the needs of the resident. -The care plan failed to reveal community integration activities for the resident. -A review of Resident #47's progress notes from 12/18/24 to 1/14/25 failed to reveal any progress notes related to PASRR. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There was no documentation from social services notes regarding Resident #47's PASRR level II or the recommendations. -There were no documentation in Resident #47's electronic medical record (EMR) to indicate the facility had communicated with the State Mental Health Agency regarding a delay or the facility's inability to follow the recommendations. IV. Staff interviews The social services director (SSD) was interviewed on 1/16/25 at 11:53 a.m. The SSD said it was the social services department's responsibility to set up PASRR recommended specialized services for residents with level II PASRRs. She said if recommendations could not be met, the social services department was responsible for documenting the efforts to meet the recommendations and the outcomes in the progress notes and the resident's care plan. The SSD said the PASRR level II recommendations for Resident #47 included case management, transportation and community integration activities. The SSD said she had sent out a few referrals for services but had not been able to secure services for the resident. She said the documentation of the referrals she sent should be in the progress notes and care plan. The social services consultant (SSC) was interviewed on 1/16/25 at 5:51 p.m. The SSC said the social services department had not sent out any referrals for community services for Resident #47 since December 2024 and the SSD had not followed up with the resident regarding services.

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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** 52045 Based on observations, record review and interviews, the facility failed to ensure the services provided or arranged by the facility met professional standards of quality two (#69 and #23) of two residents of 59 sample residents. Specifically, the facility failed to: -Follow manufacturer's directions when administering Trulicity (insulin) for Resident #69; and, -Have accurate medication orders for Resident's #69 and #23 Trulicity injections. Findings include: A. Professional reference According to the [NAME] Lilly Manufacturer's Trulicity Injection, Instructions for Use, last revised November 2024, retrieved on 1/25/25 from https://uspl.lilly.com/trulicity/trulicity.html#ug Administration of Trulicity injection pen should be held flat on the skin, press and hold the green injection button. You will hear a loud click. Continue holding the clear base firmly against your skin until you hear a second click. This happens when the needle starts retracting in about five to 10 seconds. Every dose of Trulicity comes in the easy-to-use pen, so you can continue to have the same experience with once-weekly Trulicity, regardless of the dose you've been prescribed. B. Observations On 1/14/25 at 4:08 p.m. LPN #3 was giving a Trulicity injection to Resident #69 3 milligram (mg) /0.5 milliliter (ml), single-use pen. While administering the medication injection LPN #3 pinched the upper left forearm and injected the medication. LPN #3 failed administer the medication per the manufacturer's directions (see above) by holding the pen flat to the skin and wait until two clicks were heard. -The dose given was verified as correct with the pharmacy consultant)PC); however, the order on the medication administration record was verified by LPN #3 to be inaccurate and not matching the dosage administered. C. Record Review Review of Resident #23's January 2025 medication administration record (MAR) documented a medication order for Trulicity, inject 0.75 milligrams (mg) /0.5 milliliters (ml). The administration instructions read administer 0.5 ml, ordered on 1/3/22. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The physician's order for Trulicity did not indicate the specific mg dose to be administered to the resident. Review of Resident #69's January 2025 MAR documented a physician's order for Trulicity to inject 1.5 mg/0.5 ml. The administration instructions read to administer 3 mg, ordered on 7/14/23. -However, the dosage on the Trulicity pen administered by LPN #3 (see observation above) was 3 mg/0.5 ml, which was verified to be the correct physician ordered dose for the resident (see pharmacy consultant interview below). -The physician's order on Resident #69's January 2025 MAR did not match the correct dose of the medication that was to be administered to the resident. D. Staff interviews The pharmacy consultant (PC) was interviewed on 1/14/25 at 5:00 p.m. The PC said she consulted with Resident #69's physician to verify the resident's Trulicity injection order and received confirmation that the dose administered to the resident was correct, however the order in the resident's MAR was not correctly written. The PC said she would conduct an audit on the orders for all residents on Trulicity and similar medications to ensure the orders are clearly and accurately written. The director of nursing (DON) was interviewed on 1/15/25 at 9:10 a.m. The DON said they completed a review of all residents on diabetic medications for accuracy of orders and found all residents on Trulicity had contradictory orders and administration directions. The DON said the nursing staff consulted with each prescribing physician to ensure accurate orders were entered into each resident's MAR. The DON said all of the orders had been corrected. The DON said the audit revealed that each resident had been administered the correct single-dose injection pens. The DON said the nurse who initially entered the orders was no longer working for the facility. She said the facility was planning to educate all of the current nursing staff on how to enter accurate medication orders.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 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 three (#35, #34 and #25) of 10 residents out of 59 sample residents. Specifically, the facility failed to: -Ensure Resident #35 was provided with assistance for oral care and proper nail care; -Ensure Resident #34 was provided with assistance for oral care and repositioning; and, -Ensure Resident #25 was provided with assistance for repositioning. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADL) policy, revised September 2024, was provided by the nursing home administrator (NHA) on 1/16/25 at 9:28 p.m. It read in pertinent part, Residents who are unable to carry out ADLs will receive necessary services or support from staff regarding specific needs including eating, grooming, personal hygiene, communication, oral hygiene, transfers and ambulation. II. Resident #35 A. Resident status Resident #35, age greater than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included degeneration of the brain, vascular dementia and need for assistance with personal care. The 10/1/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment and was unable to participate in the brief interview for mental status (BIMS). The resident was assessed to have difficulty focusing attention and had disorganized thinking with an altered level of consciousness. The assessment indicated the resident was dependent on staff to complete most ADLs and needed maximal assistance to complete oral hygiene. B. Resident observation and interview On 1/13/25 at 10:28 a.m. Resident #35 was in bed. Resident #35's teeth had a heavy build-up of whitish matter on the surface of his teeth and in between each visible tooth on the top and bottom jaw. His nails were long, jagged and dirty. Because his fingers were contracted, the tips of his nails were resting directly on his palms. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35 was interviewed on 1/13/25 at 10:29 a.m. Resident #35 said he felt terrible and shook his head yes when asked if he was thirsty and wanted his teeth brushed. Resident #35 tried to extend his finger to move his nails from resting on his palm but he was unable to move his fingers far enough to relieve the pressure on his palms. On 1/14/25 at 8:05 a.m. Resident #35's nails were still long and dirty and his teeth were still covered with a thick layer of white buildup. C. Resident representative interview Resident#35's representative was interviewed on 1/15/25 at 11:30 a.m. The representative said facility staff had been avoiding providing consistent care and had not been brushing the Resident #35's teeth lately. The representative said that hospice care aides came in a couple of times a week and used an oral swab to remove the food buildup on his teeth and other than the oral care she provided, the resident's teeth were not being cleaned. The representative said the nursing staff was not cutting or cleaning the resident's nails so she brought in nail clippers and cut his nails for him. D. Record review Resident #35's comprehensive care plan, revised 3/7/24, documented a care focus that the resident had a self-care performance deficit related to peripheral neuropathy and mild cognitive impairment. Interventions documented Resident #35 required substantial to maximal assistance from staff to complete oral care and personal hygiene. -There was no care focus for nail care, cleaning nails or maintaining trimmed nails to protect skin integrity. Resident #35's bedside Kardex (care plan instruction for the certified nurse aides (CNA) documented a skincare focus with interventions that included encouraging the resident to avoid scratching and keeping the resident's hands and body parts from excessive moisture and keeping the resident's fingernails short. E. Staff interviews Certified nurse aide (CNA) #8 was interviewed on 1/14/25 at 1:10 p.m. CNA #8 said Resident #35 was dependent on staff for the completion of all ADLs. CNA #35 observed Resident #35's teeth and acknowledged they needed to be cleaned. CNA #8 said the nurse would cut the resident's nails. Licensed practical nurse (LPN) #5 was interviewed on 1/14/25 at 1:55 p.m. LPN #5 said Resident #35 required total assistance with brushing her teeth and the CNAs would trim the resident's nails on both days. LPN #5 said it was the hospice CNAs responsibility to assist the resident with grooming tasks when they came to the facility to work with the resident. LPN #5 said he would follow up with the resident's care needs and ask the facility CNAs to provide the needed care. 20287 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #34 A. Resident status Resident #34, age 72, was admitted on [DATE]. According to the January 2025 (CPO), diagnoses included multiple sclerosis (MS). The 10/1/24 MDS assessment revealed the resident had minimal cognitive impairment with a BIMS score of 13 out of 15. The resident required partial assistance with oral hygiene and total assistance with repositioning. B. Failed to provide oral care 1. Resident interview and observation Resident #34 was interviewed on 1/13/25 at 1:42 p.m. Resident #34 said she had not had her teeth brushed for some time. She said she needed to tell the staff to brush her teeth because they did not help her. The resident had foul smelling breath and a white substance visible on her upper teeth. Resident #34 was interviewed a second time on 1/15/25 at 10:08 a.m. Resident #34 said she had not had her teeth brushed. She continued to have foul smelling breath and the white substance was still visible on her upper teeth. On 1/15/25 at 10:24 a.m. CNA #3 brushed Resident #34's teeth. The resident did not participate in the teeth brushing task. After her teeth were brushed, Resident #34 said she felt so much better. 