STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065168	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Falcon Heights Rehabilitation and Nursing LLC	1795 Monterey Rd Colorado Springs, CO 80910

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to promote and maintain resident dignity for two (#35 and #51) of three residents reviewed out of 49 sample residents by providing care in a dignified, respectful and individualized manner. Specifically, the facility failed to: -Ensure Resident #35 was provided meal assistance in a dignified manner; and, -Ensure Resident #51 was treated with dignity and respect when asking for assistance. Findings include: I. Facility policy The Dignity policy, revised February 2021, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. It read in pertinent part, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. When assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience. Residents may exercise their rights without interference, coercion, discrimination or reprisal from any person or entity associated with this facility. II. Resident #35 A. Resident status Resident #35, age less than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke), dysphagia (difficulty swallowing) following cerebral infarction, bipolar disorder, post-traumatic stress disorder and ataxia (neurological disorder causing lack of coordination and tremors). (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	The 7/16/24 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. She required set-up assistance for eating and substantial assistance for personal hygiene and dressing. B. Resident observations and interview On 7/28/24 at 5:49 p.m. certified nurse aide (CNA) #3 was observed assisting Resident #35 with her supper. Resident #35 was sitting in her wheelchair while CNA #3 stood beside the resident preparing her tray and assisting her with eating. Resident #35 was interviewed on 7/30/24 at 8:57 a.m. Resident #35 said sometimes the facility staff sat down when they assisted her with meals, but she said they primarily stood over her. Resident #35 said she preferred when the staff would sit down to assist her with eating. She said there was a folding chair in her room for the staff to sit in when they assisted her. On 7/30/24 at 12:31 p.m. the occupational therapist (OT) was assisting Resident #35 with lunch. The OT stood over the resident, cutting up her food and provided the resident with cueing. The resident had difficulty feeding herself due to tremors (uncontrolled muscle contractions causing shakiness) in her hands. -A folding chair was observed in the room, folded up by the dresser, however, the OT did not attempt to use the chair. On 7/31/24 at 8:34 a.m. CNA #4 was delivering breakfast to Resident #35. CNA #4 did not set up the tray for Resident #35 and started assisting the resident's roommate with eating. Resident #35 attempted to feed herself but was dropping eggs onto her lap due to her hand tremors. Resident #35 told CNA #4 she was frustrated and asked for help. When CNA #4 was finished assisting the resident's roommate, she went over and stood beside Resident #35 and assisted her with eating her breakfast. -A folding chair was observed in the room by the dresser, however, CNA #4 did not attempt to use the chair. Resident #35 was interviewed on 7/31/24 11:12 a.m. Resident #35 said when the facility staff stood when providing her assistance with eating, she felt belittled. Resident #35 said she was belittled her whole life and she would feel better if staff sat down on her level when they were assisting her with eating. C. Record review The self-care care plan, updated 7/30/24, documented Resident #35 fed herself with the use of a scoop lipped plate, black handled weighted utensils and a two handled mug with spouted lid. The 7/9/24 provider visit note documented Resident #35 reported her tremors remained impactful to her life and she had difficulty holding objects. The resident had requested to see a neurologist for worsening tremors and some further testing. The July 2024 CPO documented the resident received the following medication: (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Propranolol 10 mg (milligrams) three times a day for dystonic tremor (caused by involuntary muscle contractions), ordered on 6/10/24. D. Staff interviews The OT was interviewed on 7/30/24 at 12:34 p.m. The OT said she was trying a new scoop plate and weighted silverware with Resident #35. The OT said Resident #35 still needed help with eating some foods due to her tremors. CNA #4 was interviewed on 7/31/24 at 11:55 a.m. CNA #4 said she was taught to let residents try to eat on their own and only assist if they asked for help. CNA #4 said when assisting in the dining room, she sat down with the resident but she stood when assisting Resident #35 because there was not a chair in the room. She said she did not see the folding chair in Resident #35's room. The director of nursing (DON) was interviewed on 7/31/24 at 3:07 p.m. The DON said when staff assisted residents with eating, they should sit down to ensure they were not standing over the resident and providing a dignified dining experience. She said staff should sit down when assisting Resident #35 with meals. 38185 III. Resident #51 A. Resident status Resident #51, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the July 2024 CPO, diagnoses included hemiplegia (paralysis of one side of the body) following a cerebral infarction (stroke - disrupted blood flow to the brain due to problems with blood vessels that supply it) affecting the left non-dominant side. The 6/19/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required setup assistance with all activities of daily living (ADL). B. Resident interview Resident #51 was interviewed on 7/29/24 at 10:11 a.m. Resident #51 said the facility staff were rude at times. He said, for example, he had pushed his call light and asked licensed practical nurse (LPN) #5 to assist him with putting the blanket over the bottom of his feet. He said LPN #5 refused to help him and told him he was able to do it himself and she would stand there and watch. Resident #51 said he did not understand why LPN #5 could not just help him with the blanket instead of being rude. He said he was blamed for being rude to the facility staff but it was often a reaction to how he was treated by the staff. C. Record review (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	The 7/8/24 nursing progress note, documented by LPN #5, revealed Resident #51 activated his call light and asked LPN #5 to cover his feet with the blanket. LPN #5 documented she told the resident that he could actually put the blanket over his feet on his own and there was no need to call anybody to do that for him. Resident #51 responded he could do it himself but he chose not to. The progress note documented LPN #5 educated Resident #51 and told him she would observe the resident putting the blanket over his feet independently. LPN #5 documented she told the resident he had to help himself if he wanted to get well. D. Staff interviews The NHA was interviewed on 7/31/24 at 3:04 p.m. The NHA said all residents should be treated with dignity and respect. She said all residents should be assisted if they asked for help, whether or not they were independent. The NHA said she read the progress note documented by LPN #5 on 7/29/24. She said LPN #5 should have assisted Resident #51 to cover his legs with the blanket. She said there was no need for LPN #5 to be rude to Resident #51. She said the facility staff should be helpful.

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to choose his or her attending physician. 38185 Based on interviews and record review, the facility failed to ensure residents on five of five hallways had the right to choose his or her own attending physician. Specifically, the facility failed to allow residents to choose their primary care provider (PCP) when the facility changed medical provider groups. Findings include: I. Facility policy and procedure The Choice of Attending Physician policy, reviewed February 2021, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. It revealed in pertinent part, The resident has the right to choose his or her own attending physician. The resident is informed in writing of the name and contact information for his or her attending physician: during the admission process; any time the information changes; and upon the resident/representative's request. II. Resident and resident representative interviews The following residents, who were deemed to be cognitively intact based on facility assessment were interviewed and said the following: Resident #51 was interviewed on 7/29/24 at 10:11 a.m. Resident #51 said he had no idea his physician had been changed. He said the facility did not inform him nor obtain his permission. Resident #40 was interviewed on 7/29/24 at 10:19 a.m. Resident #40 said the facility staff never informed him that his physician had changed. He said a physician entered his room and told him that she was his new doctor. He said he told her he had not changed physicians and she responded that the facility had made the decision and he did not have a choice. Resident #40 said he was very upset that he was not given the choice for his medical provider and the facility had made the change without obtaining his consent. Resident #35 was interviewed on 7/29/24 at 10:56 a.m. Resident #35 said the facility did not inform her she was receiving a new physician nor obtain her consent. She said the facility just did whatever they wanted. Resident #21 was interviewed on 7/29/24 at 10:57 a.m. Resident #21 said the facility did not inform her about changing physicians nor obtain her consent. Resident #66 was interviewed on 7/29/24 at 11:13 a.m. Resident #66 said the facility did not ask her permission to change her physician. She said the facility never even informed her. She said the physician walked into her room one day and said she was her new doctor. (continued on next page)

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F 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 was interviewed on 7/29/24 at 11:18 a.m. Resident #2 said the facility did not obtain her consent to change physicians. She said she was not informed of the change until the physician entered her room to speak with her. Resident #8 was interviewed on 7/29/24 at 12:14 p.m. Resident #8 said the facility did not inform him nor obtain his consent to change his physician. Resident #75's representative was interviewed on 7/29/24 at 12:30 p.m. The representative said she was not aware the resident's physician had changed. She said she had not heard from the new physician and the facility did not obtain her consent for the change. III. Group interview The group interview was conducted on 7/30/24 at 10:00 a.m. with Resident #11, #68, #54 and #66, who were identified as alert and oriented through facility and assessment. All of the residents said they had not been informed the facility had changed to a new medical provider group. The residents said they were not informed they would be receiving a new physician nor did the facility ask their permission. IV. Record review -The facility was unable to provide documentation that the residents and their responsible parties had been informed and that residents' permission was obtained to change resident physicians. V. Staff interviews The NHA was interviewed on 7/31/24 at 11:00 a.m. The NHA said the facility had changed their primary medical group on 6/1/24. She said it was a corporate decision and the facility administration was not given a choice. The NHA said she was not sure if residents were informed. She said a meeting was not held with residents, nor was a letter provided to inform them or obtain their consent. The regional clinical consultant (RCC) was interviewed on 7/31/24 at 11:15 a.m. The RCC said the facility was not given a choice when the physician medical group was changed on 6/1/24. She said it was a corporate decision and the residents were not informed nor was their consent obtained.