2. Record review Resident #34's care plan, revised 12/30/24, identified the resident had a self-care performance deficit related to MS, muscle spasms and glaucoma. Pertinent interventions included providing the resident with partial to moderate assistance with teeth brushing. Review of the CNA task documentation for Resident #34's oral care revealed the resident was set up to brush her teeth on 1/13/25, 1/14/25 and 1/15/25. -There was no other documentation to indicate the CNAs had provided assistance with Resident #34's oral care. 3. Staff interviews CNA #1 was interviewed on 1/15/25 at 10:19 a.m. CNA #1 observed Resident #34's mouth and teeth. CNA #1 said the resident had foul smelling breath and she had a white substance on her teeth which indicated her teeth had not been brushed. Registered nurse (RN) #2, who was the unit manager for the Golden Gate unit, was interviewed on 1/15/25 at 12:35 p.m. RN #2 said Resident #34 required full staff assistance with brushing her teeth. She said residents' teeth should be brushed in the morning and the evening. She said she would talk with the staff in regards to the importance of brushing residents' teeth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 1/15/25 at 6:00 p.m. The DON said residents' teeth should be brushed twice a day, once in the morning and again before bed. C. Failed to provide repositioning 1. Resident interview Resident #34 was interviewed on 1/13/25 at 1:42 p.m. Resident #34 said she was assisted by staff to get out of bed in the morning, sometimes as early as 6:00 a.m. The resident said she stayed up in her wheelchair until the staff laid her back down in the afternoon. She said a mechanical lift was used for her transfers and the staff did not reposition her during the time she was up in her wheelchair. Resident #34 said she had been a registered nurse and she knew she needed to be repositioned more frequently. She said her bottom got sore from not being repositioned but she said she did not have any open areas on her bottom. Resident #34 was interviewed a second time on 1/15/25 at 10:08 a.m. Resident #34 said staff got her out of bed at approximately 7:00 a.m. that morning (1/15/25). 2. Resident observations On 1/15/25 at 7:55 a.m. Resident #34 was sitting up in her wheelchair in the common area. During a continuous observation on 1/15/25, beginning at 8:44 a.m. and ending at 12:35 p.m., the following was observed: At 8:44 a.m. Resident #34 was sitting in the common area in her wheelchair. The reclining wheelchair was slightly tilted backward. At 9:01 a.m. the resident was visiting with her husband. The resident was assisted to another common area for visiting in private. At 10:00 a.m. Resident #34 was assisted back to the common area after her visit with her husband. At 10:05 a.m. CNA #1 assisted Resident #34 to her room so he could administer an injection. CNA #1 did not offer to reposition the resident. At 10:24 a.m. CNA #3 assisted Resident #34 with brushing her teeth. CNA #3 did not offer to reposition the resident. At 10:36 a.m. Resident #34 was assisted to an activity. At 11:00 a.m. CNA #4 assisted the resident from the activity and transported her to the dining room in her wheelchair. CNA #4 did not offer to reposition the resident. At 12:18 p.m. Resident #34 was assisted away from the dining room and transported back to her room. The resident asked to lay down and the unidentified CNA told the resident that CNA #3 would be back later. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:42 p.m. Resident #34 was laid down in bed with the use of the mechanical hoyer lift. -Resident #34 was in her wheelchair for three hours and 58 minutes during the continuous observation without being provided or offered repositioning assistance from the staff. 3. Record review Resident #34's care plan, revised 12/30/24, identified the resident had a potential for pressure ulcer development related to MS and weakness. The resident had a history of pressure injuries. Pertinent interventions included repositioning the resident throughout the night as the resident would tolerate. -The care plan did not include how often to offer the resident assistance with repositioning while she was in her wheelchair. 4. Staff interview Registered nurse (RN) #2 was interviewed on 1/15/25 at 12:35 p.m. RN #2 said the resident required full staff assistance with a mechanical lift for transfers. She said the resident was unable to reposition herself. She said Resident #34 was at risk for pressure injuries and the resident should be repositioned at least every two hours. RN #2 said staff had been trained to offer the every two hour repositioning to the resident. -However, observations revealed staff did not offer to reposition Resident #34 for almost four hours when she was sitting up in her wheelchair (see observations above). 52045 IV. Resident #25 A. Resident status Resident #25, age less than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included history of urinary tract infections, pressure ulcer of the right buttock (stage 4), multiple sclerosis, Parkinson's disease and quadriplegia. The 1/10/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. She required maximum staff assistance with transfers, toileting and showering. B. Resident observation and interview On 1/13/25 at 10:30 a.m. Resident #25 was in her room sitting in her wheelchair and leaning to her left side. On 1/13/25 at 2:00 p.m. Resident #25 was in her room sitting in her wheelchair and leaning to her left side. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25 was interviewed on 1/13/25 at 2:30 p.m. Resident #25 said she was left in her wheelchair all day even though she asked staff to put her back to bed after breakfast. Resident #25 said staff had not repositioned her since getting into her wheelchair at 6:00 a.m. this morning (1/13/25). On 1/13/25 at 3:34 p.m. Resident #25 was in her room still sitting in her wheelchair, in the same position, leaning to the left side. CNA #2 and RN #2 entered the resident's room with a mechanical lift to put Resident #25 to bed. Resident #25 was interviewed on 1/15/25 at 8:30 a.m. Resident #25 said CNA #2 got her up at 6:00 a.m. this morning (1/15/25). Resident #25 said she requested to stay in bed until 9:00 a.m. but she was told by CNA #2 that she had to get out of bed. Resident #25 said she was uncomfortable in her wheelchair because it was too small but staff did not give her any other option. On 1/15/25 during a continuous observation, beginning at 8:30 a.m. and ending at 12:30 p.m., the following was observed: At 8:30 a.m. Resident #25 was in her room sitting in her wheelchair and leaning to the left side. At 9:57 a.m., director of rehabiliation (DOR) entered Resident #25's room and asked Resident #25 if she wore her pressure-relieving boots all the time. At 11:35 a.m., a CNA #1 entered Resident #25's room and escorted the resident to the dining room for lunch. CNA #1 did not assist or offer to reposition the resident before taking the resident to the dining room. At 12:15 p.m. a CNA #1 assisted Resident #25 back to her room. CNA #1 did not reposition the resident. The resident was left sitting up in her wheelchair in her room. At 12:21 p.m., Resident #25 put her call bell on requesting to go to bed. CNA #1 entered the resident's room and told Resident #25 she had to wait for CNA #2 to return from break. Resident #25 was interviewed on 1/15/25 at 12:30 p.m. Resident #25 said she asked to go back to bed and was told that she had to wait until CNA #2 returned because CNA #2 went to lunch. At 12:50 p.m. CNA #1 and CNA #2 entered Resident #25's room and transferred her to bed. -Resident #25 sat up in her wheelchair in the same position without repositioning for four hours and 20 minutes. D. Record Review Review of the comprehensive care plan, revised on 11/4/24, revealed Resident #25 had a pressure ulcer on her buttock. The care focus goal was for the resident's pressure ulcer to show signs of healing. Interventions included frequent repositioning with staff assistance. The bedside Kardex, dated 1/14/25, revealed staff should offer and encourage Resident #25 to accept turning and repositioning assistance, as necessary. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's electronic medical record (EMR) ADL task response history revealed Resident #25 did not refuse any offers for repositioning from staff. E. Staff interviews RN #2 was interviewed on 1/15/25 at 12:35 p.m. RN #2 said offloading, turning and repositioning for residents who were unable to perform the task on their own should be provided by staff every two hours. The DON and the assistant director of nursing (ADON) were interviewed together on 1/16/25 at 5:46 p.m. The DON said physically dependent residents needed to be repositioned every two hours or more frequently if the resident had a pressure wound. The DON said the CNAs were trained on the importance of repositioning dependent residents to relieve pressure points. -Documentation of the last resident positioning training for staff was requested but was not provided by the facility as of the conclusion of the survey on 1/16/25.