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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** 47150 Based on observations and interviews, the facility failed to maintain a safe, comfortable and functional homelike environment for residents, staff and the public on four of five units. Specifically, the facility failed to provide the necessary maintenance services to ensure resident's room doors #205, #304, #306, #404, #405 and #607 were easily able to be opened and closed and damaged floors were repaired. Findings include: I. Facility policy and procedure The Homelike Environment policy, revised February 2021, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:35 p.m. It revealed in pertinent part, Residents will be provided with a safe, clean, comfortable and homelike environment. II. Observations On 7/30/24 at 9:22 a.m. resident room [ROOM NUMBER] was observed. There were several dark stains on the floor caused by the room's door not being able to close properly. The door to the room was difficult to open and close. At 9:29 a.m. resident room [ROOM NUMBER] and room [ROOM NUMBER] were observed. The residents' bedroom doors were not aligned properly making the doors difficult to open and close. At 9:36 a.m. room [ROOM NUMBER] was observed. There was missing paint and chipped paint on the door and door frame. At 9:40 a.m. room [ROOM NUMBER] was observed. There was missing paint and chipped paint on the door and door frame. At 9:46 a.m. room [ROOM NUMBER] was observed. There was missing paint and chipped paint on the door and door frame. At 9:50 a.m. the main dining room was observed. There was missing flooring by the main entrance to the dining room. III. Resident interviews (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #51, who resided in room [ROOM NUMBER], was interviewed on 7/31/24 at 9:45 a.m. Resident #51 said the bedroom doors had been hard to open and close for several months. He said he had reported the door issue to the staff and nothing had been done about it. The resident said he saw the staff struggle to open and close the doors on several occasions. Resident #51 said he would have preferred having a new room until the door was fixed but no one had offered him the option to move to a safer room with easy to open and close doors. Resident #59, who resided in room [ROOM NUMBER], was interviewed on 7/31/24 at 10:15 a.m. Resident #59 said the bedroom door was hard to open and close for several months. He said he had to lift the door with both hands to get it to close or open. Resident #59 said he was not offered an alternative room. IV. Staff interviews Certified nurse aide (CNA) #8 was interviewed on 7/31/24 at 9:50 a.m. CNA #8 said most of the residents' room doors were hard to open and close. She said most of the time it required significant effort to get the doors open. CNA #8 said the door issue had been reported to the maintenance supervisor (MS) on several occasions and the staff had been informed that the facility was in the process of replacing them. The MS and the NHA were interviewed together on 7/31/24 at 10:00 a.m. The NHA said the facility had identified residents' rooms that had defective doors and the facility would be replacing them. The MS said it was a safety concern when the residents could not open and close their bedroom doors with ease. The NHA said some of the doors had been replaced and the remaining doors were scheduled to be replaced on 8/8/24.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on record review and interviews, the facility failed to take steps to protect two (#70 and #28) of two residents reviewed for abuse out of 49 sample residents. Specifically, the facility failed to ensure Resident #70 and Resident #28 were free from physical abuse from each other on two separate occasions. Findings include: I. Facility policy and procedure The Abuse Policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:00 p.m. The policy read in pertinent part, Communities do not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members and other residents. If a resident experiences a behavior change resulting in aggression toward other residents, the community will implement interventions for further protection of the alleged assailant and other residents. The resident's care plan is revised to include new approaches to reduce or eliminate any further chance of abuse. II. Incident of physical abuse between Resident #70 and Resident #28 on 5/3/24 The 5/3/24 abuse investigation documented there was a physical altercation between two residents. The residents were separated, assessed with no injuries, placed on 15-minute checks and offered emotional support. The assailant (Resident #70) was interviewed by the social services director (SSD). Resident #70 reported to the SSD that hitting Resident #28 was an accident and she did not mean to hurt anyone. The victim (Resident #28) was interviewed and said, No, did you see anyone hit the floor? No? Then no one hit me. Four residents and four staff members were interviewed and did not have additional information. A witness was interviewed and said she was in the hallway and saw a lady down the hall hit another lady in the face. The incident was unsubstantiated due to the accidental nature of the incident and the victim stating no one hit her. III. Incident of physical abuse between Resident #70 and Resident #28 on 7/19/24 The 7/19/24 abuse investigation documented there was a physical altercation between two residents. The residents were separated, assessed with no injuries, placed on 15-minute checks and offered emotional support. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assailant (Resident #70) was interviewed by the SSD on 7/19/24 and reported what occurred. Resident #70 said she was not afraid of Resident #28 because of her dementia. The victim (Resident #28) was interviewed on 7/19/24 and did not remember the incident. Five staff members were interviewed and had no additional information. Five residents were interviewed and had no additional information. A staff witness was interviewed on 7/19/24 and said the victim (Resident #28) kicked the other resident's (Resident #70) chair, responded verbally and hit the assailant who responded by hitting the victim back. There was no documentation regarding whether the incident was substantiated. IV. Resident #70 A. Resident status Resident #70, age 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (breathing problems), anxiety disorder and muscle weakness. According to the 5/17/24 minimum data set (MDS) assessment the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #70 was independent with activities of daily living (ADL). The assessment indicated the resident did not have any behaviors directed towards others. B. Resident interview Resident #70 was interviewed on 7/31/24 at 9:37 a.m. She said she was roommates with Resident #28 when they started having problems. She said Resident #28 was a mean, old nasty woman. She said Resident #28 was verbally abusive to her as well as the nursing staff. She said a couple months ago (May 2024), another resident was in their room and trying to leave when Resident #28 blocked the doorway so she could not leave. Resident #70 said an hour passed and she finally went over and hit Resident #28 on the head for her to get out of the way so the other resident could leave their room. Resident #70 said she hit Resident #28 on purpose because she was not letting the other resident out and was threatening her. She said they remained roommates for some time after that incident. Resident #70 said she moved out into a room at the end of the same hallway. She said she did not leave her room very often but said she had to go out and get her oxygen tank refilled recently. She said she had seen Resident #28 in the hallway when she was out of her room. She said Resident #28 got in her way and started to kick at her chair. Resident #70 said she told Resident #28 to stop and Resident #28 said she would hit her. Resident #70 said to go ahead. Resident #70 said Resident #28 hit her so she hit her back. C. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of Resident #70's comprehensive care plan revealed no documentation indicating the resident was physically or verbally aggressive towards others. -The care plan did not have person-centered interventions after the resident to resident incidents on 5/3/24 or 7/19/24. -The facility failed to put interventions in place to prevent the physical altercations from occurring again. V. Resident #28 A. Resident status Resident #28, age 81, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included chronic obstructive pulmonary disease, vascular dementia (memory problems) and cognitive communication deficit. According to the 5/2/24 MDS assessment, the resident had moderate cognitive impairments with a BIMS score of eight out of 15. Resident #28 required moderate to extensive assistance for activities of daily living. The MDS assessment indicated the resident had verbal behavioral symptoms directed toward others on four to six days during the review period. B. Record review The behavior care plan, initiated on 5/6/24, revealed the resident had physical and verbal aggression. The interventions included providing one on one time for support, letting the resident know she could vent to social services, supporting the resident through verbal disagreements and giving her time and space alone. -The facility failed to update the care plan after the altercation on 7/19/24. A review of Resident #28's EMR did not reveal documentation regarding the incident on 5/3/24. A skin assessment was not completed after Resident #70 hit Resident #28 on 5/3/24. The 7/19/24 nursing progress note documented a skin check was completed following the incident. There were no injuries noted. Another nursing progress note on 7/19/24 documented Resident #28 was exiting the dining room and another resident was sitting in front of the oxygen room. Resident #28 started kicking the other resident's chair. She then reached around the back of her chair and her hand struck another resident's face. The other resident struck Resident 28's face. Both residents were separated and checked out for immediate injuries. Resident #28 was started on 15-minute checks. The resident's legal representative was called. The NHA was called. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's note, dated 7/23/24, documented nursing staff reported Resident #28 was having increased agitation and aggression toward staff and other residents. The resident's Zoloft (medication to control agitation symptoms) was increased. VI. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 7/31/24 at 9:00 a.m. CNA #6 said Resident #70 was very sweet and she was not aware of any verbal or physical altercation between her and another resident. CNA #6 said Resident #28 was verbally abusive to her and any time that happened, she reported it to the nurse. Licensed practical nurse (LPN) #3 was interviewed on 7/31/24 at 9:15 a.m. LPN #3 said Resident #70 was very nice and was independent with her cares. He said she was never physically or verbally aggressive towards others. He said Resident #28 could get verbally aggressive toward staff and other residents. He said Resident #28 had interventions on her care plan that included behavior monitoring and offering emotional support. The SSD was interviewed on 7/31/24 at 9:30 a.m. The SSD said she completed the staff, resident and witness interviews for each abuse investigation. She said Resident #28 did not remember either incident. She said Resident #70 accidently hit Resident #28 on 5/3/24. She said a registered nurse assessed each resident for injuries and there were none. The NHA was interviewed on 7/31/24 at 9:45 a.m. The NHA said she was the abuse coordinator so all allegations of abuse were reported to her. She said she made sure all residents involved in resident to resident altercations were separated and free from injuries. She said after the incident on 7/19/24, each resident was placed on 15-minute checks for 24 hours. She said she reported the incidents to the state and the police. She said after each incident, care plans should have been updated.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on observations, record review and interviews, the facility failed to ensure two (#65 and #180) of five residents reviewed for assistance with activities of daily living (ADL) received fingernail care out of 49 sample residents. Specifically, the facility failed to: -Ensure Resident #65 received scheduled showers according to his preference; and, -Ensure Resident #180's fingernails were trimmed and cleaned. Findings include: I. Facility policy and procedure The Shower/Bath policy, revised February 2018, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:35 p.m. The policy read in pertinent part, The purpose of this procedure is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin Facility staff shall document the following: -Date and time the shower/bath was performed; -How the resident tolerated the shower/bath; -If the resident refused the shower/bath, the reason(s) why and the interventions taken; and, -Notify the supervisor if the resident refuses a shower/bath. The Fingernail Care policy, revised February 2018, was provided by the NHA on 7/31/24 at 4:35 p.m. The policy read in pertinent part, The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care includes daily cleaning and regular trimming for prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring their skin. Notify the supervisor if a resident refuses nail care. II. Resident #65 A. Resident status (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #65, age greater than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), Parkinson's disease (nerve damage to the brain causing uncontrollable movements), rheumatoid arthritis and dementia. The 5/3/24 minimum data set (MDS) assessment revealed the resident had mild cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. He required substantial to maximal assistance with bathing, toileting, mobility and personal hygiene. B. Resident interview and observations On 7/29/24 at 9:15 a.m. Resident #65 was in his room laying down in bed. He had white facial hair on his entire upper lip and around and below his chin. The resident said he would like to take a shower and shave. Resident #65 was interviewed again on 7/30/24 at 10:34 a.m. Resident #65 said he did not know when he was scheduled to receive showers. He said the staff would inform him when it was his shower day. The resident said he had not had a shower for a long time. He said the staff were usually busy and he did not want to bother them. Resident #65 said he would prefer to have a shower two times a week. C. Record review The activities of daily living (ADL) care plan, revised 2/26/24, revealed Resident #65 had an ADL self-care performance deficit related to Parkinson's disease. The care plan revealed the resident was dependent on staff with bathing/shower and required substantial to maximal assistance with showers/bathing. -The care plan did not include the resident's shower preferences. -A review of the resident's electronic medical record (EMR) revealed the resident's shower preferences were not documented. The May 2024 (5/1/24 to 5/31/24) certified nurse aide (CNA) shower documentation revealed Resident #65 received a bed bath on four out of seven shower opportunities. The June 2024 (6/1/24 to 6/30/24) CNA shower documentation revealed Resident #65 received four showers out of seven opportunities. The July 2024 (7/1/24 to 7/31/24) CNA shower documentation revealed Resident #65 received two showers out of nine shower opportunities. III. Resident #180 A. Resident status Resident #180, age greater than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included Alzheimer's disease, dementia, hemiplegia and hemiparesis (a severe and mild loss of strength), COPD, muscle weakness and pain. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/3/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. She was dependent on staff and required maximum assistance with transfers, dressing, eating, toileting and personal hygiene. The MDS assessment indicated the resident did not have behaviors and did not reject care. B. Resident interview and observations On 7/29/24 at 10:11 a.m., Resident #180's fingernails were long and discolored. The resident's fingernails were visibly soiled and had a dark substance under several nails. Resident #180 was interviewed on 7/30/24 at 4:16 p.m. The resident said her fingernails were long and nasty. She said she preferred them short and trimmed. On 7/30/24 at 4:26 p.m., Resident #180's fingernails were long and visibly soiled. A dark substance was still present under several nails. The resident's index fingernail was chipped. C. Record review The ADL care plan, revised 12/27/23, revealed Resident #180 had an ADL self-care performance deficit related to activity intolerance, Alzheimer's disease, confusion, dementia, fatigue, limited range of motion, and pain. The interventions included checking the length of the resident's nails and trimming and cleaning them on shower days and as necessary. -A review of the CNA nail care task documentation from 7/1/24 to 7/31/24, revealed nail care was not provided to the resident on 7/3/24, 7/6/24, 7/10/24, 7/13/24, 7/17/24, 7/20/24, 7/25/24, and 7/28/24. IV. Performance improvement plan (PIP) The shower PIP was provided by the director of nursing (DON) on 7/31/24 at 11:00 a.m. The shower PIP revealed a shower audit was completed on 6/11/24 and identified a lack of documented showers noted in residents' plan of care (POC). The PIP identified the root cause as a lack of staff accountability and education. Interventions included a whole house audit of the bathing/shower schedule to ensure it was resident-centered based on preferences, education was to be provided to all nursing staff regarding shower schedules and the shower schedule was to be updated according to resident preference. -There was no documentation to indicate the facility was continuing to audit resident showers to ensure the PIP was effective and staff was completing resident showers consistently. V. Staff interviews CNA #1 was interviewed on 7/31/24 at 2:15 p.m. CNA #1 said Resident #65 required one-person extensive assistance with his showers. She said the resident would say he needed a shower but when offered to him he would refuse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 said long fingernails could cause injuries such as skin tears and could carry bacteria that could cause infections. She said showers were important for dignity and to avoid the spread of bacteria. Licensed practical nurse (LPN) #2 was interviewed on 7/31/24 at 2:25 p.m. LPN #2 said Resident #65 and Resident #180 were dependent on staff and required extensive assistance with their ADLs. LPN #2 said the nursing staff were responsible for providing fingernail care and showers for all dependent residents. LPN #2 said Resident #180's fingernails were extremely long and dirty. She said she could not locate Resident #65's shower preference sheet. LPN #2 said she did not know why Resident #180 was not receiving nail care. LPN #2 said she would immediately assist the CNA to provide nail care to prevent any injuries to the resident. The DON was interviewed on 7/31/24 at 2:40 p.m. The DON said when the CNAs documented NO in the CNA bathing task record, it meant the care was not provided. She said NA meant not applicable. She said if a resident refused a bath or shower, the CNA would have to reattempt and if the resident continued to refuse the care then the CNA would have to inform the nurse. The DON said she became aware showers were not being completed as scheduled by the facility for most of the residents when a shower audit was conducted on 6/11/24. She said there was an ongoing shower PIP, however she did not know why some residents were still missing showers. The DON said the nursing staff were responsible for ensuring nail care was provided on shower days and as necessary for all residents. She said she did not know the reason showers were still being missed. The DON said she would immediately re-evaluate the ongoing shower PIP and monitor for staff compliance.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure one (#12) of six residents reviewed for activities out of 49 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 #12 was provided opportunities to participate in one-to-one staff visits or attend small group activities in accordance with his comprehensive plan of care. Findings include: I. Facility policy The Activity Schedule policy, revised 3/14/23, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. It read in pertinent part, Purpose: Activities provide meaning, purpose and independence, all of which are necessary to maintain a positive quality of life, Activities will be designed to meet and support the participants' physical, mental, intellectual and psycho-social well-being, Activities will create opportunities for each participant to have a meaningful life by supporting their domains of wellness (security, autonomy, growth, connectedness, identity, joy and meaning). Activities will be designed to meet participants' best ability to function, incorporating their strengths and abilities. II. Resident #12 A. Resident status Resident #12, age 75, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, aphasia (language disorder affecting ability to communicate), Parkinson's disease, Alzheimer's disease, multiple sclerosis and dysphagia (difficulty swallowing). The 7/23/24 minimum data set (MDS) assessment revealed the resident had short-term and long-term memory impairment and required assistance in making decisions for daily life. He was dependent on staff for all activities of daily living (ADL). The assessment indicated his activity preferences included listening to music and religious activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations On 7/29/24 at 2:45 p.m. Resident #12 was lying in bed. Music was playing on the radio but it was difficult to hear over the oxygen concentrator and fan in his room. The television in his room was off. At 4:52 p.m. the resident was lying in bed. The radio was turned on. On 7/30/24 at 8:54 a.m. Resident #12 was lying in bed. The radio was playing in his room. -At 12:04 p.m. Resident #12 was awake and sitting up in his wheelchair. The radio was playing but it was difficult to hear with the fan running. -At 1:28 p.m. Resident #12 was awake, sitting in his wheelchair and the radio was on. -At 2:45 p.m. Resident #12 was lying in bed awake. The radio was on. -At 3:29 p.m. Resident #12 was lying in bed with his eyes closed. The radio was on. On 7/31/24 at 8:34 a.m. Resident #12 was lying in bed awake. The radio was turned on. -At 11:08 a.m. Resident #12 was up in his wheelchair with his eyes closed. The radio was turned on. -At 3:06 p.m. Resident #12 was lying in bed awake. The television was turned on. C. Record review The activity care plan, revised 5/14/24, documented Resident #12 enjoyed leisure time in his room relaxing, and watching the news, sports or cartoons on television. It indicated he enjoyed people watching in the common area. Resident #12 responded best to small sensory groups or observing small group activities. Resident #12 sometimes attended religious services or listened while activity staff read devotionals to him. -The care plan did not indicate Resident #12 enjoyed listening to the radio, however, multiple observations during the survey revealed was in his room with no activity other than the radio being turned on. The activity care plan goal, revised 7/27/24, documented Resident #12 should receive one to one visits with activities staff two to three times per week (eight to 12 times per month) and to join group activities of his choice two times per week as desired and tolerated. -According to the activity documentation, one to one visits were provided to Resident #12 six out of 13 opportunities in May 2024, five out of 12 opportunities in June 2024 and three out of 13 opportunities in July 2024. There were no refusals by the resident documented. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-According to the group activity documentation, Resident #12 did not attend any group activities from 6/15/24 through 7/30/24. It did not indicate that Resident #12 had refused, however, he was documented as being unavailable. III. Staff interviews The activity director (AD) was interviewed on 7/30/24 at 10:35 a.m. The AD said the activity staff provided one to one visits to residents who were isolated, unable to leave their room or who did not like to go to group activities. She said one to one visits should be documented as an intervention in the care plan and documented in progress notes. The AD said Resident #12 was on a one to one program and he was receptive to receiving visits. She said the activity staff were documenting one to one visits on paper and she would look for that documentation for Resident #12. The AD said Resident #12's television did not work. The AD was interviewed again on 7/31/24 at 11:49 a.m. The AD said the activity department was not meeting Resident #12's activity goal and she developed a performance improvement plan (PIP) yesterday (7/30/24). The AD said she would check on his television to see if it had been fixed. She went to Resident #12's room and turned on the television. The AD reported the television was working and said she had assumed it was not working. Certified nurse aide (CNA) #4 was interviewed on 7/31/24 at 12:00 p.m. She said Resident #12 enjoyed listening to music and listening to staff talk to him. CNA #4 said he followed instructions and followed the staff with his eyes. -However, listening to music was not one of Resident #12's care planned activities of interest. The AD and the activity assistant (AA) were interviewed on 7/31/24 at 1:16 p.m. The AA said she documented Resident #12 was unavailable for group activities because he was in bed. She said Resident #12 could not physically participate in group activities due to his immobility. The AD said the activity staff should have offered group activities to Resident #12 and brought him to observe and listen. The AD said the activity staff could assist Resident #12 to participate in physical activities. The NHA was interviewed on 7/31/24 at 2:18 p.m. The NHA said each resident's comprehensive care plan should include one to one visits if it was identified as a need. She said the AD should have a list of those who required one to one activity visits. The NHA said if the care plan goal was to provide two to three visits per a week then the documentation should reflect the visits occurred or the resident refused.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interview, the facility failed provide treatment and services in accordance with professional standards of practice for one (#9) of one resident out of 49 sample residents. Specifically, the facility failed to ensure Resident #9 received quality care when the on-call physician did not return calls upon Resident #9 experiencing a change of condition. Findings include: I. Facility policy The Choice of Attending Physician policy, revised February 2021, was received from the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. It documented in pertinent part, The attending physician must be monitoring changes in the resident's medical status, providing consultation or treatment when called by the facility, overseeing the plan of care, prescribing an appropriate medical regimen, providing timely information about the resident's condition and medical needs to the resident, representative and interdisciplinary team and visiting the resident at appropriate intervals. II. Resident #9 A. Resident status Resident #9, age 77, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (lung disease restricting airflow and breathing problems), pulmonary hypertension (high blood pressure in lungs), dependence on supplemental oxygen, hypertensive heart disease with heart failure (heart failure from high blood pressure) and hypertension (high blood pressure). The 5/21/24 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. She required partial assistance with transferring, dressing, toileting and bathing. B. Record review A nurse progress note dated 6/4/24 at 5:16 p.m. documented Resident 9's condition had changed and was deteriorating. It read that the resident continued to have a non-productive cough, which caused the resident to gag. PO2 (partial oxygen pressure) was 90% (percent) on 3 liters per minute (lpm) of oxygen. Resident #9's lung sounds had inspiratory and expiratory wheezing (whistling sound caused by narrowing airway). The nurse called the on-call provider two times to discuss the resident's condition. She reached voicemail both times. She left extensive messages to call the nurse back for treatment orders. -The on-call physician never returned the nurses call to provide further instruction of care for Resident #9. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse called the retired medical director due to the on-call physician not calling back after two extensive messages were left. A chest x-ray was ordered by the retired medical director on 6/4/24. Resident #9 went to the emergency roiagnom on [DATE] and was discharged back to the facility on [DATE]. Documentation from the hospitalization on [DATE] revealed Resident #9 was diagnosed with acute on chronic heart failure (inadequate pumping of blood through heart), pneumonia (infection in the lungs), chronic obstructive pulmonary disease, chronic anemia (low red blood cell production) and renal insufficiency (poor kidney functioning). A physician's note from the retired medical director dated 6/5/24 at 5:46 p.m. read in pertinent part, I asked nursing to call [the resident's primary care physician], to discuss the case with her. Chest x-ray showed findings consistent with congestive heart failure (heart failed to pump blood efficiently). Pneumonia could not be ruled out. I asked nursing to call back if the on-call (physician) did not call back within 1-2 (one to two) hours, as is the standard of care in our community long term care settings. This patient (Resident #9) will need a physician visit this week to ensure that she is improving. That responsibility belongs to [the primary care physician] and her team. A nursing note dated 6/16/24 at 12:56 a.m. documented Resident 9's condition had changed again and continued to deteriorate. It read that the resident's partial oxygen pressure was at 77% (normal is greater than 90%) and she was coughing and having trouble breathing. Resident #9 was sent to the emergency room and arrived back to the facility on [DATE] at 1:49 p.m. A physician's progress note, dated 6/16/24 at 12:18 p.m., was written by Resident #9's primary care physician. The note indicated 6/16/24 was the first time the new physician had seen and evaluated the resident. The note documented Resident #9 was transferring care to (name of provider group) for medical management. III. Staff interviews The director of nursing (DON) was interviewed on 7/31/24 at 11:20 a.m. The DON said the corporation had made a decision to change medical groups at the facility. She said the residents were not informed, nor was their consent obtained. Cross reference F555: the facility failed to inform and obtain consent from the residents and/or