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review and interviews, the facility failed to ensure three (#23, #34 and #21) of four residents reviewed for activities out of 59 sample residents received an ongoing program of activities designed to meet needs and interests and promote physical, medical and psychosocial well-being. Specifically the facility failed to: -Ensure Resident #23 and Resident #34 were offered more mind stimulating activities; and, -Ensure Resident #21 was provided with a personalized activity program. Findings include: I. Facility policy and procedure The Quality of Life policy, updated December 2024, was received from the nursing home administrator (NHA) on 1/16/25 at 9:26 p.m. The policy read in pertinent part, It is the policy of this facility to ensure that activities are available to meet resident needs and interests that support the physical, mental and psychosocial well-being of the resident. The Activities policy and procedure, revised December 2024, was provided by the NHA on 1/16/25 at 9:37 p. m. It read in pertinent part, The facility will ensure that activities are available to meet resident needs and interests that support the physical, mental, and psychosocial well-being of the resident. Activities may be facility sponsored, group or independent. Activities procedures: Residents who wish to meet with or participate in social or religious activities, or other community activities, at or away from the facility are encouraged to do so as they are able. Some activities can be adapted to accommodate the resident's change in functioning due to physical or cognitive limitations. II. Activity calendar The Golden Gate unit's January 2025 activity calendar for the week of 1/12/25 through 1/18/25 revealed there were four to six activities scheduled per day. The activity calendar had mind stimulating activities scheduled on four of seven days for the week (1/12/25, 1/13/25, 1/16/25 and 1/18/25). There were no mind stimulating activities scheduled on the remaining days of the week (1/14/25, 1/15/25 and 1/17/25). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January 2025 Summit Park unit calendar had similar activities scheduled, however, the residents from the Golden Gate unit could not attend those activities, as the elevator had not been working for the past several months. III. Resident #23 A. Resident status Resident #23, age 73, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included unspecified protein- calorie malnutrition, diabetes type II. The 11/5/24 minimum data set (MDS) assessment dated revealed the resident had no cognitive impairments with a brief interview for mental status (BIMS) score of 15 out of 15. The 4/9/24 MDS assessment revealed it was very important to Resident #23 to do activities she liked. B. Resident interview Resident #23, who resided on the Golden Gate unit, was interviewed on 1/14/25 at 9:50 a.m. Resident #23 said she enjoyed going to the activities. She said a lot of the activities were geared towards residents who were cognitively impaired. She said she liked trivia and word games. She said she was told by someone in activities that they could not have word games or trivia because everyone needed to be able to participate. She said because of this, many of the activities provided ended up being coloring pictures. Resident #23 was interviewed a second time on 1/16/25 at 4:30 p.m. Resident #23 said the board game activities the facility had were only scheduled three to four times a month. She said it made her sad that she was not able to attend more thought provoking activities. C. Record review The 11/1/24 psychiatric follow up note documented Resident #23 enjoyed watching television (TV), playing bingo, trivia and games. She preferred to participate in activities in a group setting. The note further documented that staff should attempt to tailor the activities to the resident's interests and ability level. The 11/4/24 activity assessment documented Resident #23 was spending more time in her room instead of attending group activities. Resident #23's activity care plan, updated 11/5/24, identified Resident #23 enjoyed watching TV in her room, reading, word puzzles, coloring and listening to music. Pertinent interventions included assisting the resident to the activities, inviting the resident to intergenerational programs, inviting the resident to exercise groups and inviting the resident to creative arts and crafts and music programs. -The care plan did not address the resident's desire to attend thought provoking activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #34 A. Resident status Resident #34, age 72, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included multiple sclerosis (MS). The 10/1/24 MDS assessment revealed the resident had minimal cognitive impairment with a BIMS score of 13 out of 15. The resident required total assistance with mobility. The 7/1/24 MDS assessment revealed it was very important to the resident to do activities she liked. B. Resident observations On 1/15/25 at 10:29 a.m. Resident #34 was asked if she wanted to go to the activity of coloring. On 1/15/25 at 10:45 a.m., the resident had a coloring sheet she was coloring, there was an activity assistant at the table, with two other residents, however, there was no talking. C. Resident interview Resident #34 was interviewed on 1/13/25 at 1:42 p.m. Resident #34 said she attended the activities on a regular basis, however, she said she wished there were more trivia type games. She said she liked the cognitively challenging activities. Resident #34 was interviewed a second time on 1/16/25 at 4:20 p.m. Resident #34 said she did have books in her room, however, she said she had nothing new to read. She said she had not received a book from the activity department for quite some time. She said she continued to enjoy reading. Resident #34 again said she liked the cognitively challenging activities. D. Record review Resident #34's activity care plan, updated 12/26/24, identified the resident enjoyed watching TV in her room, reading, word puzzles, coloring and listening to music. Pertinent interventions included assisting the resident to the activities, inviting the resident to intergenerational programs, inviting the resident to exercise groups, inviting the resident to creative arts and crafts, and music programs, offering the resident the daily chronicle and magazines, inviting the resident to resident council and community meetings and inviting the resident to religious programs. -The care plan did not address the resident's desire to attend cognitively challenging activities. The 9/27/24 activity note documented Resident #34's activity interests included bingo, trivia and crafts. V. Staff interview (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activity director (AD) was interviewed on 1/16/25 at 4:00 p.m. The AD said Resident #23 and Resident #34 attended all the activities and never complained about the activities. She said the activity calendar did have trivia type games on the schedule. The AD said Resident #23 could attend the activity planning meetings and voice her requests. The AD said Resident #34 had visits from her family and she liked to read. She said the activity department provided her books. 51711 VI. Resident #21 A. Resident status Resident #21, age 82, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included hypertension (high blood pressure), cognitive communication deficit, heart failure and depression. The 10/31/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 12 out of 15. She required maximum assistance with all activities of daily living (ADL). B. Resident interviews and observations Resident #21 was interviewed on 1/13/25 at 11:08 a.m. Resident #21 said she participated in activities approximately one time a month but had not been able to participate with the larger group activities downstairs due to the elevator being disabled. She said she would like to get out of bed more, however, she said she was dependent on staff assistance. She said she had not received assistance from the facility staff for watching movies on her cell phone. On 1/15/25 at 9:43 a.m. activity assistant (AA) #2 was inviting residents to join her in the common area for coffee and reminiscing, which was the 10:00 a.m. scheduled group activity. AA#2 went room to room asking residents on the 2200 hall if they would like to attend the activity. AA#2 approached Resident #21's room, but did not enter. Resident #21 was not invited to participate in the group activity. C. Record review The activities care plan, initiated 1/24/24 and revised 12/26/24, documented Resident #21 enjoyed word searches, reading, watching television, playing bingo and visiting with friends. It indicated the resident structured her own day with self-directed independent activities and attendance of group activity programs of her interest. The interventions included providing an activity calendar to ensure the resident's knowledge of upcoming activities and encouraging participation in expressed individual and/or group activities. The 12/26/24 activity progress note documented Resident #21's religious preference was Catholic and she would have the opportunity to attend in-house services when scheduled. Resident #21 enjoyed reading, playing bingo, knitting/crocheting, arts/crafts, watching television and word searches. Resident #21 attended group activities of her choice. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/12/24 and 11/14/24 certified nurse aide (CNA) documentation revealed the resident would only get out of bed to attend the group activity of bingo, however, Resident #21 was unable to attend the group activity because the elevator was not working. -Resident #21 was unable to attend group activities downstairs in the facility due to the elevator being out of service as of 11/7/24. D. Staff interviews The activities director (AD) and the activities consultant (AC) were interviewed together on 1/16/25 at 2:00 p. m. The AD said an initial activity assessment/evaluation was completed for residents upon admission. She said the interventions were determined based on the resident's likes and interests. The AD said all residents received the facility monthly activities calendar. She said currently, there were two different activities calendars issued due to the need to separate the activities based on the elevator being unusable. The AD said all residents received both calendars but the calendar for their specific floor was posted.