their responsible party when the corporation changed primary medical groups. The DON said it took over a month for the new medical group to enter the facility and see residents. She said the new medical group would not return calls to nursing overnight or on the weekends. She said she directed the nurses to contact the retired medical director (RMD) to receive care instructions if they had not received a call back within 15 minutes. She said she was frustrated and the nurses on the floor were frustrated the new physician group would not return calls after hours. The DON said it had the potential for negative outcomes for residents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RMD was interviewed on 7/31/24 at 11:30 a.m. The RMD said the corporation of the facility decided to change primary medical groups in the facility, along with taking over all of his residents without the resident's or their responsible parties' consent. The RMD said the nurse had reached out to him on 6/4/24 for treatment orders for Resident #9 since the on-call physicians did not call her back after leaving multiple messages. He said since Resident #9 was not his patient, he did not feel comfortable treating her over the phone so he sent orders to send her out to the emergency room to get checked out. He said the professional standard of care would be to see a resident within 24 to 48 hours after hospitalization . He said it was his understanding that Resident #9 was not seen for more than 10 days after her initial change of condition on 6/4/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible for three (#35, #43 and #66) of eight residents out of 49 sample residents. Specifically, the facility failed to: -Ensure safe smoking practices were followed, including adequate supervision, for Resident #35; -Ensure a thorough investigation was completed after Resident #35 burned her fingers while smoking; and, -Ensure medications were not left at the bedside without appropriate self-administration assessments for Resident #35, Resident #43 and Resident #66. Findings include: I. Facility policy and procedure The Smoking policy, dated 5/10/23, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. It read in pertinent part, Supervised smokers shall not be permitted to smoke without the direct supervision of a designated staff member, family member or volunteer. Direct supervision will be provided throughout the entire smoking period. The Medication Administration policy, dated 2/29/24, was provided by the NHA on 7/31/24 at 4:44 p.m. It read in pertinent part, Medications are administered in accordance with written orders of the attending physician or physician extender, Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with the guidelines for self-administration of medication. The Self-Administration of Medication policy, dated February 2021, was provided by the NHA on 7/31/24 at 4:44 p.m. It read in pertinent part, As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Resident #35 A. Resident status Resident #35, age less than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke), dysphagia (difficulty swallowing) following cerebral infarction, bipolar disorder, post-traumatic stress disorder and ataxia (neurological disorder causing lack of coordination and tremors). The 7/16/24 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 indicated Resident #35 needed set-up assistance for eating and substantial assistance for personal hygiene and dressing. B. Resident observations On 7/29/24 at 5:48 p.m. a medication cup containing three medication capsules was observed on Resident #35's overbed table. The resident was sitting in her wheelchair at the table waiting for her supper. On 7/31/24 at 8:31 a.m. a medication cup containing three medication capsules was observed on Resident #35's overbed table. The resident said it was her Creon (a medication used to treat insufficient pancreas function) and the night nurse left it for her to take with breakfast. Resident #35 was observed taking the medications without assistance. C. Resident interviews Resident #35 was interviewed on 7/29/24 at 2:44 p.m. She said she burned her fingers while smoking about a month ago (June 2024). Resident #35 said when she burned her fingers she was smoking a cigarette and was unsupervised. Resident #35 was interviewed again on 7/31/24 10:52 a.m. Resident #35 said the nurses brought her Creon medication and left it on her table because she wanted it right when her meal came and the nurse was usually in the dining room at that time. She said sometimes she could take it herself and sometimes the nurse had to come back and help her due to her tremors. Resident #35 said usually stayed in her room until she took the medication. She said if she left her room before she took the medications, her roommate watched the pills for her. D. Record review The July 2024 CPO included a physician's order, dated 4/2/24, to give Resident #35's Creon to keep at bedside with meals so the resident could take the medication after the first bites of food. -The order was discontinued on 7/29/24, during the survey. -A review of Resident #35's electronic medical record (EMR) did not reveal a self-administration assessment was completed for the resident to self-administer the Creon, nor was it indicated on the resident's comprehensive care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The smoking assessment, completed 6/7/24 indicated Resident #35 was an unsafe smoker and required supervision. According to a progress note, dated 6/10/24, Resident #35 reported two burns to the nurse. The burns were located on her right second finger measuring 1 centimeter (cm) by 0.8 cm by 0.2 cm and on her right third finger measuring 3 cm x 1 cm x 0 cm. The risk management report, completed 6/10/24, indicated Resident #35 said she burned herself while smoking but did not know when it happened. According to the report, the resident obtained cigarettes from other sources and smoked on her own at times. -There was no documentation to indicate the facility had thoroughly investigated how or when Resident #35 burned her fingers when smoking. E. Staff interviews Licensed practical nurse (LPN) #5 was interviewed on 7/31/24 at 3:01 p.m. LPN #5 said she was the nurse for Resident #35. She said nurses left the Creon medication for Resident #35 so she could take it when her meal arrived. LPN #5 said the night nurse left the medication on the overbed table this morning (7/31/24) around 7:25 a.m. -Resident #35 was not observed taking the medication until 8:31 a.m. The DON was interviewed on 7/31/24 at 2:35 p.m. The DON said Resident #35 came to her and showed her the burns on her fingers on 6/10/24. The DON said she did not know how the burns happened because Resident #35 was only supposed to be smoking electronic cigarettes at that time. The DON said the facility did not interview the staff who had taken Resident #35 out for smoke breaks to determine if she was smoking regular cigarettes prior to the burns being found. The DON said all of Resident #35's smoking materials should be locked up in a lock box or with the nurse and she should not have a lighter. The DON said Resident #35 sometimes got cigarettes from her roommate or other residents and she sometimes left the building with friends and would smoke regular cigarettes with them. The DON was interviewed again on 7/31/24 at 3:07 p.m. The DON said the nurses were leaving the Creon medication at the bedside for Resident #35 about one half hour before meals. However, the DON said the physician's order had been discontinued on 7/29/24 because Resident #35 was too shaky and needed assistance with taking her medication. The DON said the Creon should not have been left at the bedside today (7/31/24). -The Creon was left at the bedside 7/29/24 and 7/31/24, after the order had been discontinued. Certified nurse aide (CNA) #7 was interviewed on 7/31/24 at 1:10 p.m. CNA #7 said she knew who the regular smokers were and which residents needed a smoking apron. She said there was not a list of who was a supervised smoker because all smokers were to be supervised and could go out only during smoking times. CNA #7 said Resident #35 was a supervised smoker when she burned her fingers. CNA #7 said she did not know how it happened but said Resident #35 was only able to smoke electronic cigarettes now. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was interviewed on 7/31/24 at 2:11 p.m. The NHA said a smoking assessment was completed quarterly for all residents. The NHA said if a resident was a safe smoker they could go outside to smoke anytime and they had a lock box in their room to keep smoking materials. The NHA said if a resident was determined to be an unsafe smoker the staff kept their smoking materials and they could go outside to smoke only at designated times with staff supervision. The NHA said staff must stay with the supervised smokers the entire time the residents were smoking. The NHA said she did not recall what was found on the accident investigation for Resident #35. 38185 III. Resident #43 A. Resident status Resident #43, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the July 2024 CPO, diagnoses included chronic kidney disease, post-traumatic stress disorder, major depressive disorder, anxiety disorder, low back pain and restless leg syndrome. The 7/2/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required set up assistance with activities of daily living (ADL). B. Resident interview and observations On 7/29/24 at 11:16 a.m. Resident #43 was lying in bed watching television. On the overbed table, next to the resident's bed, three different bottles of eye drops were observed, along with a bottle of nasal spray and dairy relief pills. Resident #43 said her eyes were really dry and she administered the eye drops daily. She said she used the nasal spray a couple of times per week and she took the dairy relief pills when she ate anything that consisted of dairy products. On 7/30/24 at 4:15 p.m. Resident #43 was lying in bed watching television. Resident #43 described the three bottles of eye drops as Systane Lubricant eye drops, Systane Gel eye drops and Eye Allergy Itch Relief (Olopatadine Hydrochloride Ophthalmic Solution). She said the Systane eye drops were given to her by her ophthalmologist and her family member provided her with the allergy eye drops. Resident #43 said she used both of the Systane eye drops after she was given the prescription eye drops by the nurse every day. Resident #43 said the nasal spray was Deep Sea Premium Saline, which she used when her allergies were acting up. She said she used the Dairy Relief Lactase Enzyme/Dietary Supplement whenever she consumed food with dairy products. During the interview with Resident #43, Resident #55, who had severe cognitive impairment and a documented history of wandering, entered Resident #43's room. Resident #55 was speaking Spanish and appeared aggressive. Resident #43 told Resident #55 to leave her room in Spanish. Resident #55 continued to come into the room, until Resident #43 continued to yell, vamanos, vamanos, vamanos. Resident #55 ended up leaving Resident #43's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #43 said Resident #55 and another resident would enter her room quite often. She said the two residents wandered up and down the hallways, entering everyone's rooms. Resident #43 said her roommate, Resident #66, tried to give her some Aspercreme spray, but she did not think it was right to use since she did not know what it was (see observations below for Resident #66). C. Record review -The July 2024 CPO did not reveal a physician's order for the Systane Lubricant eye drops, the Systane Gel eye drops, Eye Allergy Itch Relief eye drops, Deep Sea Premium Saline nasal spray or Dairy Relief Lactase Enzyme/Dietary. -A review of Resident #43's EMR did not reveal a self-administration assessment was completed for the resident to self-administer medications, nor was it indicated on the resident's comprehensive care plan. IV. Resident #66 A. Resident status Resident #66, age 71, was admitted on [DATE] and readmitted [DATE]. According to the July 2024 CPO, diagnoses included chronic respiratory failure with hypoxia (progressive condition that occurs when the airways to the lungs become damaged and narrow, restricting airflow and oxygen intake), polyneuropathies (damage to peripheral nerves), pain in the left shoulder and displaced fracture of the lateral end of the left clavicle. The 7/24/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with all ADLs. B. Resident interview and observations On 7/29/24 at 11:16 a.m. Resident #66 was lying in bed watching television. Resident #66 and Resident #43 were roommates. On Resident #66's overbed table, a can of Aspercreme Lidocaine maximum strength dry spray was observed with the lid off. Resident #66 said she used the Aspercreme Spray when she was having muscle pain. C. Record review -The July 2024 CPO did not reveal a physician's order for the Aspercreme Lidocaine Spray. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of Resident #66's EMR did not reveal a self-administration assessment was completed for the resident to self-administer the Aspercreme Spray, nor was it indicated on the resident's comprehensive care plan. V. Staff interviews LPN #5 was interviewed on 7/30/24 at 4:25 p.m. LPN #5 said she did not know if residents should have medications at the bedside. She said she did not know who was responsible for conducting self-administration assessments. LPN #5 said she was not sure if either Resident #43 or Resident #66 had a self-administration assessment. She said she did not know how to find that information. The DON was interviewed on 7/31/24 at 11:20 a.m. The DON said all medications kept at the bedside should have a physician's order for self administration, a self-administration assessment completed and be noted on the comprehensive care plan. She said all medications that the resident requested to have in their room should be kept in a lock box to ensure another resident did not access them by accident. The DON said Resident #43 did not have a physician's order to self-administer medications nor a physician's order for the eye drops, nasal spray and daily relief supplement. She said Resident #66 did not have a physician's order to self-administer medications nor a physician's order for the Aspercreme Lidocaine spray. The DON said the facility did not complete self-administration assessments for Resident #43 and Resident #66. She said the comprehensive care plan did not include self-administration for Resident #43 and Resident #66. The DON said the facility was in the process of obtaining physician's orders for the medications, completing the self-administration assessments, updating the comprehensive care plans and providing lock boxes for Resident #43 and Resident #66.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on record review and interviews, the facility failed to manage pain for one (#43) of two residents out of 49 sample residents in a manner consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Specifically, the facility failed to provide pain relieving cream to Resident #43 as ordered by the physician. Findings include: I. Facility policy and procedure The Pain Management policy and procedure, dated May 2023, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. It revealed in pertinent part, Pain is subjective and is what the resident says it is, existing when and where the resident says it does. Around the clock dosing for continuous pain, whether it be chronic or acute, is the key to effective pain management. Intermittent pain can be managed with intermittent analgesic administration. II. Resident #43 A. Resident status Resident #43, age 76, was admitted on [DATE] and readmitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included chronic kidney disease, post-traumatic stress disorder, major depressive disorder, anxiety disorder, low back pain and restless leg syndrome. The 7/2/24 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. She required set up assistance with activities of daily living (ADL). The assessment indicated the resident received a scheduled pain medication regimen and the resident had almost constant pain. The pain occasionally made it hard for her to sleep at night and frequently limited her daily activities. The assessment indicated her worst pain during the past five days of the assessment period was 3 out of 10. B. Resident interview Resident #43 was interviewed on 7/29/24 at 11:16 a.m. Resident #43 said she had arthritis which caused her pain daily. She said she had arthritis pain in her wrists, neck, lower back, hips and arms. She said she was supposed to receive a cream four times per day, however, she said she had not received it today (7/29/24). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #43 was interviewed again on 7/30/24 at 4:15 p.m. She said she still had not received her arthritis cream. She said she had a hard time with licensed practical nurse (LPN) #5 administering her medications. She said she was not surprised she had not received the arthritis cream because that particular nurse was working. Resident #43 said the arthritis cream really helped with her pain but since she had not received it she felt achy all over. C. Record review The pain care plan, initiated on 6/28/23 and revised on 7/12/24, revealed Resident #43 reported she had pain with contributing factors such as kidney disease, depression, osteoporosis and restless leg syndrome. The interventions included administering analgesia per physician's orders. The 6/30/24 pain evaluation documented the resident had chronic lower back pain and said she had been told she had arthritis. She described the pain as throbbing. It indicated the resident experienced pain to the left hip, left knee, lower back, neck and shoulders. The resident's acceptable level of pain was 3 out of 10. The resident's pain was relieved by medication, relaxation, position changes and diversional activities. It indicated that the resident was on a scheduled pain medication regimen with scheduled Tylenol and she had scheduled Biofreeze gel four times per day. The July 2024 CPO documented the following physician's orders: Biofreeze External Gel 4% (percent) topical analgesic: apply to neck, lower back and hips topically four times a day for pain, ordered 4/11/24. The July 2024 medication administration record (MAR) documented that the resident was administered the Biofreeze External Gel four times on 7/29/24 and three times on 7/30/24. -However, according to the resident, who was alert and oriented, she had not received the topical analgesic (see resident interview above). III. Staff interviews LPN #5 was interviewed on 7/30/24 at 4:25 p.m. LPN #5 said she administered Resident #43 received Biofreeze three times per day. She said she could not remember if she had administered the medication that day (7/30/24). She said Resident #43 was alert and oriented and the resident was usually right which meant she probably did not administer the medication that day. LPN #5 said the July 2024 MAR documented that the medication was given on 7/30/24. She said she should not have marked off the medication as given on the MAR when she did not administer the medication. LPN #5 pulled out the Biofreeze gel and began pumping it into a medication cup. She said she would call the physician and make a note in the resident's electronic medical record (EMR) that the medication was not given as indicated on the MAR. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 7/30/24 at 5:01 p.m. The DON said medications should be given as ordered by the physician. She said medications should not be signed off as given if they were not administered. The DON said LPN #5 should not have signed off the medication as given on the MAR if she did not administer the Biofreeze gel. She said she should have contacted the physician and made a note in the resident's EMR. She said she would conduct a medication error investigation and provide education immediately to LPN #5. The DON said she was concerned what other medications LPN #5 might not have administered but had signed off as she had.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review, and interviews, the facility failed to ensure it was free of a medication error rate of five percent (%) or greater. Specifically, the medication administration observation error rate was 8%, or two errors out of 25 opportunities for error. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 606-607, retrieved on 8/1/24, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. II. Facility policy and procedure The Medication Administration policy, dated 2/29/24, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:44 p.m. The policy read in pertinent part, Medications are administered in accordance with written orders of the attending physician or physician extender. Verify the medication label against the medication administration record (MAR) for accuracy of drug frequency, duration, strength, and route. Double-check the amount of medication to be administered. Medication is to be given in compliance with physician orders and or manufacturer's recommendations. III. Manufacturer's Guidelines According to the manufacturer's guidelines for Lexapro (escitalopram oxalate), retrieved on 8/1/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/021323s047lbl.pdf, (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lexapro is an orally administered selective serotonin reuptake inhibitor (SSRI) used to treat depression and anxiety. The recommended dose for elderly patients is 10 milligrams. According to the manufacturer's guidelines for levothyroxine sodium, retrieved on 8/1//24 from https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=a8db0f7d-8863-9309-e053-2995a90a284a&type=display, Administer once daily, preferably on an empty stomach, one half to one hour before breakfast. IV. Observations and interviews On 7/31/24 at 9:21 a.m. licensed practical nurse (LPN) #2 was preparing and administering medications for Resident #45. Resident #45 had a physician's order for Lexapro five milligrams (mg) two tablets by mouth one time a day, ordered on 7/4/24. The medication was scheduled for 8:00 a.m. Resident #45 had a physician's order for levothyroxine sodium 150 micrograms (mcg) one tablet by mouth in the morning for hypothyroidism, ordered on 4/18/24. The medication was scheduled for 8:00 a.m. LPN #2 took the card of Lexapro from the medication cart and punched one five mg tablet into the medication cup. She administered one tablet to Resident #45. Upon prompting when LPN #2 returned to the medication cart, she reread the physician's order. LPN #2 said the physician's order was for two tablets and she should have given Resident #45 two tablets. LPN #2 obtained another five mg tablet of Lexapro from the medication cart and administered it to the resident. LPN #2 took the levothyroxine sodium 150 mcg from the medication cart and administered it to Resident #45 at 9:29 a.m. Resident #45 had an empty breakfast plate on his bedside table and said he finished breakfast. The levothyroxine sodium was scheduled to be administered at 8:00 a.m., however, LPN #2 administered the medication at 9:29 a.m., which was 89 minutes after it was scheduled and after the resident had already eaten breakfast. LPN #2 said levothyroxine sodium should be given on an empty stomach. V. Additional staff interviews The director of nursing (DON) was interviewed on 7/31/24 at 4:00 p.m. The DON said levothyroxine sodium should be administered on an empty stomach. She said medications should be administered according to the physician's order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50853 Based on observations and interviews, the facility failed to ensure medications and biologicals were properly stored and labeled in accordance with professional standards in three of five medication carts and one of two medication storage rooms. Specifically, the facility failed to: -Ensure medications were properly labeled with open dates; and, -Ensure expired medications were removed from the medication carts and the medication storage room. Findings include: I. Professional reference The United States Food and Drug Administration (USFDA) (2/8/21) Don't Be Tempted to Use Expired Medicines, was retrieved on 8/6/24 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it. II. Observations On 7/31/24 at 8:48 a.m. the medication cart on the 200 hallway was observed with licensed practical nurse (LPN) #2. The following item was found: -An open Tresiba FlexTouch insulin pen 100 units/milliliter was not labeled with the date it was opened. On 7/31/24 at 9:47 a.m. the medication cart on the 500 hallway was observed with LPN #4. The following item was found: -One bottle of liquid haloperidol 2 milligrams (mg)/milliliter (ml) that expired on 6/24/24. On 7/31/24 at 10:14 a.m. the medication storage room was observed with the director of nursing (DON). The following item was found in the refrigerator: -Three one mg vials of lorazepam liquid 2 mg/ml single dose that expired on 4/18/24. On 7/31/24 at 11:24 a.m. the medication cart on the 300 hallway was observed with LPN #3. The following items were found: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One bottle of Tylenol 500 mg that expired in June 2024; and, -One bottle of Stress Formula vitamin supplement that expired in April 2024. On 7/31/24 at 11:46 a.m. the medication cart on the 200 hallway was observed with LPN #2. The following item was found: -One vacutainer blood collection needle that expired 10/31/23. III. Staff interviews LPN #2 was interviewed on 7/31/24 at 8:48 p.m. LPN #2 said the insulin pen should have been dated when it was opened. LPN #2 said she was unsure how long an insulin pen was good for after it was opened. LPN #3 was interviewed on 7/31/24 at 11:24 a.m. LPN #3 said he checked for expired medications in the cart. He said the expired medications should have been removed from the medication cart. The director of nursing (DON) was interviewed on 7/31/24 at 4:00 p.m. The DON said the expired medications and supplies should have been removed from the medication storage room refrigerator and medication carts. The DON said the insulin pen should have been dated when it was opened.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47150 Based on observations, record review and interviews, the facility failed to ensure residents consistently receive food prepared by methods that conserved nutritive value and was palatable in taste, texture, appearance and temperature. Specifically, the facility failed to ensure the residents' food was palatable in taste, texture, appearance and temperature. Findings include: I. Resident interviews Resident #24 was interviewed on 7/29/24 at 9:00 a.m. Resident #24 said he preferred eating in his room. He said the room trays were always delivered about 15 minutes to 45 minutes late. Resident #24 said he received a texture modified diet and sometimes the staff delivered the wrong diet tray to him. Resident #21 was interviewed on 7/29/24 at 9:02 a.m. Resident #21 said she only ordered hamburgers and hot dogs from the kitchen because the rest of the food did not taste good. She said the hot dogs and hamburgers were usually served cold. She said they put barbeque sauce on the hamburgers and it did not taste right. Resident #51 was interviewed on 7/29/24 at 10:14 a.m. Resident #51 said the food tasted terrible and was always served late. He said the staff would always forget to provide condiments and he would have to ask the staff to get some for him. He said the tray sat longer and got cold while he waited for staff to bring him the condiments. Resident #40 was interviewed on 7/29/24 at 10:23 a.m. Resident #40 said the food tasted bad and was always served late. He said he went to dialysis every Monday, Wednesday and Friday. He said he left the facility at 4:30 p.m. and did not return until 9:45 p.m. He said the kitchen staff often forgot to make his dinner to take with him for his appointments and they would then offer him a peanut butter sandwich. Resident #40 said the sandwich often did not hold him and he would return to the facility feeling hungry. He said he got sick at the entrance of the facility when he returned from dialysis due to not eating enough food before his appointments. Resident #66 was interviewed on 7/29/24 at 11:19 a.m. Resident #66 said the food did not taste right and had no flavor. She said the drinks were watered down. Resident #5 was interviewed on 7/31/24 at 2:15 p.m. Resident #5 said the food was awful and tasted bad. He said he ate his meals in his room and the food was delivered to him cold. Resident #5 said the encrusted pork loin was overcooked and tasted dry. He said the gravy did not taste right because it tasted as if it was missing seasoning. II. Test tray (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A test tray for a regular diet and pureed diet was evaluated by four surveyors immediately after the last resident had been served their room tray for lunch on 7/31/24 at 1:22 p.m. The regular texture test tray consisted of encrusted pork loin, mashed potatoes, cabbage vegetables, diner rolls and sweet potatoes. The following observations were made: -The encrusted pork loin was dry; -The mashed potatoes were bland; -The gravy on the mashed potatoes and the pork loin tasted bland and was watery; and, -The cabbage vegetables were bland and mushy. The pureed texture test tray consisted of puree pork loin, mashed potatoes, puree cabbage, puree sweet potatoes with gravy and pureed green peas. The following observations were made: -The mashed potatoes tasted bland; -The gravy was watery and tasted bland; and, -The pureed pork loin tasted mushy and dry. III. Staff interviews The dietary account director (DAM) and the regional dietary manager (RDM) were interviewed together on 7/31/24 at 1:50 p.m. The DAM said he noticed the encrusted pork loin was a little overcooked. He said, because it was almost time to begin serving lunch, he did not have time to fix it. The DAM said the kitchen was running out of gravy in the middle of serving lunch so cook (CK) #1 asked him to prepare additional gravy. He said the additional gravy came out a little watery because it was prepared very quickly. The DAM said the cooks should always ensure they had enough of every menu item according to the census of the facility. The DAM said the kitchen staff should always taste the food items they prepared for the residents to ensure the appropriate texture and taste were obtained before serving the food to the residents. The RDM said it was important to ensure the right food texture and taste were obtained to avoid residents not eating their food, which could help to prevent unwanted weight loss. The RDM said more education would be provided immediately to the kitchen staff in regards to food preparation and palatability. The nursing home administrator (NHA) was interviewed on 7/31/24 at 2:50 p.m. The NHA said more education would be provided immediately to all kitchen staff and a monitoring plan would be initiated to ensure staff complied with the facility's food preparation protocol.