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42838 Based on observations, record reviews and interviews, the facility failed to ensure proper treatment and assistive device to maintain hearing abilities for one (#138) of three residents reviewed for hearing and vision services out of 59 sample residents. Specifically, the facility failed to provide a hearing exam for Resident #138 when requested Findings include: I. Facility policy and procedure The Hearing policy, revised April 2024, was provided by the nursing home administrator (NHA) on 1/16/25 at 7:00 p.m. It read in pertinent part It is the policy of this facility to ensure that all residents have access to hearing and vision services and receive adaptive equipment as indicated. The facility will utilize the comprehensive assessment process for identifying and assessing a resident's vision and hearing abilities in order to provide person-centered care. This process includes: obtaining history from medical records, the family, and the resident regarding hearing and vision abilities, MDS (minimum data set) and care area assessments, ongoing monitoring of sensory problems, care plan development and implementation and evaluation. II. Resident # 138 A. Resident status Resident #138, age 68, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses include anxiety disorder, hypothyroidism and dysphagia (difficulty swallowing). The 12/13/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The MDS assessment indicated the resident did not have any hearing concerns. B. Resident interview Resident #138 was interviewed on 1/13/25 at 11:12 a.m. Resident #138 said he needed to see an audiologist (hearing doctor) because his hearing was worsening and he wanted to get hearing aides. Resident #138 said he told staff about his concerns but the facility was not helping him to see the audiologist. Resident #138 was interviewed again on 1/16/25 at 8:42 a.m. Resident #138 said he had not had any hearing appointments since he had been admitted to the facility on [DATE]. Resident #138 said he just wanted his hearing tested and that he had spoken to the staff about trying to make an appointment. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record Review A progress note, dated 12/7/24, documented Resident #138 had poor hearing and he did not have hearing aids. -Review of Resident #138's electronic medical record (EMR) did not reveal documentation that the resident had seen the audiologist. -Review of Resident #138's EMR did not revealed documentation indicating the facility provided the resident education regarding the consent form to receive hearing services (see interview below). D. Staff interview Social services assistant (SSA) #2 was interviewed on 1/16/25 at 2:51 p.m. SSA #2 said Resident #138 told her he wanted to see the audiologist but when he refused to sign the consent to get hearing services, she did not proceed. SSA #2 said because the resident would not sign the consent for treatment the audiologist would not have agreed to see the resident. She said she was not sure if the resident understood the nature of the consent but thought it was probably explained to him. SSA #2 said she had not asked the audiologist if the resident could give verbal consent with a witness since he did not want to sign the consent document. SSA #2 said she would follow up with Resident #138 about the consent form and hearing services.

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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** 46849 Based on observations, record review and interviews, the facility failed to ensure a resident who displayed or was 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 two (#72 and #80) of eight out of 59 sample residents. Specifically, the facility failed to -Develop and implement effective dementia management focused interventions to prevent Resident #72 from wandering into other resident's rooms; -Develop person centered interventions to communicate with Resident #72 and #80; and, -Reassess the effectiveness of care-plan intervention and adjust intervention approaches based on behaviors for Resident #72 and #80. Findings include: I. Resident #72 A. Resident status Resident #72, age 85, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included unspecified dementia with agitation and mood disorder. The 11/7/24 minimum data set (MDS) revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. The assessment indicated the resident had behaviors of physical and verbal aggression directed at others and wandering. The behaviors interfered with the care of others, the activities and socialization of others, the privacy of others, and put others at risk for physical harm. The assessment documented the resident required set up and supervision with all activities of daily living (ADLs). The MDS assessment indicated it was very important to the resident to listen to music and have the opportunity to go outside. B. Record review (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive behavior care plan, revised on 1/15/25 (during survey), revealed the resident had impaired cognitive functioning related to dementia. Interventions included communicating with the resident clearly, identifying oneself, providing distractions and using simple, direct sentences during communication and engaging the resident in simple and structured activities. The comprehensive elopement care plan, revised on 1/15/25 (during survey), revealed the resident wandered without purpose and could fluctuate between being easy to redirect to being difficult to redirect. Interventions included offering structured activities, food, and conversation to distract the wandering behavior and documenting wandering behavior and attempted diversional interventions. The comprehensive discharge care plan, revised on 1/6/25, revealed due to increased wandering/elopement attempts, the family wanted the resident to be placed in a secure unit (facility that offered locked doors to prevent elopement). Review of the comprehensive care plan failed to include a target focus for communication deficits related to the resident who was not primarily English speaking. The January 2025 CPO revealed the following physician orders: Behavior monitoring for aggression towards others and delusions with non-pharmological interventions of approach/speak to in calm manner, provide back rub, change position, offer fluids, offer food, redirect, assess for pain and offer a quiet environment, ordered on 11/1/24; Behavior monitoring for low mood and tearfulness with non-pharmological interventions of providing one on one interaction, offer activity, adjust room temperature, provide back rub, change position, offer fluids, offer food, redirect, remove resident from environment and offer toileting, ordered on 11/26/24; and, Behavior monitoring for exit seeking behavior every shift with no indicated non-pharmological interventions, ordered on 12/27/24. Behavior monitoring dated 11/1/24 to 1/16/25 revealed: Behaviors of low mood and tearfulness were observed on 11/26/24, 11/27/24, 11/28/24, 11/29/24 and 11/30/24. No behaviors of low mood or tearfulness were observed in December 2024 (12/1/24 to 12/31/24) or January 2025 (1/1/25 to 1/15/25). Behaviors of aggression towards others were observed on 11/3/24, 11/9/24, 11/21/24, 11/28/24, and 11/29/24. Behaviors of aggression towards others were observed on 12/2/24, 12/15/24, 12/21/24, 12/22/24 and 12/23/24. Behaviors of aggression towards others were observed on 1/1/25, 1/4/25, and 1/15/25. Behaviors of exit seeking were observed on 12/27/24, 12/28/24, 12/29/24, 12/30/24 and 12/31/24. Behaviors of exit seeking were observed on 1/1/25, 1/2/25, 1/3/25, 1/4/25 and 1/5/25. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes reviewed from 11/1/24 to 1/15/25 revealed: Daily skilled note, dated 11/2/24, revealed the resident was taking other residents' property, went into other resident's rooms, collected dishes and piled them, collected items and wrapped them in napkins and plastic bags and only spoke Korean. Nursing note, dated 11/4/24, revealed the resident had been moved to a new room. She had smeared feces all over the floor and bed. She was filling the trashcan and tub with water. The staff moved Resident #72 to a private room. Nursing note, dated 11/21/24, revealed the resident had taken clothing belonging to another resident and when the staff tried to retrieve the clothing, the resident grabbed and punched the staff member. Nurse management was able to calm the resident by using a translation line to communicate and contacting the family. Nursing note, dated 12/3/24, revealed the resident was agitated while staff attempted to change her. The resident was hitting and kicking the staff. Nursing note, dated 12/15/24, revealed the resident was wandering into another resident's room and attempting to drink lotion from a bottle. The staff took the bottle of lotion and the resident began hitting the staff. Redirections were unsuccessful. Nursing note, dated 1/4/25, revealed the resident was following a nurse into another resident's room during colostomy care. Nursing note, dated 1/15/25, revealed the resident was following the nurse, touching things on the medication cart, interfering in other resident's care and hitting the nurse. C. Additional resident interview Resident #47, who was cognitively intact through facility assessment was interviewed on 1/15/25 at 1:27 p. m. She said she was new to the facility and would like to make friends. She said she was fearful to leave her room because the staff were not able to prevent Resident #72 from entering her room and touching or taking her belongings. She said she had heard Resident #72 had hit the staff and this concerned her. Resident 47 said she felt she had to remain in her room to protect her belongings. II. Resident #80 A. Resident status Resident #80, age greater than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included unspecified dementia, hallucinations and mood disorder. The 11/13/24 MDS revealed the resident had severe cognitive impairments and was unable to answer assessment questions with a BIMS score of zero out of 15. The MDS assessment indicated the resident did not have any behaviors. The resident required set up and supervision with all ADLs. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident observations Resident #80 was observed on 1/14/25 at 4:40 p.m. The resident was sitting in the hallway between her room and the dining room on the second floor yelling at another resident sitting near her. Resident #80 yelled in Korean and the other resident did not understand. The staff removed the other resident from the hallway. -However, the staff did not provide any person centered interventions to address Resident #80's behaviors. During a continuous observation on 1/15/25 starting at 4:45 p.m. and ending at 5:25 p.m., At 4:45 p.m. Resident #80 was sitting in her wheelchair in the hallway between her room and the dining room on the second floor. She was yelling in Korean. There were several staff nearby that were watching the resident. The staff were shaking their heads but no one approached the resident. At 5:00 p.m., a nurse attempted to coax the resident to go to the nurse's station with the nurse in order to contact the resident's family. The resident did not appear to understand and grabbed the arm railing and continued yelling. At 5:10 p.m., the nurse convinced the resident to go to the nurse's station. The resident continued to yell. -The staff did not attempt to use a translation app, call a translator on a portable phone or any other methods to communicate in a language that the resident would understand. At approximately 5:20 p.m, the nurses were able to reach the grandson, but the call was disconnected. The nurse then called the language line and the resident continued to yell at the translator. The translator told the nurse the resident was repeating, if you are going to kill me, go ahead and kill me. The resident also expressed to the translator that she believed someone was going to get her but could not explain. At this time, there were two nurses, another unidentified staff member, and social services assistant (SSA) #1 surrounding the resident at the nurse's station. The resident continued to persist with the delusion that someone was coming for her and kept asking the staff to leave her alone. SSA #1 offered the resident food and fluids but the resident only made fun of SSA #1 to the translator. C. Record review The January 2025 CPO revealed the following physician orders: -Behavior monitoring for exit seeking behavior every shift with no indicated non-pharmological interventions-, ordered on 11/2/24. -Psychosocial charting on 11/27/24 to 12/12/24, ordered on 11/27/24. Behavior monitoring was from 11/1/24 to 1/15/25. There were no behaviors documented during this timeframe. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive language care plan, revised on 7/23/24, revealed the resident had communication difficulty related to a language barrier. The resident knew some basic English but spoke Korean. The resident preferred the family to assist with translation. The resident required the use of a language line interpreter due to language barrier. Interventions included anticipating and meeting the residents needs and providing a translator as necessary. The comprehensive psychosocial care plan, revised 2/22/24, revealed the resident had a diagnosis of dementia and major depressive disorder. The resident had a history of hallucinations and delusions with changes in perception with hearing, seeing, or smelling things that were not present. Interventions included anticipating and meeting the residents needs, providing positive interaction, approaching the resident in a calm manner, reassuring the resident she was safe and providing a program of activities that were of interest and accommodated the resident's needs. Progress notes reviewed from 11/1/24 to 1/15/25 revealed: Nursing note, dated 12/8/24, revealed the resident had been screaming at staff in Korean. A call was placed to the family to speak with the resident. The family said the resident was having delusions and believed people at the facility were accusing her of things she did not do. III. Staff interviews Certified nursing aide (CNA) #7 was interviewed on 1/15/25 at 2:38 p.m. CNA #7 said Resident #72 went into other resident's rooms almost daily and the staff put stop signs on the doors but Resident #72 just removed the sign. CNA #7 said when the staff tried to redirect her or remove her from a room, she became aggressive towards the staff. CNA #7 said she did not know what person centered interventions were implemented to help Resident #72's behaviors other than offer food, fluids and trying to redirect. She said she did not know where the information was for the language line. She said, she tried to use gestures when communicating with Resident #72. CNA #7 said Resident #80 yelled out in Korean frequently and the staff did not understand what the resident was yelling out. She said the staff tried to call the family to translate but the family was not always available. She said she did not know the specific person centered behavior interventions for the resident. CNA #11 was interviewed on 1/15/25 at 2:45 p.m. CNA #11 said Resident #80 yelled out in Korean all the time and the staff just left her alone until she stopped yelling. CNA #11 said Resident #72 wandered the unit daily and went into other resident's rooms, which upset them. CNA #11 said the staff tried to redirect her or distract her with food or fluids. Licensed practical nurse (LPN) #1 was interviewed on 1/15/24 at 2:49 p.m. LPN #1 said Resident #80 yelled out in Korean all the time and the staff just left her alone until she stopped yelling. LPN #1 said she did not know what the tracking for psychosocial charting was except to document if the resident became aggressive or displayed behaviors out of the ordinary. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) and SSA #1 were interviewed together on 1/16/25 at 2:20 p.m. The SSD said the facility provided dementia care training to the staff through the electronic training modules. The SSD said there had not been a dementia care in-service or additional training with the staff on the second floor. The SSD said she had not provided any in-person dementia care training with staff in over a year. The SSD said the psychotropic drug meeting was conducted monthly with the director of nursing (DON), assistant director of nursing (ADON), the nursing home administrator (NHA), the psychologist and the psychiatrist who provide services to the facility, the social services department and the pharmacist. The SSD said behaviors, medications and non-pharmological interventions were discussed. The SSD said resident was having challenging behaviors, the resident was discussed at the psychotropic meeting. The SSD and SSA #1 said they would also reach out to the psychiatrist and psychologist between meetings to discuss challenging behaviors. The SSD said these conversations were not documented. The SSD and SSA#1 said the documented behaviors for Resident #80 were confusing and not clear. The SSD and SSA #1 said they did not know why Resident #72 had not been discussed in the psychotropic drug meeting for her aggressive and disruptive behaviors. SSA #1 said she was aware Resident #47 was declining to leave her room for meals and activities due to being fearful Resident #72 would enter her room and touch her belongings if she was not there. The NHA, the corporate consultant (CC) and the DON were interviewed together on 1/16/25 at 3:49 p.m. The NHA said the facility utilized online training modules for dementia care training but the facility did not follow up with staff on their comprehension of the training material. The NHA said for residents with aggressive behaviors, the facility would increase activities, medication review, behavior health services and psychiatry intervention. The NHA said the facility had been trying to work with Resident #80's family on medication interventions but the family declined and the resident frequently refused medications. The NHA said the facility has tried using velcro stop signs on resident doors to deter Resident #72 from attempting to enter others rooms but this had not been successful. The CC said the facility had not attempted to utilize a phone translation application with Resident #72 or Resident #80. He said the facility did not believe the residents would understand how to use the application. He said using an application would help the staff with day to day interactions to understand what the residents were saying in Korean or to convey some words to the residents in Korean which might deescalate agitation.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42838 Based on observations, record review and interviews, the facility failed to assist residents to obtain routine or emergency dental services, as needed, for two (#60 and #23) of two residents out of 59 sample residents. Specifically, the facility failed to: -Follow up on a social services referral for denture replacements for Resident #60; and, -Place a timely referral for dental services for Resident #23. Findings include: I. Facility policy and procedure The Dental Policy, revised October 2024, was provided by the nursing home administrator (NHA) on 1/16/25 at 7:00 p.m. It read in pertinent part, It is the policy of this facility, in accordance with residents' needs, to promptly assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, taking impressions for dentures and fitting dentures. Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums, or palate, broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. Promptly means within 3 (three) business days or less from the time the loss or damage to dentures or need for emergent services is identified unless the facility can provide documentation of extenuating circumstances that resulted in the delay. II. Resident #60 A. Resident status Resident #60 age 78, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included dementia, anxiety and depression. The 12/27/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively intact with a brief interview for mental health status (BIMS) score of 10 out of 15. The MDS assessment did not document any dental concerns or problems. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interviews Resident #60 was interviewed on 1/15/25 at 10:30 a.m. Resident #60 said she had been waiting for her new dentures for the past seven months. She said the facility was supposed to be assisting her through the process and she had not heard anything since her admission to the facility regarding the status of her dentures. Resident #60 said not having dentures was problematic and bothered her because she was having a hard time chewing. Resident #60 was interviewed a second time on 1/16/25 at 12:10 p.m. Resident #60 said she required both upper and lower dentures and could only eat soft foods at this time. Resident #60 said she needed to eat slowly in order to chew her food due to needing dentures. She said she wanted dentures. C. Record review The comprehensive care plan, initiated on 2/27/24, documented a care focus for activities of daily living (ADL) self-care performance deficit. The goal was the resident would safely perform ADLs with appropriate assistance. Interventions included oral hygiene and indicated the resident was waiting for dentures (initiated on 3/11/24). The nutrition note dated 3/4/24 documented Resident #60 told the nurse that her appetite had been good and she had been eating her meals. The resident reported she had no teeth but she was supposed to be getting dentures soon. -However, the note did not document who was helping the resident obtain her dentures or when they would be arriving. The social services note dated 3/4/24 documented the resident wore dentures but did not have dentures at that time. The note documented that the social worker sent a referral for new dentures and the new dentures would be coming in about two months (May 2024). The social services note dated 6/3/24 documented Resident #60 used dentures. -However, Resident #60 did not have dentures during the interviews on 1/15/25 and 1/16/25 (see resident interviews above). -Review of Resident #60's progress notes revealed there was no documentation to indicate the facility had followed up when the resident's dentures did not arrive at the facility. D. Staff interviews Social services assistant (SSA) #2 was interviewed on 1/16/25 at 12:29 p.m. SSA#2 said she was not aware of any dental concerns for Resident #60 and she did not know the resident was still waiting for dentures. SSA#2 said she would have to check into the status of the resident's dentures. SSA #2 said, from what she remembered, the social services department initially thought Resident #60 had been fitted for dentures but realized that was not the case, so a denture referral was placed for the resident in March 2024. SSA #2 said she would follow up. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	20287 III. Resident #23 A. Resident status Resident #23, age 73, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included unspecified protein-calorie malnutrition and type 2 diabetes. The 11/5/24 MDS assessment revealed the resident had no cognitive impairments with a brief interview for mental status (BIMS) score of 15 out of 15. The 4/9/24 MDS assessment revealed the resident had no natural teeth or tooth fragments (edentulous). B. Resident interview and observation Resident #23 was interviewed on 1/14/25 at 10:06 a.m. Resident #23 was wearing an upper set of dentures, but she was not wearing a lower denture. Resident #23 said her bottom denture was missing. She said she ate in bed and she snacked on cheetos. She said without her bottom denture she had difficulty eating. She said she was told by a social worker that, because she had received dentures within the past two years, she could not get a replacement for her bottom denture due to cost. C. Record review The nutrition assessment dated [DATE] documented Resident #23 used to have a full set of dentures, however, she now only had the upper dentures. The resident denied having difficulty with eating. The care plan, updated 6/4/24, identified that Resident #23 had the potential for oral health problems related to being edentulous (no teeth). Pertinent interventions included assisting the resident with dental appointments. -Review of Resident #23's electronic medical record (EMR) did not reveal any documentation to indicate the resident had been referred to the dentist for follow up regarding her missing lower denture. D. Staff interviews The social services director (SSD) was interviewed on 1/16/25 at 8:00 a.m. The SSD said she was not aware Resident #23 was missing her lower dentures because another social worker maintained the ancillary appointments for residents. She said she would look into the situation. The nursing home administrator (NHA) was interviewed on 1/16/25 at approximately 5:00 p.m. The NHA said if the facility was made aware that a resident had lost their dentures, the facility would pay for new dentures when there was no other funding available to the resident. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SSA #1 was interviewed on 1/16/25 at 6:30 p.m. SSA #1 confirmed Resident #23 did not have lower dentures. She said she was told the resident's dentures were lost and found several times. However, she said the facility had been unable to locate Resident #23's lower dentures since November 2024. SSA #1 said the resident was currently on the list to see the dentist. SSA #1 was interviewed a second time on 1/16/25 at 6:52 p.m. SSA #1 said Resident #23 had just been placed on the dentist list earlier today (1/16/25). She said there was no documentation regarding the resident's missing dentures in the resident's EMR.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 51711 Based on observations, record review and interviews, the facility failed to ensure menus were followed to meet the resident's nutritional needs. Specifically, the facility failed to: -Follow the correct portion sizes to ensure adequate nutrition was provided to the residents; and, -Follow the weekly menu to ensure adequate nutrition was provided to the residents. Findings include: I. Facility policy and procedure The Food and Nutrition Services, Menus policy, dated August 2019, was provided by the nursing home administrator (NHA) on 1/16/25 at 9:28 p.m. It revealed in pertinent part, This facility's menus and extensions shall be prepared in advance. Menus procedures: If any meal served varies from the planned menu, the change and the reason for the change are noted in the kitchen and /or in the record book used solely for recording such changes; these changes are to be reviewed and approved by the dietitian. Menu spreadsheets are utilized to ensure all menu items are served at the correct portion sizes. II. Failure to follow the correct portion sizes to ensure adequate nutrition was provided to the residents. A. Observations and record review During a continuous observation during the lunch meal on 1/15/25, beginning at 11:15 a.m. and ending at 12:08 p.m., the following was observed: An unidentified dietary aide placed one gray #8 scoop of tortellini on each resident's meal trays who received a regular diet. -The menu extensions documented residents who received a regular diet should have received two gray #8 scoops of tortellini. III. Failure to follow the weekly menu to ensure adequate nutrition was provided to the residents A. Observations and record review Review of the menu and the menu extensions for the 1/14/25 dinner meal revealed that 2% (percent) milk was to be served with dinner. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a continuous observation on 1/14/25 of the dinner service, beginning at 4:17 p.m. and ending at 5:43 p.m., in the main and second floor dining rooms, the following was observed: -The dietary aides in the main and second floor dining rooms did not offer or serve residents milk as a beverage during the observation period. They offered coffee and juice instead. The dietary aides did not offer a dairy substitute to the residents. IV. Staff interviews The dietary consultant (DC) and the registered dietitian (RD) were interviewed together on 1/15/25 at 3:36 p. m. The DC said during the lunch meal on 11/15/25 the wrong amount of tortellini was served. She said two scoops, using the gray #8 scoops of tortellini should have been served. The DC and the RD were interviewed again on 1/16/25 at 3:09 p.m. The DC said the calorie count was inclusive of all items noted on the menu for the day. The DC said the milk should be offered, however, if the resident refused the milk, an alternative to the milk should be offered.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711 Based on observations, record review and interviews, the facility failed to provide accessible dining equipment and utensils for residents who need them for one (#172) of one resident reviewed for adaptive equipment out of 59 sample residents. Specifically, the facility failed to provide adaptive drinking equipment for Resident #172. Findings include: I. Facility policy and procedure The Adaptive Equipment policy and procedure, revised October 2024, was provided by the nursing home administrator (NHA) on 1/16/25 at 9:22 p.m. It read in pertinent part It is the policy of the facility to evaluate and provide adaptive equipment for residents who have been identified at risk for contractures, skin breakdown, assisting with eating. On admission the resident will be assessed for needs for adaptive devices. Residents needing adaptive equipment will be screened by therapy or nursing and equipment will be supplied for respective residents Residents will be reassessed quarterly for continued needs of the adaptive equipment. II. Resident #172 A. Resident status Resident #172, age less than 65, was admitted to the facility on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included dysphagia following cerebral infarction (swallowing difficulties following a stroke), cerebral vascular disease affecting left dominant side, hemiplegia and hemiparesis following other cerebral vascular disease (decreased or no movement on one side of the body following a stroke) and need for assistance with personal care. The 12/20/24 minimum data assessment (MDS) assessment documented the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. The resident was dependent on facility staff for most activities of daily living (ADL) and eating. B. Observations On 1/13/25 at 3:57 p.m., Resident #172 was drinking a can of Sunkist soda. Resident #172 was not provided with a straw or a spill-proof cup that is designed to be used with a straw. The resident had visible spills on the front of her shirt. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 4:20 p.m., Resident #172 was observed in the small dining room on the second floor Resident #172 was served milk and hot coffee in a styrofoam cup without a lid or a straw. Throughout the entire observation of the dinner meal, Resident #172 was served multiple beverages in styrofoam cups and not in an adaptive cup. On 1/14/25 at 1:18 p.m., Resident #172 was observed in the common area on floor two with a styrofoam cup without handles and a straw or lid. The resident had visible spills on her blue shirt. C. Record review The nutrition care plan, initiated on 1/10/24, revealed Resident #172 had a nutritional problem related to diagnosis of dysphagia, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), hemiplegia and hemiparesis, muscle wasting and atrophy. Pertinent interventions included providing adaptive equipment, an adaptive cup. A dietary meal ticket from 1/16/25 revealed Resident #172 required a spill-proof cup that is designed to be used with a straw with all meals. III. Staff interviews The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 1/16/25 at 5:34 p.m. The DON said updates to care plans related to adaptive equipment would be completed by the dietitian and/or the therapy department. The DON said the nursing staff did not update the care plan for adaptive equipment. The DON and the ADON said they were unsure how the dietary department and the therapy department communicated the changes. The dietary consultant (DC) was interviewed on 1/16/25 at 4:48 p.m. The DC said Resident #172's dietary meal ticket documented the resident should receive a spill-proof cup that is designed to be used with a straw for all beverages with every meal. The DC said Resident #172 did not receive a spill-proof cup that is designed to be used with a straw, which was part of the comprehensive plan of care. The DC said she would provide education to the kitchen staff to ensure Resident #172 received the appropriate adaptive equipment.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849 Based on record review and interviews, the facility failed to ensure specialized rehabilitative services to maintain highest practicable level of functioning for one (#158) of two residents reviewed for specialized rehabilitative services out of 59 sample residents. Specifically, the facility failed to ensure services for Residents #158 were provided to maintain the residents highest practicable levels of functioning. Findings include: I. Resident #158 A. Resident status Resident #158, age 85, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included stroke, polyneuropathy and adult failure to thrive. The 11/20/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. He required extensive assistance for bed mobility, repositioning, bathing, dressing, transferring and toilet use. Staff provided only set up assistance for meals. The MDS assessment indicated the resident had no deficits with swallowing or eating and was not receiving speech therapy services. B. Resident observation and interview Resident #158 was interviewed 1/14/25 at 4:30 p.m. Resident #158 said the facility sometimes helped him eat his meals in his room and other times the staff just left his tray on the bedside table for him to feed himself. He was unable to say how long this had been occurring. On 1/15/25 at 6:10 p.m. Resident #158 was in his room. A staff member brought in his meal tray and left it on his bedside table. The staff member did not remain in the resident's room to assist the resident with eating. II. Record review The January 2025 CPO revealed the following physician orders: ST (speech therapist) to evaluate and treat related to pocketing food in the mouth and intermittent cough when swallowing, ordered on 12/15/24. Regular diet, mechanical soft texture, thin liquids consistency, ordered on 12/21/24. Supplement shakes two times a day for weight maintenance, ordered on 1/6/25. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #158's nutrition care plan, revised 12/20/24, revealed the resident had nutritional deficits related to a history of throat cancer. Interventions included to provide and serve diet as ordered. -The care plan failed to identify the degree of eating assistance or monitoring the resident required. -Review of Resident #158's comprehensive care plan revealed there was no speech therapy care plan focus related to pocketing food or intermittent coughing when swallowing for the resident. A review of Resident #158's electronic medical record (EMR) from 12/15/24 to 1/16/25 revealed the following progress notes: A nursing note, dated 12/15/24, revealed Resident #158 was noted to have a generalized decline as evidenced by being more lethargic and sleepier. The staff encouraged fluids and assisted the resident with the meal. The resident was observed by nursing to be pocketing food and fell asleep while he was eating. The nurse had to remain with the resident to provide cueing to ensure he swallowed his food. The nurse notified the physician and an order for speech therapy was obtained. A registered dietitian (RD) nutrition note, dated 12/20/24, revealed Resident #158 had triggered for an 8 pound (lb) weight loss since 11/22/24. The note indicated the potential cause of the weight change may have been related to increased confusion, lethargy, difficulty swallowing and decreased intake. A RD nutrition note, dated 1/6/25, revealed the RD had changed Resident #158's diet order on 12/21/24 to mechanical soft texture. -Despite the documentation in the progress notes that Resident #158 was having difficulty with swallowing and had been noted to have an 8 lb weight loss, there was no documentation in the resident's EMR to indicate that a speech therapy evaluation had been completed (see physician's order above). III. Staff interviews The director of rehabilitation (DOR) and the speech therapist (ST) were interviewed together on 1/15/25 at 2:09 p.m. The DOT said Resident #158 had been receiving physical and occupational therapy for balance, transfers and general functional mobility with upper extremities. The DOT said the resident had not received speech therapy. The DOT said orders for therapy services were communicated in the morning management meetings, during the Risk Management meeting or the nurses reached out to the therapy department directly. The DOT said he was unable to explain why the 12/15/24 physician's order for a speech therapy evaluation for Resident #158 had not been completed by the therapy department. The ST said she would complete an evaluation with the resident by the end of the day (1/15/25). Certified nurse aide (CNA) #7 was interviewed on 1/15/25 at 2:38 p.m. CNA #7 said the staff did not provide Resident #158 with eating assistance. CNA #7 said the resident ate in his room and the staff checked on him because he ate slowly but the staff did not assist him with eating. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 1/16/25 at 3:49 p.m. The DON said the nursing department communicated new physician's orders for therapy in the morning management meetings, where the therapy department was in attendance. The DON said the therapy department also reviewed the daily physician order reports. The DON acknowledged the facility did not have an explanation for why the 12/15/24 speech therapy evaluation order for Resident #158 was missed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52045 Based on observations, record review and interviews, the facility failed to ensure infection prevention and control programs (IPCP) were maintained and followed to provide a safe, sanitary and comfortable environment for residents and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to: -Ensure staff wore the proper personal protective equipment (EBP) for Resident #25, who was on enhanced barrier precautions (EBP); -Ensure pull cords were free from debris; -Ensure the resident's rooms were cleaned appropriately; and -Ensure Resident #98's nebulizer was cleaned and stored appropriately. Findings include: I. Failure to follow enhanced barrier precautions A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), retrieved on 1/22/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care: any skin opening requiring a dressing. B. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 3:15 p.m. there was a sign on Resident #25's door indicating he was on EBP. There was personal protective equipment (PPE) including gloves, gowns, eye protection and masks stocked on the back of Resident #25 door. On 1/13/25 at 3:34 p.m. Resident #25 was in her room when certified nurse aide (CNA) #2 and registered nurse (RN) #2 entered the resident's room with a Hoyer lift (mechanical lift) to assist Resident #25 to bed. Neither staff applied personal protective gowns prior to providing personal care assistance to the resident. On 1/15/25 at 12:50 p.m., two unidentified staff members entered Resident #25's room with gloves on but no gown or mask to transfer the resident to bed. CNA #2 grabbed a blue protective gown. RN #2 told CNA #2 that she did not need to use the blue protective gown. CNA #2 proceeded to empty Resident #25's nephrostomy tube without applying the required PPE. C. Resident interview Resident #25 was interviewed on 1/15/25 at 8:30 a.m. Resident #25 said the staff never used gowns, masks or eye protection when emptying her nephrostomy tube. Resident #25 said the staff did wear gloves. D. Staff interviews CNA #2 was interviewed on 1/15/25 at 12:55 p.m. CNA #2 said she just needed to wear gloves to empty Resident #25's nephrostomy tube because she did not want to get urine on her hands. The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 1/16/25 at 2:41 p.m. The ADON said when a resident was placed on EBP, the staff were expected to put on a mask, gown,and wear face shield/goggles when splashing was likely to occur during care where they came into contact with bodily fluids and open areas of the body. The ADON said the staff received education following EBP in October 2024. The DON said they also provided the staff a more recent in-service in December 2024 on infection control measures. 