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47150 Based on observations, record review and interviews, the facility failed to ensure food items were stored and served under sanitary conditions in the main kitchen. Specifically, the facility failed to ensure staff correctly and accurately tested for the correct parts per million (ppm) of the dishwasher, chemical sanitizer solution of the three sink compartments and sanitizer buckets. Findings include: I. Professional reference According to The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 8/8/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view, Chemical sanitizers that are used to sanitize equipment and utensils shall be provided and available for use during all hours of operation. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times and be used in accordance with the Environmental Protection Agency (EPA) registered label use instructions. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. II. Facility policy and procedure The Warewashing Kitchen Sanitation policy, revised September 2017, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:35 p.m. It read in pertinent part, All dishware, serviceware, and utensils will be cleaned and sanitized after each use. The dining services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. Temperature and sanitizer concentration logs will be completed, as appropriate. III. Observations and interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/29/24 at 9:10 a.m., dishwasher (DW) #1 was in the dishwashing area working on filling a rack with dirty dishes to run through the dishwasher. DW #1 said the dish machine was a low temperature machine. He said he checked the chemical concentration of the machine at the beginning of his shift and documented the outcome on a test trip log hanging on the wall in the dishwashing room. DW #1 ran a test strip through the dishwasher and the strip registered 10 ppm. The DW said the solution tested 100 ppm in the morning (7/29/24) and the machine needed to be primed. DW #1 said the solution in the red and green buckets was used to clean equipment and surfaces in the food preparation area and the dining room. The solution in the bucket was tested with a test strip by the DW. The solution registered 10 ppm on the strip. Dietary aide (DA) #1 said she did not check the chemical concentration of the sanitizer when she filled the bucket with the sanitizer solution. The dietary account manager (DAM) said the kitchen had an automatic solution dispenser that mixed the solution with water. He said they did not tamper with the dispenser and would call (name of company) for all maintenance issues. The DAM said the staff used the machine to fill the red sanitizer buckets. He said the staff needed to test the solution each time they filled the buckets to ensure the strength of the solution was correct by testing the ppm. He said the kitchen staff should document the test strip result each time they filled the red sanitizer buckets, however, he said there was no test strip log for the red sanitizing buckets. At 9:30 a.m. the DAM tested the three sink compartment chemical sanitizer solutions with a test strip and it registered 200 ppm. The DAM said he called the (name of company) who were the manufacturers of the dispenser and the chemical sanitizing solution. DW#1 primed the dishwasher and completed another test strip which measured 100 ppm. IV. Record review A review of the July 2024 (7/1/24 to 7/29/24) sanitizing test strip log on 7/31/24 at 9:50 a.m. revealed the log was completed once a day in the morning. The label on the sanitizing chemical solution dispenser read (Oasis multi quat sanitizer) the concentration of the sanitizer should measure 150 ppm. The manufacturer's recommendation from the (name of company) technician was to test the ppm at least three times a day to ensure the accuracy of the chemical solution. V. Staff interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DAM and the regional dietary account manager (RDM) were interviewed together on 7/30/24 at 3:55 p. m. The DAM said he had noticed the testing strip was completed only once a day when he started as the manager a few weeks ago, which was contrary to the manufacturer's recommendation for testing at least three times per day. The DAM said he was now aware of the recommendation and would follow the manufacturer's recommendations of running the test strip at least three times a day. The RDM said the facility would immediately educate the kitchen staff on how to test the quat solution correctly and would ensure testing strips were completed and documented accurately. The NHA was interviewed on 7/31/24 at 2:50 p.m. The NHA said the kitchen staff should ensure the chemical sanitizing solution was measured accurately before using it on equipment and surfaces in the food preparation area and in the dining room where residents ate. She said testing needed to be conducted accurately to ensure surfaces were sanitized appropriately to avoid contaminating the food preparation areas. The NHA said she would immediately reach out to (name of company) to offer additional training for the kitchen staff on the proper use and maintenance of the dishwasher and the management of the testing strips.

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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** 50315 Based on observation, record review and interviews, the facility failed to establish a sanitary environment to help prevent the transmission of communicable diseases and infections on three of five hallways. Specifically, the facility failed to: -Ensure nursing staff completed proper hand hygiene during medication pass; and, -Ensure housekeeping completed proper hand hygiene when cleaning resident rooms. Findings include: I. Failure to ensure nursing used proper hand hygiene during medication pass A. Observations On 7/29/24 at 4:24 p.m. registered nurse (RN) #1 was observed preparing and administering medication for three residents in the 300 hall. -RN #1 did not perform hand hygiene prior to preparing medication or between administering medication to the residents. On 7/30/24 at 11:50 a.m. licensed practical nurse (LPN) #3 was observed preparing and administering medication to four residents in the 300 hall. -LPN #3 did not perform hand hygiene prior to preparing or between administering medication to the residents. B. Staff interviews RN #1 was interviewed on 7/29/24 at 4:24 p.m. RN #1 said she should have performed hand hygiene between preparing medications for each resident. LPN #3 was interviewed on 7/30/24 at 11:50 a.m. LPN #3 said he should have performed hand hygiene between preparing medications for each resident. The director of nursing (DON) was interviewed on 7/31/24 at 4:00 p.m. The DON said the nurses should perform hand hygiene when preparing and administering medications. She said hand hygiene should be performed between preparing medications for each resident. II. Failure to ensure housekeeping used the proper hand hygiene when cleaning resident rooms A. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Housekeeper (HSK) #1 was observed on 7/30/24 at 11:08 a.m. HSK #1 was beginning to clean room [ROOM NUMBER]. She cleaned the bathroom by wiping down the grab bar, wiping the toilet and cleaning the inside of the toilet. She disposed of the dirty rag. -Without changing gloves or performing hand hygiene, HSK #1 applied a clean mop head to the mop. She then mopped the bathroom. She disposed of the dirty mop head. -Without performing hand hygiene or changing her gloves, HSK #1 proceeded to sweep the room. She applied a clean mop head to the mop and mopped side B of the room. -She disposed of the dirty mop and applied a clean mop head to the mop without performing hand hygiene or changing her gloves She mopped side A of the room. She removed her gloves and performed hand hygiene when she was finished mopping the room. HSK #1 moved to the next room down the hallway and applied gloves. She cleaned the bathroom by wiping down the grab bar, wiping the toilet and cleaning the inside of the toilet. She disposed of the dirty rag. -Without performing hand hygiene or changing her gloves, HSK #1 applied a clean mop head to the mop. She then mopped the bathroom. She took the dirty mop head off and disposed of it. She then swept the room. She applied a clean mop head to the mop and mopped side B of the room. She disposed of the dirty mop and applied a clean mop head to the mop without changing gloves or performing hand hygiene. She mopped side A of the room. -HSK #1 failed to perform hand hygiene or change her gloves during the whole process of mopping the bathroom and then cleaning both sides of the room. B. Staff interviews The infection preventionist (IP) was interviewed on 7/31/24 at 10:00 a.m. The IP said the housekeeping staff should remove gloves, perform hand hygiene and apply new gloves between moving from room to room. She said they should have completed hand hygiene after cleaning the bathroom. 50853

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. 47150 Based on observations and interviews, the facility failed to provide adequate ventilation by means of mechanical ventilation for three of four resident shower rooms. Specifically, the facility failed to ensure exhaust fans in resident shower rooms were functioning efficiently. Findings include: I. Facility policy and procedure The Homelike Environment policy, revised February 2021, was provided by the nursing home administrator (NHA) on 7/31/24 at 4:35 p.m. The policy read in pertinent part, Residents are provided with a safe, clean, comfortable and homelike environment. The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting such as institutional odors. II. Observations An observation of the resident's environment was completed on 7/30/24 at 2:40 p.m. and 7/31/24 at 10:15 a.m. The exhaust fans in the shower rooms on the 300 hall, the 400 hall and the 600 hall had no audible sound and were not functioning effectively. The shower rooms had a strong urine odor and were humid. III. Staff interviews The maintenance supervisor (MS) and the NHA were interviewed together on 7/31/24 at 10:30 a.m. The MS said the exhaust fans and ventilation maintenance had not appeared on the system he used to track maintenance and repairs, so he was not aware the exhaust fans were not functioning appropriately. The NHA said the shower room exhaust fans should be in good working condition to eliminate odors in the resident's shower rooms. The NHA said she would immediately include the exhaust fans in the shower rooms as part of an ongoing quality improvement plan which would include periodic checks on all ventilation systems.