51916 II. Failure to ensure pull cords were clean A. Observations On 1/15/25 between 3:10 p.m. and 3:50 p.m., resident shower rooms and resident in-room bathrooms were observed. -The first shower room on the first floor was observed; the call light string near the toilet was soiled with a brown substance -The second shower room on the first floor was observed; the call light string near the toilet was soiled with a brown substance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The shower room on the second floor's call light string was brown. -Nine resident's bathrooms (#1007, #1008, #1210, #2007, #2001, #2204, #2109, #2112, and #2311) were observed. All of them had brown call light strings by their toilets. B. Staff interviews The DON and the ADON were interviewed together on 1/16/25 at 2:20 p.m. The ADON said the housekeeping staff was responsible for cleaning the call light strings. The housekeeping supervisor (HKS) and housekeeper (HK) #3 were interviewed together on 1/16/25 at 4:54 p.m. The HKS said the material that the pull cords were made out of were difficult to clean. The HKS said he would work to create a plan to replace all of the call light strings with a plastic material that would be able to be cleaned. III. Failure to ensure resident's rooms were cleaned appropriately A. Professional reference According to the CDC Prevention Guidelines for Environmental Infection Control in Health Care Facilities (2003), last reviewed 1/8/24, retrieved on 1/21/25 from https://www.cdc.gov/infection-control/hcp/environmental-control/environmental-services.html, High-touch housekeeping surfaces in patient-care areas (doorknobs, bedrails, light switches, wall areas around the toilet in the patient's room, and the edges of privacy curtains) should be cleaned and/or disinfected more frequently than surfaces with minimal hand contact (since the transferral of microorganisms from environmental surfaces to patients is largely via hand contact with the surface). Infection-control practitioners typically use a risk-assessment approach to identify high-touch surfaces and then coordinate an appropriate cleaning and disinfecting strategy and schedule with the housekeeping staff. Cleaning solutions should be replaced frequently. B. Facility policy and procedure The Housekeeping policy, revised September 2024, was provided by the HKS on 1/16/25 at 9:26 p.m. It read in pertinent part, The facility requires effective environmental sanitation to lessen the hazards of exposure to contaminated air, dust, furnishings, equipment and other fomites, including thorough scrubbing for all environmental surfaces in resident care areas taking dwell times for disinfectants into consideration; frequently changing mop heads, cloths and cleaning solutions; cleaning horizontal surfaces in care areas daily or more often if soiled; disinfectants and detergents must be EPA-approved. C. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/16/25 from 10:12 a.m. to 10:50 a.m., a continuous housekeeping observation of room [ROOM NUMBER] was conducted. HK #1 started the cleaning by spraying the sink, bathroom floor and toilet. HK #1 began wiping down the bathroom surfaces and then began wiping the resident's table surfaces with the same towel she used to wipe surfaces in the bathroom. HK #1 also used the same wet towel for both resident spaces in the shared room. The call light string in the bathroom had a brown substance on it. HK #1 did not attempt to clean or replace the soiled call light string. -HK #1 failed to clean high touched areas including the light switches, door knobs, sink handles and call lights. D. Staff interviews The HKS was interviewed on 1/16/25 at 4:54 p.m He said the housekeepers should clean either side of the room using different cleaning towels for different surfaces. 42838 IV. Failed to ensure Resident #98's nebulizer was cleaned and stored appropriately A. Professional reference According to the American Lung Association, How to Clean your Nebulizer, last updated 3/27/23, retrieved on 1/22/25 from https://www.lung.org/lung-health-diseases/lung-disease-lookup/copd/resource-library/how-to-clean-a-nebulizer#:~:text=Cleaning%20your%20nebulizer%20is%20important, top%20piece%2C%20and%20medicine%20cup. Many people with chronic lung diseases such as COPD or asthma use a nebulizer to take their medication in the form of a mist that is inhaled into the lungs. Cleaning your nebulizer is important to prevent the spread of germs and keep you from getting sick. It will also keep your device working properly. It is recommended to wash the parts of your nebulizer after each use, including the mouthpiece or mask, top piece, and medicine cup. To start, take the nebulizer apart by removing the tubing and setting it aside. (The tubing should never be placed underwater.) Remove the mouthpiece or mask, and medicine cup from the top piece, and wash the medicine cup, top piece, and mouthpiece or mask, in warm soapy water, and rinse. Shake off the excess water and let the pieces air-dry in a cool, dry place until the next use. Your nebulizer will also need a thorough cleaning once a week. Soak the mouthpiece or mask, top piece, and medicine cup in a white vinegar and water solution for 30 minutes, or as recommended by your device manufacturer. After 30 minutes, rinse and air-dry in a cool, dry place. Clean the surface of the compressor and the outside of the tubing with a soapy cloth or disinfectant wipe. (The compressor and the tubing should never be submerged in water.) and, remember, most compressors have an air filter that will need to be replaced every six months, or as recommended by your manufacturer. B. Resident interviews and observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/13/25 at 1:56 p.m., Resident #98's nebulizer was lying on her nightstand on top of her personal care items. The table was cluttered with papers and used drinking cups. The nebulizer was not clean of the moisture built up from the last use. The nebulizer was not stored on a protective sheet or in any type of protective covering. Resident #98 was interviewed on 1/13/25 at 4:54 p.m. She said the nebulizer needed to be cleaned after each use. She said the staff did not clean it, so she cleaned it herself. On 1/14/25 at 9:30 a.m. and 1/15/25 at 9:30 a.m., the nebulizer was observed, it was still lying on the nightstand with dried water stains. It did not have a protective covering. C. Staff interviews CNA #8 was interviewed on 1/16/25 at 10:30 a.m. CNA #8 said Resident #98 used her nebulizer as needed. CNA #8 said when she requested the nebulizer the nurse would go into her room and give her the medication in the nebulizer. CNA #8 said the nebulizer was then cleaned after each use by nursing staff and it was placed next to her bed on her table. RN #3 was interviewed on 1/16/25 at 11:30 a.m. RN #8 said nursing staff were responsible for taking the nebulizer apart for each cleaning and it dried on the medication cart. RN #8 said once dry it was put back together and placed next to her bed on her table until the next use. The DON and the ADON were interviewed on 1/16/25 at 2:00 p.m. The DON said the nebulizer should be washed after each use and placed in a bag after it was washed and air-dried. The DON said the nurses have access to bags at every nurse's station. The DON did not say why they were not following the procedure for Resident # 98.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42838 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure the dining room tables were stable and in good condition. Findings included: I. Facility policy and procedure The Safe and Homelike Environment policy, revised November 2023, was provided by the nursing home administrator (NHA) on 1/16/25 at 7:00 p.m. It read in pertinent part, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. A. Observations and resident interviews On 1/15/25 at 12:45 p.m., there were five dining room tables that were found to be unbalanced. When a resident leaned on the table the table top dipped causing the surface to move up and down in an unsteady manner. On 1/16/25 at 4:15 p.m., the evening meal was observed. There were multiple tables that were unbalanced that residents were eating their meals. Resident #189 was interviewed on 1/16/25 at 4:15 p.m. Resident #189 said the tables wobbled so he had to fold up a paper towel and place it under the leg of the table to stabilize it so his food did not spill when he ate his meal. Resident #189 said the paper towels he stuck under the leg helped but they had to keep replacing it when the table was moved around. Resident #60 was interviewed on 1/16/25 at 4:16 p.m. Resident #60 said the tables were unbalanced and it made it difficult to eat and drink. On 1/16/25 at 4:20 p.m., the dining area was observed and there were pieces of paper towels placed under the table leg to keep the tables balanced. Some tables did not have paper under the legs and were unbalanced. B. Staff interviews (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The maintenance director (MTD) was interviewed on 1/16/25 at 11:11 a.m. The MTD said the maintenance team was dependent on the nursing staff to report any repair needs. The MTD said the facility had an electronic report database but were not putting it to use. The MTD said all of the maintenance needs observed by staff or requests reported by residents were provided to the maintenance department verbally or by passing along a written note. The MTD said he utilized a legal pad to document his repair to do list. The MTD said there was no backup for this system and no historical data was available to show past repairs. He said once as the repairs were completed he tossed out his to do list. The MTD was interviewed again on 1/16/25 at 4:30. The MTD said he checked the tables in the dining area a few times weekly and did not find any problem with the steadiness of the tables. He said he was not aware of the unbalanced tables. The MTD said he would look at the tables, and he and the maintenance staff would fix any broken tables.